London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 27 NOVEMBER 2018 AT 10:00-15:00, 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/18/97** Oral	**Welcome and apologies** To welcome attendees and note any apologies received.	HL	
10.05	**2.**	**TB/18/98** Oral	**Declarations of interest** To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	3.	**TB/18/99** Attachment	**Minutes of the meeting held in public on 25 September 2018** To approve the minutes of the meeting held on 25 September 2018.	HL	Decision
	4.	**TB/18/100** Attachment	**Matters arising** To review the action schedule arising from previous meetings.	HL	Information
10.10	**5.**	**TB/18/101** Attachment	**Report from the Chair** To receive a report from the Chair.	HL	Information
10.20	**6.**	**TB/18/102** To follow	**Report from Chief Executive** To receive a report from the Chief Executive (CEO).	GE	Information
STRATEGY & PLANNING					
10.30	**7.**	**TB/18/103** Attachment	**People and Culture Strategy Refresh** To approve a refreshed People and Culture Strategy, reflecting the Trust-wide Strategy approved by the Board in April 2018	PG	Decision
10.45	**8.**	**TB/18/104** Attachment	**Workforce Race Equality Standard Action Plan (WRES)** To approve the Trust's WRES Action Plan.	PG, MB	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
11.00	**9.**	**TB/18/105** Attachment	**London Ambulance Service Strategy – Six Month Review** To receive information about the progress being made by the Trust against its Strategy agreed in April 2018.	AF, LB	Assurance
			BREAK		
QUALITY, PERFORMANCE AND ASSURANCE					
11.45	**10.**	**TB/18/106** Attachment Attachment Attachment Attachment To follow	**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) Logistics and Infrastructure Committee meeting on 09 October 2018** **(ii) Audit Committee meeting on 05 November 2018** **(iii) People and Culture Committee meeting on 08 November 2018** **(iv) Finance and Investment Committee meeting on 13 November 2018** **(v) Quality Assurance Committee meeting on 20 November 2018**	TdP	Assurance
12.15	**11.**	**TB/18/107** To follow	**Integrated Quality & Performance Report** To receive the integrated quality & performance report.	LB	Assurance
12.30	**12.**	**TB/18/108** To follow	**Board Assurance Framework and Corporate Risk Register** To receive the Board Assurance Framework and the Corporate Risk Register.	PH	Assurance
12.40	**13.**	**TB/18/109** Attachment	**Carter Report – high level overview of the opportunity** To review the Trust's response to the publication in September of the Lord Carter of Coles publication entitled the '*Operational productivity and performance in English Ambulance Trusts: Unwarranted variations' on 27 September 2018.*	LB	Decision

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
12.55	**14.**	**TB/18/110** Attachment	**Preparedness for departure from the European Union** To receive an update on the Trust's position on preparedness for departure from the European Union on 29 March 2019.	LB	Discussion
13.10	**15.**	**TB/18/111** Attachment	**Serious Incident Quarterly Thematic Report** To note an overview of the incidents reported and declared to the CCG, and a thematic analysis of serious incidents (SIs) submitted to the CCG and closed in Q2 2018/19.	TB	Discussion
13.20	**16.**	**TB/18/112** To follow	**CARU Annual Reports** To receive the summarised annual reports on Stroke, Cardiac Arrest and STEMI.	FW	Discussion
GOVERNANCE					
13.30	**17.**	**TB/18/113** To follow	**Report of the Trust Secretary – policies** To receive the Trust Secretary's report on a number of proposed changes to Trust policies.	PH	Decision
13.40	**18.**	**TB/18/114** Attachment	**Trust Board Forward Planner** To receive the Trust Board forward planner.	PH	Information
13.50	**19.**	**TB/18/115** Oral	**Questions from members of the public**	HL	Information
14.00	**20.**	**TB/18/116** Oral	**Any other business**	HL	Information
14.10	**21.**	**TB/18/117** Oral	**Review of the meeting** To consider: - Display of Trust values and behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge.	HL	Information
14.20	**22.**	**TB/18/118**	**Staff Story** To hear about the experiences of a Trust member of staff.		
14.50	**23.**		**Meeting close** The meeting of the Trust Board in public closes.	HL	

Timing	Item	Ref.	Owner	Status Assurance Decision Discussion Information
	Date of next meeting: The date of the next Trust Board meeting in public is on Tuesday 29 January 2019 at a venue to be confirmed.			

Additional reports, circulated for information only:

TB/18/119 Quality Report

TB/18/120 Health and Safety Update Report

London Ambulance Service NHS Trust

TRUST BOARD: Public meeting – Tuesday 25 September 2018

DRAFT Minutes of the public meeting of the Board held on 25 September 2018 at 10.00am in the Green Room at ETC Venues, Avonmouth House, 6 Avonmouth Street, London SE1 6NX

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
Jessica Cecil	JC	Associate Non-Executive Director
Jayne Mee	JM	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
Katy Crichton	KC	Freedom to Speak Up Guardian (until item 9)
Rita Phul	RP	Corporate Secretary

1. Welcome and apologies (TB/18/74)

1.1. The Chair welcomed all to the meeting.

2. Declarations of interest (TB/18/75)

2.1. There were no declarations of interest.

3. Patient Story (TB/18/90)

3.1. The Board was joined by a member of the public who shared her patient experience story.

3.2. The Board heard details of the incident, which related to the unacceptable treatment, conduct and behaviour of an experienced female paramedic attending an emergency call alongside a trainee. The patient had subsequently made a complaint to the Trust and had been satisfied with regard to the manner in which the complaint had been handled.

3.3. Members of the Board offered apologies on behalf of the Trust and the patient was told that lessons had been learnt and improved networks were now in place to provide appropriate support to staff and assist with managing stress, which could lead to inappropriate behaviours when treating patients.

3.4. The patient was further assured that these type of complaints were very much in the minority at the Trust, but that nevertheless, the patient should not have suffered this experience. The Chief Executive added that attitude and behavioural complaints were less than 1 in every 1000 complaints received; nevertheless such complaints were taken very seriously.

3.5. Board members thanked the patient for sharing her story, emphasising that her feedback was valuable and would assist the Trust in improving its service.

4. Minutes of the meeting held in public on 31 July 2018 (TB/18/76)

4.1. The minutes of the Trust Board meeting held in public on 31 July 2018 were approved as a true and fair record of that meeting, subject to the amendments below:

4.1.1. The first sentence of paragraph 6.3 (Minute ref TB/18/54) should be amended to read ”Board members discussed the Friends and Family team results and commended LAS for the positive response and net promoted scores, particularly in relation to place of work and quality of care.”

4.1.2. Paragraph 9.3 (Minute ref TB/18/57(i)), should be amended to read “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. This would provide the necessary assurance with regard to the effectiveness of any further work to mitigate the risk associated with cyber security and inform any decision to de-escalate this risk in the future.”

4.1.3. Paragraph 10.2 (Minute ref TB/18/58), refers to Cat 1 Mean as 7 minutes – 13 minutes; this should be amended to read “7 minutes – 13 seconds”.

4.1.4. The first sentence of paragraph 21.2 (Minute ref TB/18/69) should be amended to read “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 the internet to use Convene; and the location was convenient and easy to reach.”

5. Matters arising (TB/18/77)

5.1. The action log was reviewed and Board members noted that actions were on track and there was nothing to raise at the meeting.

6. Report from the Chair (TB/18/78)

6.1. The report from the Chair was noted.

6.2. The Chair emphasised the importance of the Workforce Race Equality Standard (WRES) Action plan and encouraged colleagues to apply more focus to this as a collective leadership team, driving change. It was noted that this was due to be presented to the Board for consideration at its next meeting on 27 November 2018.

6.3. The Chair's visit to the Trust's North East London Integrated Urgent Care (NEL IUC) service was noted and Board members acknowledged that, as an early adopter of integrated urgent care the Board should adopt a strong assurance relationship with NEL IUC.

6.4. The Board was informed that NED recruitment was underway and it was hoped to appoint in October.

6.5. The Board noted the report of the Chair.

7. Report from the Chief Executive (TB/18/79)

7.1. GE presented his report on progress and key issues, events and activities for the months of July and August.

7.2. The Board noted that, whilst July had been a challenging month where demand had risen by 6%, August and September had seen a return to normal levels; it was noted that the Trust was continuing to broadly meet national standards.

7.3. Board members welcomed the update that discussions regarding partnership arrangements with South Central Ambulance Service NHS Foundation Trust had concluded and that an announcement regarding the partnership would be made at the Annual Public Meeting later in the day. Members observed it would take some time to build an effective joint partnership but agreed this would be a positive move towards evolving into a joint working of ambulance services across the country, in alignment with the recommendations of Lord Carter's review into unwarranted variation in NHS ambulance trusts (known as the Carter Report).

7.4. The Board was updated on the changes to the Operations directorate and understood that engagement events were taking place to improve the structure across the Emergency Operations Centre (EOC), particularly with regard to addressing career pathways.

7.5. Board members were reassured that there would be no loss in capacity with regard to gold and silver command members and their capabilities. PW gave reassurance to the Board that location group managers were required to undertake tactical command training in line with national requirements and the Trust was also enhancing its resilience and gold level tactical structure through a phased method.

ACTION: PW to provide a briefing to the Board with regard to progress against the Operations division structure.

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

8. Freedom to Speak Up – Quarterly Update and Proposed Strategy (TB/18/80)

8.1. PH introduced the report which set out the Trust's recent activity with regard to Freedom to Speak Up (FTSU), including the development of a FTSU Strategy for approval by the Board. The Board welcomed Katy Crichton (KC) the FTSU Guardian who had been appointed into her part time post in July 2018.

8.2. KC outlined the role of FTSU and the Board was made aware that many employees (60% of respondents to the FTSU survey at end of 2017/18) did not know about FTSU, and those who had heard of it were unclear about its role. The Board noted the degree of work required to publicise FTSU, together with promoting outcomes to encourage trust in the program. It was noted that a dedicated FTSU Guardian would have a real impact in this regard; following publicity and engagement across the Trust, there had been 15 concerns raised so far in the current quarter, equating to twice the number raised in the whole of the previous year.

8.3. KC commented on the valuable support received by PH and Fergus Cass (FC) (Executive and Non-Executive FTSU Leads respectively). The Board observed that work was being undertaken to establish a network of FTSU Advocates to support the FTSU Guardian and ensure that dissemination of FTSU information became more widespread. KC affirmed that Advocates would not be handling cases but would operate as a single point of contact.

8.4. Board members referred to the importance of integrating FTSU into the Trust's Well-Led activities. The Board considered that, when issues were raised through FTSU, care should be taken to determine the most appropriate method of considering these, for both those raising the concern and those who were the subject of the concern. It was emphasised that there should be opportunity for both parties to engage to achieve a constructive outcome which could be used as lessons learnt in the future. The Board accepted a change in culture was required to encourage confidence to speak up and for issues to be handled in a non-judgemental fashion. FC emphasised the importance of ensuring that appropriate support was provided to members of staff against whom concerns had been raised, whilst investigations were being undertaken.

8.5. The Board observed that concerns were also raised through other routes including through the Equality and Inclusion consultant and through the Bullying and Harassment Specialist, and that a careful collation of metrics was required to avoid duplication of numbers.

8.6. The Board sought assurance that the opportunity to raise concerns was also afforded to third party contractors, including the crews involved in the vehicle preparation contract. BM confirmed that FTSU would be aligned with all contractors and integrated within the Trust's policies.

ACTION: Contracts with third party service providers to include reference to FTSU.

8.7. In response to a suggestion that leaders have an opportunity to tell their story, to show willingness and openness and a desire to progress a change in culture, it was agreed the appropriate forum should be investigated.

ACTION: PH to liaise with Chair and discuss how to facilitate senior individuals sharing their experiences of speaking up.

RESOLVED:

8.8. The Board resolved to approve the Freedom to Speak Up strategy.

9. Trust Board Committee Assurance Reports (TB/18/81)

(i) Audit Committee meeting on 3 September 2018 (TB/18/81(i))

9.1. JJ presented the report, which set out the main points arising from the Committee's meeting on 3 September 2018. The Board noted a report on the Losses and Special Payments to July 2018, reviewed by the Committee, and that expenditure on vehicle accidents continued to be at a high level, subject to further investigation with actions being taken to seek reductions.

9.2. The Board were referred to the attached Annual Audit Letter for 2017/18 which provided positive assurance over the financial statements for 2017/18 and arrangements of value for money.

9.3. JJ acknowledged that the Committee could provide reassurance at the current time with regard to GDPR, cyber security and Business Continuity Planning (BCP); a lot of activity was being undertaken and good progress was being made towards providing the Board with the necessary assurance. The Board noted that business continuity needed to be considered with regard to the United Kingdom's exit from the European Union. An update would be brought to the Trust Board meeting on 27 November 2018.

9.4. Board members observed that the first report from the Trust's newly appointed auditors had been received with positive assurance in relation to the Trust's Cost Improvement Programme; the next Audit Committee would receive five internal audit reports.

(ii) People and Culture Committee meeting on 6 September 2018 (TB/18/81(ii))

9.5. JM presented the report, which set out the main points arising from the Committee's meeting on 6 September 2018. The Board noted the update on the agency plan which had identified work being undertaken to address agency spend. It was noted whilst the Board was not yet fully assured that the Trust would meet its cap, the improved agency plans would provide this additional assurance by including trajectories showing how each directorate would reduce their agency expenditure. These were due to be presented to the Committee at its meeting in November 2018.

9.6. The Board welcomed the update regarding two large engagement events in July focusing on Workforce Race Equality Standard (WRES) action planning and 'The Big Conversation', which focused on race and the Trust's WRES.

9.7. Board members acknowledged the Staff Survey would be launched on 28 September 2018 and would consist of a slightly different approach to the processing of summary indicators and key findings.

9.8. The Trust's training review risk was considered by the Board and discussion ensued whether the risk merited being added to the Board Assurance Framework (BAF). The Board concurred the training review and related action plan would be re-presented to the People and Culture Committee in November and should remain as a corporate risk, but not added to the BAF at the current time.

(iii) Finance and Investment Committee meeting on 11 September 2018 (TB/18/81(iii))

9.9. FC presented the report, which set out the main points arising from the Committee's meeting on 11 September 2018. Key escalation points noted were the importance of the procurement strategy which was being developed with the aim of achieving substantial savings in non-pay costs; the Board was also sighted on the change of environment resulting from the recent national announcement relating to NHS funding and of efficiency targets arising from national benchmarking; the Board were informed that the draft five year Financial Plan would incorporate these changes and would be discussed at the Committee's meeting in November 2018.

9.10. The Board noted the review of cash flow performance and projections and that the Trust's cash balance was £8.3m above plan; the Board also noted that 85% of the Trust's creditors were being paid within 30 days.

9.11. Matters for escalation were considered by the Board including; further work required to address the actions necessary to assure delivery of financial targets; addressing non-pay operating expenditure which was over budget by £1.9m YTD; and expenditure relating to agency staff.

9.12. LB briefed the Board on the estimated financial impact of providing sufficient resource to achieve ARP performance targets and it was considered that additional funding may be required to support the transitional period. The Chair confirmed the need to furnish a public report with regard to this position.

ACTION: LB to report to November Board meeting in public on the Trust's financial position.

RESOLVED:

9.13. The Board resolved to approve the proposed amendments to the Finance and Investment Committee's FIC Terms of Reference, as recommended by the Committee.

(iv) Quality Committee meeting on 18 September 2018 (TB/18/81(iv))

9.14. Robert McFarland (RM) presented the report, which set out the main points arising from the Committee's meeting on 18 September 2018. The Board received an update to the new national specification for out of hours service and the practical working of the new Clinical Assessment Service (CAS) introduced in the Trust's NEL 11/IUC service, as presented to the Quality Assurance Committee (QAC) by its leadership team. RM commented that the scrutiny and ongoing governance structures to manage quality standards presented at the QAC meeting provided assurance of a robust future process.

9.15. The Board were made aware of the requirement that all staff have Level 3 Safeguarding training and that this was a requirement directed by the Care Quality Commission. HL informed members that safeguarding training would be provided at the Board Development Session in October 2018.

9.16. The Board also discussed the Trust's performance against the 16 minute target for stroke, and reviewed the decision, following the analysis of stroke clinical outcomes, to focus on 'on scene time' and '90' centile (call to hospital time) rather than the 60-minute percentage.

9.17. RM communicated to the Board that the Mental Health Annual Report and Infection Prevention and Control Annual Report had been presented at the meeting. Board members were advised that a review of all annual reports was to be undertaken to determine their purpose and to streamline reports; this would be led by PH and TB.

9.18. Risks arising from the QAC were considered, including the delivery of the Ambulance Response Programme and concern whether there were appropriate staff and resources to deliver the programme. This would be discussed further under the substantive Board item on this issue (ref: TB/18/86).

10. Integrated Quality and Performance Report (TB/18/82)

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 6 minutes-43 seconds, and LAS ranked 2nd in both Cat 1 90th centile compared to other Trusts. Statutory and Mandatory Training and appraisal rates continued to achieve above 85% compliance. TB informed the Board that fire drills were being reviewed; the Board was assured these were being undertaken but not effectively reported, and that this was now being addressed.

10.3. Board members considered the performance update and PW reaffirmed that July had been a challenging month with events including the World Cup quarterfinal and Pride attended by one million people. The Board was assured that call handling performance had improved again in August with 90% of calls answered within five seconds.

10.4. PW referred to the stable position of Non-Emergency Transport Services (NETs) and that consideration would be given to how NETs could provide greater support with the integrated care model across north east London and south east London in the future.

10.5. An update was provided to the Board on people and culture, noting the Emergency Operations Centre Emergency Medical Dispatcher vacancy rate was at 12.7%, significantly lower than previous years and retention had also improved. The Board were informed of other initiatives to improve intelligence and therefore focus on retention including a new e-Forms system which had now been rolled out to Sectors and Corporate teams and was more fully utilising the ESR exit questionnaire functionality.

ACTION: LB to incorporate information about non conveyance to future Integrated Performance reports.

11. Board Assurance Framework and Corporate Risk Register (TB/18/83)

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

11.2 Board members observed the lack of movement of risks in July and were made aware there could be some movement in relation to BAF risk 50 and 51 following the Logistics and Infrastructure Committee meeting on 9 October 2018, and the progress of the Ambulance Response Programme.

12. Bi-Annual Quality Account Report and Progress (TB/18/84)

12.1. The Board received a report providing an overview of the Trust's position in regards to its Quality Priorities as described in the Quality Strategy and Account. Board members observed the report also provided an overview of the Care Quality Commission (CQC) quality action plan which had 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 detailed progress of the pioneering service programme of work within the Trust, incorporating Mental Health, Falls, Maternity and End of Life Care.

12.2. Board members were made aware that HealthAssure was being implemented; there had been a delay uploading data against the CQC plan due to team restructures, but this would be on track again by end of October.

ACTION: TB to share detailed CQC action plan with the Board for information.

12.3. Members of the Board observed inaccurate data populated in the Allocate CQC Assure table and were reassured this was dummy data and would be amended to clarify it as dummy data in future reports.

13. Serious Incident Reporting and Progress (TB/18/85)

13.1 TB provided an overview to the Board of the main contributory factors that influenced serious incidents and the actions taken by the Trust to address recurring themes.

13.2 The Board noted the report.

14. Working with Regional Partners to Meet National Performance Standards (TB/18/86)

14.1 PW presented a report updating the Board on the Trust's preparations to meet national performance standards. The Board was made aware that the national oversight of meeting the standards would be managed by the Ambulance Integration Programme (AIP) who would be accountable to the Ambulance Improvement Programme Board and responsible for the oversight of progress towards achieving the Ambulance Response Programme (ARP). The Trust's position was reported to the AIP on 3 September 2018.

14.2 PW assured Board members that LAS was broadly meeting the national standards and was not causing regulators any concerns. The Board was informed of the work being undertaken to reduce unnecessary ambulance conveyance to emergency departments by 1% this year. The Board considered that an action plan had been developed to ensure the delivery of this target and would be monitored by commissioners on a monthly basis.

15. Report of the Trust Secretary (TB/18/87)

15.1 The Board noted the report providing information about decisions that had been undertaken since the last meeting of the Board on 31 July 2018:

- Chair's action taken on 2 August 2018 with regard to an outline case for deployment of 2018/19 capital budget to purchase double crewed ambulances.
- Report considered in correspondence on 1 September 2018 relating to a Regulation 28 Report to Prevent Future Deaths received by the Trust from the Assistant Coroner for the coroner area of Inner West London.

16. Trust Board Forward Planner (TB/18/88)

16.1 The Board noted the Forward Planner.

16.2 Board members observed the following updates:

- Annual accountability statement should be in May 2018
- Budget/financial accounts should be added to March 2018
- Trust Strategy update to be presented to the Board in November 2018

17. Unaudited Charitable Funds Annual Report and Financial Statements for 2017/18 independently examined by Ernst & Young LLP (TB/18/89)

17.1 LB presented the paper informing the Board that, as corporate trustees of the London Ambulance Service charity the Trust Board had a statutory requirement to publish an annual report and financial statements. The Board observed that the term 'unaudited' related to the size of the funds which required independent examination rather than audit. The Board noted the examination had been undertaken by Ernst & Young and there had not been any issues arising. The Board was informed that the accounts had

also been reviewed by the Charitable Funds Committee and the Audit Committee. During that review it had been noted that the following amendments (reported orally to the Board) were required:

- Amendment of the names of Trustees to reflect the membership of the Trust Board; and
- Amendment of the membership of the Charitable Funds Committee to reflect John Jones, the Chair of the Audit Committee.

RESOLVED:

17.2 The Board resolved, subject to the amendments set out above, to approve the unaudited annual report and financial statement of the London Ambulance Service Charitable Fund for 2017.18, which had been independently examined by Ernst & Young LLP and the attached letter of representation.

18. Questions from members of the public (TB/18/90)

18.1 There were no questions from members of the public.

19. Any Other Business (TB/18/91)

19.1 There was no other business.

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

20.1 Board members confirmed that they considered the quality of the papers presented to the meeting to be continuously improving.

20.2 The Chair commented that Trust Board meetings were likely to be live streamed in the future and the Board should consider this in terms of behaviours.

20.3 The Board agreed the standard of debate had been good with appropriate challenge exercised by the Board.

21. Meeting close

The meeting closed at circa 12.45pm. The next Trust Board meeting in public will take place on 27 November 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/18/56	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	**CLOSED**	Addressed at the Quality Assurance Committee on 18 September 2018 and reported to the Board through Assurance Report. RCA outcome to be reported to the QAC in January 2019.
TB/18/79	PW to provide a briefing to the Board with regard to progress against the Operations division structure.	Paul Woodrow	25/09/18	27/11/18	**CLOSED**	See Chief Executive's Report
TB/18/80 para 8.6	Contracts with third party service providers to include reference to FTSU.	All	25/09/18	01/01/19	**On track**	
TB/18/80 para 8.7	PH to liaise with Chair and discuss how to facilitate senior individuals sharing their experiences of speaking up.	Philippa Harding	25/09/18	01/01/19	**On track**	
TB/18/81(iii	LB to report to November Board meeting in public on the Trust's financial position.	Lorraine Bewes	25/09/18	27/11/18	**CLOSED**	See integrated performance report
TB/18/82	LB to incorporate information about non conveyance to future Integrated Performance reports.	Lorraine Bewes	25/09/18	27/11/18	**CLOSED**	See integrated performance report
TB/18/84	TB to share detailed CQC action plan with the Board for information.	Trisha Bain	25/09/18	18/12/18	**On track**	CQC breifing scheduled for December informal Board meeting

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 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 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 of the Chair

Saxton Bampfylde Thought Leadership Dinner 13 September 2018

1. I contributed to a piece of work titled “Live, Breathe, Data” which explored how boards are responding to the strategic opportunities presented by the advancement of technology, data and analytics. As a result I was invited to attend a dinner to discuss the report ahead of its wider publication. I will share the full report with the Board once it is available.

WRES and London Regional Meeting 24 September 2018

2. One of the key findings emerging from the Workforce Race Equality Standard (WRES) data analyses from NHS trusts in England is the fact that across most of the WRES indicators of BME staff experience and opportunities, London as a region fairs badly.

3. I was invited to attend a meeting to discuss the possibility of a focused regional approach and action planning. To this end, together with two other Chairmen, I will be sharing my experience at the London Chairs’ meeting on 13 November 2018.

   I have attached the link to the latest WRES data report for NHS trusts: https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-december-2017/

4. Our WRES action plan is to be discussed and agreed as an agenda item at this meeting.

Annual Public Meeting 25 September 2018

5. As you will all know we held the last Annual Public Meeting at the London Fire Brigade Headquarters during the evening of 25 September 2018. This time I wanted to highlight some of our achievements over the past year and showcase our work on mental health and the importance of the pioneer services. We hosted several key experts in the field of mental health care whilst also hearing on a patient’s perspective.

6. The meeting attracted a larger audience than we have previously enjoyed and for the first time we live streamed the event which resulted in 800 unique views and over 20 questions on Instagram which were captured and responded to. The Chair of the Patients Forum sent a message congratulating us on a very successful meeting.

Police Committee Dinner 10 October 2018

7. The Chairman of the Police Committee of the City of London invited me to attend a dinner on the 10 October 2018 held at the Old Bailey. The focus of the evening’s discussion was on responding to terrorism and inner city knife crime.

London Assembly Health Committee – London Ambulance Service Evidence Session 11 October 2018

8. Together with the Chief Executive (CEO) I attended an evidence session as part of the Health Committee’s routine ‘investigation’ into the work of the service, the committee was chaired by Dr Onkar Sahota. The session went extremely well and both the CEO and myself were able to highlight the journey the organisation has been on, the strong

performance recently and to offer an update on the on- going blue light services collaboration.

9. There were a number of questions around recruitment, Brexit and BME representation at Board level and throughout the organisation.

10. The entire session can be viewed on line using: Here online

Baroness Jolly's Visit 11 October 2018

11. On 11 October 2018 I hosted a visit by Baroness Jolly which came about following a briefing, provided by the Trust, to all Peers ahead of the second reading of the Assaults on Emergency Workers (Offences) Bill. Coincidently Baroness Jolly also personally witnessed violence towards members of our ambulance staff. The meeting was also attended by Paul Woodrow, Director of Operations, and focussed on assaults on our staff and how we are training ambulance crews. Baroness Jolly has a deep appreciation of the issues our staff face and is currently Non-Executive Director of a Mental Health Trust.

VIP Visit 25 October 2018

12. Together with the CEO I hosted a visit by HRH the Prince of Wales to our headquarters. His Royal Highness visited the control room and met and spoke to colleagues from a range of departments including the Public Education, Community Resuscitation and Recruitment teams before having a chance to see some vehicles past and present and learning more about the new team that will be dedicated to responding to 999 calls to patients with mental health problems.

13. Speaking to around 120 staff assembled for a photo at the end of the visit, Prince Charles said: "Thank you for the most remarkable job you do. It makes us all very proud of what you do – thank you."

Meeting with the Mayor Sadiq Khan

14. The CEO and I met with the Mayor of London for the first time since coming out of special measures and being rated as Good overall with outstanding for care by the Care Quality commission. He was very complimentary about this and recognised that it was a significant turnaround from 2015. He also appreciated the progress the Executive has made in implementing the new Ambulance Response Programme.

London Health Board Conference 25 October 2018

15. I attended the London Health Board conference which is a non-statutory group chaired by the Mayor of London. The session was entitled 'Working Together to make London the World's Healthiest City'. Members of the London Health Board took part in a panel discussion followed by a panel debate with some of London's health and care leaders. Knife crime featured in the discussion and I noted that a Black Man's Project exists in Hackney focusing on inequality and disadvantage.

Internal

EOC Consultation Meetings

16. I attended four of the Emergency Operations Centre (EOC) Consultation meetings both at Waterloo and Bow which were part of the Management of Change process following a review and restructure proposal for a number of roles within this operational area. Staff were vocal and shared their views and concerns. One of the newer members of staff explained that he did not want to be called a 'call handler' as this was in his view demeaning as it did not represent the type of call he deals with which is not as simple as working for a food retailer. It also became clear that some cultural issues remain to be resolved. The events were well attended by staff and were led by Pauline Cranmer Head of 999 Clinical Contract Centres. The consultation period ran from 30 August 2018 to 7 October 2018 and it is envisaged that the new structure will be in place in March 2019.

Heather Lawrence OBE
Chairman

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	27 November 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. The Trust achieved all nine key response time measures within the National Standards during October 2018. In October the trust implemented the re-categorisation component of the Ambulance Response Programme Spring Review which has, together with our improvement initiatives, shown a positive impact on the performance across the categories. The demand level in October increased by 6.24% compared to the previous month.

3. The Category 1 mean returned 6 minutes 12 seconds while the Category 1 90th centile was 10 minutes 14 seconds. These results provide assurance to the Board.

	C1 Mean	C1 90th Centile	C1T Mean	C1T 90th Centile	C2 Mean	C2 90th Centile
September 2018	00:06:57	00:11:27	00:12:01	00:20:28	00:19:29	00:39:50
October 2018	00:06:12	00:10:14	00:11:02	00:18:49	00:17:36	00:35:21
Year to Date (2018/19)	00:06:53	00:11:20	00:11:53	00:20:13	00:18:43	00:38:06

111 Operations

4. South East London 111 (SEL) responded to 85.7% of calls within the SLA of 60 seconds in October against the target of 95%. This remains below target and was impacted upon due to the balancing of 111 calls from North East London to SEL. The number of calls abandoned by patients in the month of October was recorded at 1.8%, a marginal increase compared to September's 1.7%, but still below the 5% national target. SEL calls to ambulance service remained above 9%, which compares to the regional (London) average of 10%.

5. North East London (NEL) call answering performance increased to 75.1% in October from 74.2% in September. NEL experienced an increase in their daily calls offered increasing from 1,356 per day in September to 1,408 in October an increase of 52 calls per day. Calls abandoned after more than 30 seconds finished at 1.8% which was marginal increase on September's 1.7%. NEL saw a reduction in calls being passed to the ambulance service reducing from 7.4% in September to 7.0% in October, this is the third consecutive month that a month on month reduction has been achieved. NEL is the top performing provider in London in respect of calls referred to the ambulance service.

Location	Month	Calls Offered (Inc Balanced Calls)	SLA calls in 60s (Target 95%)	Abandonment	Calls to Ambulance Service
SEL	Sep 2018	32,243	86.3%	1.7%	9.2%
	Oct 2018	34,937	85.7%	1.8%	9.3%
NEL	Sep 2018	40,677	74.23%	1.7%	7.4%
	Oct 2018	43,646	75.14%	1.8%	7.0%

6. I continue to hold weekly meetings with the 111 SEL and NEL teams to review the operational delivery and mobilisation of the full Integrated Urgent Care (IUC) service. Also telephone conferences have been held with the commissioners to provide oversight of the delivery of 111 services as well as providing assurance of our resilience over the winter period.

7. The Operations Directorate is focused on improving efficiency and productivity metrics and, during October, refreshed action plans were published relating to reducing unnecessary conveyances to emergency departments, reducing the number of hours lost to handover to green, improving hear and treat rates and improving call answering times. An Assistant Director of Operations (ADO) visited the West Midlands Ambulance Service in October to review their operating model and the senior operations team are now considering what London can learn from West Midlands, particularly in relation to conveyance reduction.

8. The Winter Plan 2018/19 was published in October and has been shared with the Board. This plan provides the tactical overview of the Trust's arrangements for maintaining effective and continued delivery of urgent and emergency care services during the 2018/19 winter period. All Trust support services (including Information Technology, Fleet and Logistics) will have their own supporting operating plans for winter which will be aligned with the over-arching winter plan. As is the consistent theme across Trust plans, the Winter Plan 2018/19 sets out to maintain the optimum levels of service provided to service users across the capital by deploying, when and where necessary, innovative and different solutions to manage demand and capacity. Actions to increase available staffing, capacity management regimes and alternative ways of dealing with the demand for emergency ambulances are at the heart of the plan.

9. Progress continues to be made in implementing the new operational management structure. The three remaining 'Head of function' roles were advertised internally and externally once the internal process for those affected by change had been completed. A recruitment and selection process has taken place throughout late October/early November and further details about these appointments will be available later in the month.

10. In relation to Location Group Managers (LGM), all 18 positions have now been filled following a second internal and external recruitment process. The development of the new Clinical Team Manager role is now in its final stages.

11. In terms of the Emergency Operations Centre (EOC) restructure, the response to the consultation and final structure was published on 29 October. No redundancies are expected and only a small number of staff are likely to require pay protection. Band 7 managers in the new structure are expected to be appointed by November 2018, however, the new structure will not be officially implemented until February/March 2019 in order to minimise disruption over the winter period.

12. One of the Operations Directorate's key objectives is to improve the level of engagement that takes place with operational managers. An all-day engagement event was therefore held for operational managers on 7 November and was led by the Head of 999

Operations and the Head of Operational Compliance and Standards. The first half of the event provided operational managers with an overview of the winter plan with specific focus on the refreshed surge plans; the scope for the new Tactical Operations Centre in the EOC over winter; new co-horting arrangements at emergency departments; and the expectations of the NHS England (London) winter cell. The second half of the event was focused on improving operational efficiency and productivity, specifically looking at the recently-published and refreshed action plans for reducing unnecessary conveyances to emergency departments and improving the number of hours lost to handover to green.

13. The Directorate has implemented the next phase of the end of shift protected time arrangements. The Trust extended the initiative to Hillingdon, Brent, Friern Barnet, Camden and Romford station groups in North London on 31 October. Location Group Manager (LGM) project leads have been identified in each of the respective station groups and they are engaging with local management teams and frontline staff. Regular checkpoint reviews are scheduled and, with continued assurance of safety and success, the intention is to extend the arrangements to all remaining stations on 28 November. Results from the initiative continue to be encouraging with the percentage of double crewed ambulances (DCAs) that receive a rest break, and then subsequently finish late, dropping from a pre-pilot average of 77.5% across London to 28.1% in the pilot areas.

14. The Board will be aware from previous reports this year that 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 takes 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, NHS Improvement and Clinical Commissioning Group (CCG) partners initially reported to the AIP on the Trust's position in September 2018. Planning for the next meeting, which is scheduled for late January 2019, is now underway with all partners.

15. NHS England (London) is hosting its own pan-London winter cell again this year at Skipton House and, like last year, the Trust has seconded a senior operational manager to the pan-London cell until March 2019. This arrangement will ensure that the Trust's objectives and priorities are fully represented over winter as part of the pan-London system. This will also enable the Trust to rapidly escalate any issues which impact on our ability to deliver effective patient care through the senior leadership team at NHS England (London).

Strategic Assets and Property

16. The refurbishment of the 2nd floor at Waterloo Headquarters has now been completed, providing space for an additional work stations. The floor has been reconfigured to an open plan arrangement, providing more flexible working, new meeting rooms, and space for the Performance Team to be brought together from two separate locations.

17. The design and planning of the 3rd floor at Waterloo Headquarters is being developed with the People and Culture team, this will result in the recruitment team who operate from Cody road being brought together from two locations, with work being completed by the end of the financial year.

18. To further improve and ensure consistency of service across LAS workshops, technical standards have been developed for the fleet technicians. Training on the new standards has commenced, and general feedback has been good. We are aiming for all technicians to have completed their training by early December. Once this technical training has concluded stock management and systems will be introduced so the teams

will able to trace what parts and work has been done on each vehicle and this will take till the end of March.

19. To mark Remembrance Day and 100 years since the First World War ended, this year 100 of our vehicles have been decorated with the poppy to remember all those who fought and gave their lives for their country and an additional 10 new vehicles have had specially designed livery for this event and will remain in place until the end of the month.

20. With Collaboration being key to LAS success, we are now working with Transport for London, Mayoral Office Police and Crime (MOPAC), GLA, the Metropolitan Police and London Fire Brigade, the group are focusing on Estates and Facilities and their remit is to develop joint estates and facilities-related opportunities across our organisations, to maximise the performance of property portfolios and drive operational and financial efficiencies through collaborative thinking and joint work streams.

21. 22 new Double Crewed Ambulances (DCA) have been deployed into service since October and a further 10 will be in operation by early December. Also 13 Tiguans have been reconfigured and MDT3 have been installed. Eleven of our electric vehicles (Nissan Leafs) have been deployed into service for use by our Location General Managers.

Finance & Performance

22. As reported elsewhere on the agenda the Trust is £0.1m ahead of plan at the end of September (Q2). Income for the first half of the year was £2.0m lower than planned, incident activity increased during Q2 due to the prolonged hot weather throughout July and into August. Call levels remain high. Pay expenditure was £4.1m lower than plan to the end of quarter 2 due to frontline vacancies partially offset by private ambulance, overtime and bank usage. The executive team continues to focus on recruitment and retention to reduce reliance on overtime and PAS to maintain safe and effective rosters.

23. The Trust has delivered savings of £5.1m at the end of quarter 2 and work currently underway across the organisation continues to ensure the full £12.3m is delivered in 2018/19. Approximately 72% of this is currently expected to be delivered recurrently. The Trust forecast is to exceed its £1.6m control total deficit by £1.9m ensuring access to additional Provider Sustainability Funding (PSF) from NHS Improvement.'

24. A number of changes have recently been made to the logic in the data warehouse supporting the reporting of the national AQIs. The Business Intelligence team have worked closely with IM&T developers and the CAD support team to test data within the test environment, review clock start and stop times for duplicate calls, and patients that have received a re-categorisation as per the AQI document. During October, the newly developed and tested logic was successfully applied to the live data feed, meaning the LAS are now compliant against all the new ARP AQIs introduced following the Spring Review. Work remains to apply corrections prior to 16 October 2018.

25. The Forecasting & Planning team have recently devised an Evaluation Framework in conjunction with Strategy and Quality Executives, CARU, and clinical leads. This framework will act as reference document for the forthcoming pioneer service pilots, and will steer the development of robust evaluation for each of the pilots in turn, making its debut with the roll-out of the Mental Health pilot this Winter.

26. Business Intelligence have successfully recruited into two Senior Analyst roles for the support of 111 service delivery, with one Senior Analyst being in post, and the other undergoing pre-employment processes. These analysts will provide the datasets and reports mandated by NHS England, along with any ad hoc reporting to support service delivery and patient care.

27. The Forecasting & Planning team continue to support Winter Planning, having developed winter activity forecasts and performance predictions, and have now created a scenario tool to allow for capacity planning options to be tested efficiently when planning to respond to pressure days across the festive period. The team will be working closely with Operational colleagues in the lead up to peak Christmas and New Year activity.

28. The Performance Directorate is leading the analytics elements of this year's Business Planning process, ensuring that any strategic business decisions are supported with the appropriate underlying quantifiable evidence.

29. The Performance Directorate is engaging with the newly established Centre for Urban Science and Progress (CUSP*) at King's College London University. Through this, we are engaging with a number of students and academics with expertise in geo-spatial services, urban informatics, visualisation, and data science, and are establishing foundations for future collaboration and research as well as promoting specialist technical careers with the LAS.

    *https://cusplondon.ac.uk/

IM&T

30. Our Integrated Urgent Care and NHS111 clinical IT and telephony systems have been continually refined since the service went live in August. Working with system partners we have enhanced clinical records access, improved workflows and developed richer management information and performance analytics. We are working on outstanding actions to complete full mobilisation of NEL 111/IUC.

31. The Trust has signed up to implement the nationally procured NHS England national licensing of Windows 10 and have completed our testing of Microsoft's Advanced Threat Protection which will provide NHS-wide cyber and response.

Strategy & Communications

32. Significant progress has been made over the last month in the delivery of a number of our enabling strategies. Following extensive development work, the People and Culture Strategy and the draft IM&T and Digital Strategy will be presented to the board today for consideration and sign off.

33. Following the 5 September workshop, a volunteering strategy framework has been developed and a Board briefing session will take place in December to further shape the strategy.

34. The Clinical Strategy was the basis for a workshop held on the 6 September, a Board briefing session took place in October which considered the workshop outputs, Carter Review implications and our Medical Director and Director of Operations visions for our future clinical response model.

35. Following the Board briefing session in June, the operational estates strategy is continuing to be developed. A draft strategy is expected to be presented to Logistics and Infrastructure Committee in February 2019 and to the Trust Board in March 2019.

36. Further detail on progress against delivery of each of our enabling strategies is provided in the strategy 6 month update paper which is being presented at this Trust Board meeting.

37. As part of the London Blue Light Collaboration work the Directors of Estates of the three organisations met and discussed each service's respective estate overview and future strategies and explored the following:

- Strategic fuel reserves
- Potential of a combined asset strategy that seeks opportunities based on neighbouring estate and proximity
- A group of representatives from all 3 services had an initial meeting to discuss the third runway at Heathrow and a formal group will be convened

External Communications

38. Following September's Trust Board meeting, the Evening Standard Health Editor wrote a story on Carolyn Thompson, who was incorrectly diagnosed by a paramedic and told her personal story to the Board.

39. An interview with Incident Response Officer, Andy Whatling, featured in the Telegraph online classic cars section. Andy talked about our fleet of old vehicles which he helps to maintain and restore, and the importance of the Service's history.

40. On 25 October, together with the Chair, I hosted a visit of His Royal Highness the Prince of Wales to our Headquarters. HRH met frontline crews, call handlers and those working behind the scenes. As part of his tour, he learnt about and launched our new mental health car, which will see mental health nurses and paramedics respond together to assess a patient's mental and physical health, reducing unnecessary and stressful hospital trips.

41. The trust has been shortlisted for Provider Trust of the Year by the Health Service Journal (HSJ) for their annual health awards programme. This is a significant recognition of our achievements over the last year and the category is the top award of all of the categories available.

42. In September, we featured in a national BBC News story following the publication of the Lord Carter Report into the efficiency of ambulance services. We were a positive case study, with Chief Clinical Information Officer, Stuart Crichton, interviewed about how we are using technology to support our new strategy and particularly the use of mobile devices by our frontline crews. This featured on BBC Breakfast.

43. On 12 September, the Assaults on Emergency Workers Bill received Royal Assent. I was interviewed by BBC News about our support for the law featured across BBC radio channels, including BBC Radio 1, 2, 3, 4 and 5 Live.

44. On the day of our Annual Public Meeting (25 September), we went out to media with a release about our new partnership with South Central Ambulance Service.

45. On 16 October, our community resuscitation team went out to 11 locations to teach hundreds of people CPR and how to use a defibrillator as part of international 'Restart a Heart Day'. This was covered by the Evening Standard and ITV News bulletins.

46. On 19 September the London Assembly Health Committee released the results of a survey they commissioned as part of their work looking into the Service. The survey found high levels of confidence in our service but also highlighted a lack of understanding of when to call 999. BBC Radio London ran a positive story about the survey results being a great testament to the skills and professionalism of all of our frontline staff and about alternatives to calling 999.

47. As part of the London Assembly Health Committee investigation, which looks into the work of the London Ambulance Service, the Chair and I attended an evidence session on 11 October. This went well and we took the opportunity to highlight the journey the organisation has been on, the strong performance of late, the new strategy and the collaboration with both our blue light counterparts in London and the wider NHS.

48. Around the middle of September, we released quotes and pictures about the ŠKODA fast response unit damaged during World Cup celebrations. The car was repaired by a ŠKODA dealership at no cost to the Service, but the story also had the additional angle of fundraising from the Millwall FC Supporters' Club which, with their support, are now being used to restore a historic ambulance. The story featured in the Evening Standard and local newspapers.

49. The then Health Minister, Steve Barclay MP**,** visited Waterloo HQ on the 1 November. During his visit, he received a tour of some of our vehicles, shadowed an emergency medical dispatcher and hosted a roundtable with frontline staff. While with us the Minister was given a flu jab in order to promote the use of winter vaccinations. The Minister was particularly interested in hearing about the specifications of our new vehicles and about the challenges that are faced by our staff. He was also interviewed by the Evening Standard about NHS preparations for winter and referred positively to LAS's overall readiness.

Internal Communications

50. In October, I held my second round of staff roadshows this year. A total of 31 were held and I saw and spoke to more than 1300 members of staff. I was joined by a number of Directors at each meeting, as well as our Freedom to Speak Up lead, and following a short presentation, attendees were able to ask questions on any topic or issue.

51. For the first time, a number of the meetings were also broadcast live on our closed staff Facebook group, further increasing the number of people reached and meaning that people could also submit comments and questions online.

52. The Executive Leadership Team is now reviewing all the points raised so that details of the actions to be taken can be confirmed and then shared with staff.

53. On 22 November, we held our annual Celebration of Service ceremony for recently retired staff, along with those who have reached 20 years of service and so were eligible to receive either the Queen's Ambulance Service (Emergency Duties) Long Service and Good Conduct Medal or the London Ambulance Service Long Service Medallion.

Quality Improvement

54. The Quality and Assurance safeguarding team presented a paper to the Executive Committee that sets out the increased resources required to meet the new national Safeguarding training standards. The new standards require the majority of staff to be trained at Level 3 by specialist trainers. The paper will be discussed at the Executive Committee meeting on 30th November and a decision in relation to the costs of implementation and the impact on the current training programmes will be made and an implementation plan developed.

55. The Programme Management Office (PMO) is currently being developed and a revised structure and work programme was presented to the Portfolio Management Board on November 10th. Recruitment to the agreed structure will commence. The key priority in relation to work programmes is agreeing the programmes and projects for the remaining 2018-19 plan and the 2019-20 business plan, supported by the Finance directorate.

56. Twelve members of staff from various directorates are being trained in Agile project management techniques, this is in conjunction with the rolling programme of Quality Service Improvement training and will build further improvement capacity. Infrastructure, systems and processes to ensure we embed a continuous improvement culture by utilising these skills is being developed and will be in place by February 2019.

57. The Directorate has been working with the Clinical Hub and acute trusts to ensure that nurses working in the hub can access rotational shifts in the acute setting to ensure they maintain their clinical skills.

58. Paramedics have now been recruited to assist the mental health pioneering services pilot which began in the second week of November. Currently the model has been used on various shifts and has shown that in the majority of cases conveyance was not required. The pilot phase will therefore be evaluated at 3 months (instead of 6) with the aim of agreeing the service development resources before the end of the financial year.

59. The Directorate has agreed changes to the frequent caller dashboard which includes a drop down menu of interventions and initiation dates which will more readily allow mapping of impact. This will be included in the quality and performance report and shared with CCGs.

60. The Patient Engagement Strategy is now in draft format and will be taken to the Executive Committee at the end of December for agreement. Plans will be developed and taken forward for January onwards and monitored via the Quality Oversight Group.

61. The Directorate is working with South Coast Ambulance Service (SCAS) to explore opportunities to share skills, resources and improvement programmes. Currently identified areas relate to investigation and human factors expertise, pioneering services, training in maternity, mental health, end of life care and conflict resolution training.

People and Culture

62. Our overall vacancy rate continues to be below the average from FY17/18, and slightly above target. Our most significant vacancy issue is with our non-paramedic frontline staff. We continue to actively recruit and have a significant programme of domestic recruitment events, a strong pipeline and continue where possible to streamline our recruitment processes for Emergency Operations Centre, Trainee Emergency Ambulance Crew and Paramedics

63. The Electronic Staff Record E-Forms solution across the Trust has been delivered with the exception of Control Services which has a target date of 30th November 2018. We have purchased the Electronic Staff Records/Global Rostering System interface to facilitate our planned implementation in January 2019 which will improve sickness reporting. We have also submitted a business case for the next phase of the HR Information System Transformation Programme which covers the 12 month period from Q4 18/19 to Q3 19/20. This includes further streamlining of information flows, an Employee Relations Case Management System, recording and monitoring agency staff and staff assets and improved intelligence and analytics for all managers

64. We had a very successful Internal Careers Event over two days 22 and 23 October. More than 20 stands were arranged at Southwark College to share information about both internal and external services and opportunities. We had over 130 staff attend, some in breaks and some on their day off with pre-booked 121 career discussions with members of our People and Culture team. There were also 10 x 10 minute snapshot storyteller sessions delivered by guest speakers ranging from a range of colleague in different roles.

65. Statutory and Mandatory Training compliance is 88%. Each Sector now has a compliance lead to ensure that statutory and mandatory and performance appraisal levels meet trajectories. EOC, the subject of the CQC MustDo action, is at 83.7% and a specific trajectory and action plan has been agreed with the EOC management team to achieve compliance.

66. The appraisal completion rate is 82.6% at the end of September. Compliance has now dropped below the 85% target, predominantly linked to a number of Corporate staff who

became non-compliant in September and the focus is now on achieving improvement in this area.

67. The Leadership, Education and Performance team were in attendance at every roadshow and individuals and groups who raised career and personal development matters have now been followed up.

68. There has been a decline in the physiotherapy treatment via PAM our external occupational health provider, which became apparent at the Roadshows. A meeting with the Director of People and Culture and the PAM Managing Director and Account Manager has now taken place and PAM have been required to put forward their remedial plan to address the situation as a matter of urgency. The situation is being monitored closely with a follow up meeting with PAM arranged in early December.

69. Our National Staff Survey response rate as at 21 November is 57.2%, currently the highest response rate for any ambulance service nationally. We have held our first Staff Survey Champion Network Meeting (31 October) with champions and trade union colleagues. Weekly infographics with response rate broken down to Group Station level are being published and discussed at relevant meetings. Concerns were raised that some staff were not completing the survey due to confidentiality and that comments made might lead to action being taken against them. A joint statement has been issued in partnership with the Trade Unions to reassure staff that feedback is completely anonymous.

Medical Directorate

70. The Clinical Directorate supported the CEO Roadshows and were able to answer questions about the clinical career structure, rotational paramedic opportunities, clinical equipment and education and training.

71. The Clinical Education and Standards department has been focused on the induction of the UK graduates, and delivering the associated Blue Light driving training. Core Skills Refresher (CSR) 2018:2 is due for completion mid-November so the 'Train the Trainer' for CSR 2018:3 has commenced in preparation for the November start. Visits are being arranged to partner universities to advise on the new streamlined recruitment process.

72. Progress continues to be made on the development of clinical career opportunities. This was shared at both the CEO Roadshows and the Trust Careers Fair. We are currently recruiting to vacancies for Advanced Paramedics Critical Care, cohorts 2 and 3 of the Advanced Paramedics Urgent Care have commenced their educational models. Based on feedback from the APP UC clinicians a decision has been made to delay further recruitment until April 2019 to allow consolidation of practice within existing group and to ensure that future recruitment dovetails with university start dates.

73. Practice Development Manager posts for both urgent care and critical care are being recruited to support the educational development of both the advanced paramedics and the wider organisation. The recruitment process for the Senior Sector Clinical Leads has concluded with the appointment to 3 of the 5 positions.

74. Learning from Experience has had a poster accepted to the National Learning from Excellence Conference in November. We will be able to showcase the progress the LAS has made with relation to learning. Internal and external meetings have taken place to progress the work on learning from deaths to reduce preventable deaths. In addition the Clinical Audit and Research team ran a stall over the two days of the Careers Day event and spoke to a variety of staff about how their career path could lead to or be enhanced by participating in clinical audit and research.

75. The Chief Clinical Information Officer has commenced in post – this is the first such appointment in a UK Ambulance Service and is critical to provide the clinical leadership for the ambitious digital strategy.

76. Learning from incidents continues to be a Trust wide focus overseen by the Clinical and Quality Directorates – a new Insight and Clinical Update have both been produced and shared service wide. Insight includes a patient case where every member of staff involved in the delivery of care for the individual patient is celebrated. 45 excellence reports have been received in October – which is double any previous months reporting. A "Perfect PRF" workshop was created and delivered on the back of examining emerging themes in SI and Legal investigations. Two have been held so far (both fully subscribed) and there are a further three planned for next month.

77. A Health Informatics Oversight Group (HIOG) has now been fully established along with a Clinical Informatics Reference Group (CIRG). The Mobile Directory of Service (MiDos) have funded an educational video to be made featuring LAS staff. The video is for the LAS to use freely to promote MiDos services. Hopefully should increase its use and reducing pressures on Emergency Departments. Work continues with Commissioners and Healthy London Partnership to secure on-going funding for MiDos.

78. It has been another busy period for Clinical Audit and Research (CARUI) who have successfully won two bids for research funding starting next year (both from the NIHR) – one looking at a termination of resuscitation, the other looking at frequent callers. We have recruited successfully to 11 posts in the last two months (some replacing leavers, some newly created posts).

79. The clinical focus on healthcare recruitment, senior clinician training and healthcare professional governance. There is significant external engagement with the wider health system and commissioners.

80. We continue to encourage staff to have their flu jab and uptake currently stands at 46.18%.

Garrett Emmerson
Chief Executive Officer

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	People and Culture Strategy Refresh			
Agenda item:	07			
Report Author(s):	Patricia Grealish, Director of People and Culture			
Presented by:	Patricia Grealish, Director of People and Culture			
History:	The Trust's People and Culture Strategy was approved by the Trust Board in September 2017. Following the introduction of the Trust's new strategy a number of enabling strategies will be updated to ensure alignment with this strategy and the People and Culture Strategy was one of those. The People and Culture has been considered and agreed by ExCo on 31 October 2018 and by People and Culture Committee on 8 November 2018.			
Status:	☐	**Assurance**	☒	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

In April 2018, the Trust approved its 2018/19 to 2022/23 Strategy – A world class ambulance service for a world class city. Whilst the Trust had already put in place a people and culture strategy in November 2017 and much of this work is underway and evolving, it was agreed that all enabling strategies should be reviewed and refreshed. This will enable them to be aligned to the new organisational strategy and be updated to reflect the evolution of the Trust's vision, values and behaviours.

The Board is asked to note that the People and Culture Strategy will be published in its final format (consistent with other enabling strategies and the Trust's overarching strategy) once it is approved.

Recommendation(s):

The Board is asked to note, make comment on and approve the People and Culture Strategy.

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

BAF47. The Trust may be unable to maintain service levels due to insufficient staff in the Emergency Operations Centre.

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

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

London Ambulance Service (DRAFT) People and Culture Strategy 2018 -2023

Contents

Introduction

With the new trust strategy in place for 2018/19 – 2022/23 this people and culture strategy updates our previous version to ensure it supports delivery of the three strategic themes in the trust strategy:

- Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
- A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital
- Collaboration with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

Recruitment and retention are key challenges identified in the trust strategy and our ambitions for the future of London Ambulance Service can only be delivered if we have the right people with the right skills; who are happy, proud of what they do, and engaged in delivering the improvements we want to make for patients. Recruiting new people and developing those already in the trust is a top priority to which we must commit time and resources.

There are many positives in the trust strategy which will help us tackle the recruitment and retention challenge. There will be new roles and new ways of working with opportunities for all. The future will see changes in the skills mix of our workforce with new roles being developed and more multi-disciplinary working. Supported by enhanced educational programmes and workforce development, we are building clear career pathways for people to shape long-term careers with us. Supporting this we will provide opportunities for our people to learn new approaches to dealing with different situations and helping patients in different ways.

There will also be a shift in our organisational structure to a flatter and more agile organisation where people at all levels are empowered to make appropriate decisions and lines of communication are strengthened. There will be more collaboration across the trust and with external partners and we will change how we support our patient facing teams with a business partner model in people and culture, finance and IM&T and quality.

Other changes outlined in the trust strategy which we must support our people to adopt and adapt to include:

- Greater use of technology and data
- A new approach to delivering education and training
- Relocation and refurbishment of premises - shifting where people are based and creating more open plan and flexible working
- Greater use of volunteers.

Each of these areas will have a dedicated strategy, but there are many co-dependencies with the people and culture strategy.

Our proposition to our people through the new trust strategy is that we will create a richer, more supportive working environment with greater opportunities for learning and career development, attracting and retaining the best people in the country from all walks of life. This people and culture strategy is focussed on how we can deliver on this promise.

The previous people and organisational development strategy (2017-2020) identified seven themes; which we are delivering against. The core elements remain relevant to the new trust strategy, but we have reorganised them into five themes and updated the priority challenges and actions against each.

Background

As part of creating our trust strategy we developed a new vision and a clearly defined purpose, focused on our people, patients, partners and the public.

Vision and purpose

Our vision is ***Building a world-class ambulance service for a world-class city: London's primary integrator of access to urgent and emergency care - on scene, on phone and online.***

We exist to:

- Provide outstanding care for all our patients
- Be a first class employer, valuing and developing the skills, diversity and quality of life of our people
- Provide the best possible value for the tax-paying public, who pay for what we do
- Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London

Golden Threads

As before it is vital that our people strategy is sustained by key overarching threads that run across all elements of the work we do with and for our people.

- **Workforce planning**. We must build an organisation that provides a flexible and learning environment for our people throughout their careers. This will mean that we build and maintain expertise in strategic workforce planning, design flexible working blueprints
- **Inclusion**. Organisations that are committed to effectively embedding 'difference' demonstrate the ability to deliver better decisions, better performance and better outcomes, in our case for our patients. This work will sit at the very heart of transforming our culture and building a motivated workforce which delivers outstanding outcomes for our patients
- **Well Being**. In order to building a sustainable workforce we are committed to ensuring the support we give our people is the best that it can be. Increasingly this will mean greater focus on mental health as well as moving to a proactive approach to supporting well-being at work.

Values and behaviours

As part of creating our new organisational strategy we worked with people across the trust to articulate a new set of values and behaviours that must be embedded to deliver on our vision. These values and behaviours inform every stage of the employee journey at London Ambulance and further actions set out in this strategy will help to embed them.

Values The qualities we embody	Behaviours How we demonstrate our values in actions
Respectful	• Caring for our patients and each other with compassion and empathy • Championing equality and diversity • Acting fairly
Professional	• Acting with honesty and integrity • Aspiring to clinical, technical and managerial excellence • Leading by example • Being accountable and outcomes orientated
Innovative	• 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 and transparent • Building trust

Recent progress on people and culture

We have set out here a summary of progress made on actions identified in our people and organisational development strategy 2017-2020.

- Completed recruitment to our executive leadership team.
- Worked with staff and other stakeholders to develop a new vision and behaviours aligned to values.
- Moved the annual staff survey to a fully online format in 2017, after consulting with colleagues and other Trusts, and achieved our highest ever response rate.
- Established a network of staff survey champions who will lead local action plans.
- Increased leadership roadshow sessions to engage with more staff more regularly.
- Improved understanding of health, safety and wellbeing responsibilities.
- Implemented Freedom to Speak Up policy with a new role to support staff in raising concerns.
- Developed coaching and mentoring including a dedicated programme for BME staff.
- Introduced a ‘management essentials’ toolkit to support managers.
- Developed career pathways to show opportunities for growth and development.
- Started introducing 360 feedback.
- Started introducing a business partnering model for support services.
- Improved compliance with the Workforce Race Equality standard.
- Established an Equalities Committee including Patient Forum members.

- Updated wellbeing, health and safety and stress management policies.
- Our ESR Transformation Programme has transformed our delivery and decision-making for training and development and also helped to change the way we communicate with our people.
- Implemented MyESR across the London Ambulance with over 98% of staff now able to update their own employee record and complete eLearning via mobile devices.
- Designed and implemented the ESR Workforce Dashboard, enabling our managers to access key workforce information about their teams and staff and ensuring the Trust has far greater understanding and assurance of StatMan training and appraisal compliance
- Launched Management Development Programme with the start of the Visible Leader Programme
- Completed organisational restructures across all directorates except Strategic Assets and Property

Co-dependencies

The people and culture strategy will work with and support the other enabling strategies of the trust:

- Clinical
- Clinical education and training
- Estates
- Fleet and equipment
- IM&T
- Partnerships
- Quality
- Volunteering
- Operational transformation plan

These strategies are being developed in parallel, so we will need to review the people and culture specific actions as the other strategies are finalised. To develop this strategy, we have also considered the following papers.

Internal to London Ambulance

- Care Quality Commission Reports: 2015, February 2017, May 2018
- Workforce Race Equality Standard Report 2017
- London Ambulance Trust Business Plan 2018/19
- Chief Executive Objectives 2018/19
- Staff survey responses 2016/17 and 2017/18
- Gender Pay Report 2017/18

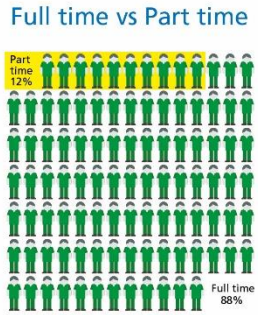
External

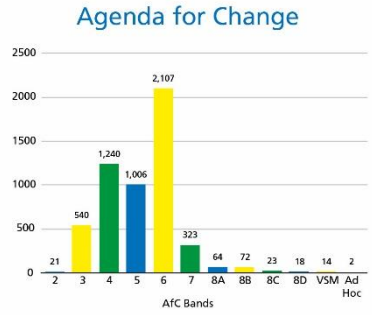
- Lord Darzi Report, Better Health and Care for All 2018
- Skills for London, Mayor's Office, 2018
- Carter Review on NHS productivity 2015/2016
- Carter Review on Ambulance Productivity October 2018
- IUC/NHS 111 Workforce Blueprint
- Association of Ambulance Chief Executives Strategic Objectives 2018

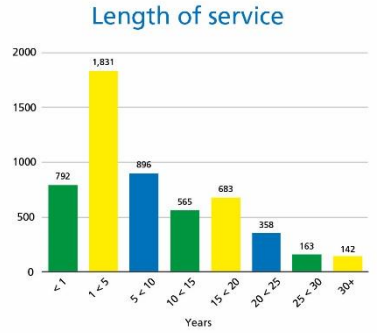
London Ambulance Service and our people

We are the largest and busiest ambulance service in the UK and the only London-wide NHS Trust. We have over 5,400 staff providing a 24/7 service for Londoners, commuters and visitors to the capital. We cover around 620 square miles and work from over 70 bases.

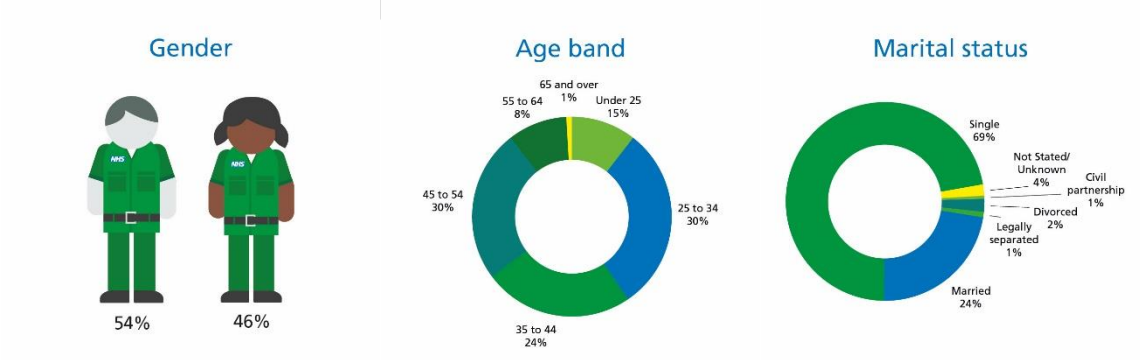
In 2017/18 we answered 1.9 million 999 calls and attended 1.2 million incidents. Our South East London NHS 111 service answered 356,826 calls. From August 2018 we will also be running the North East NHS 111 service. We also have a non-emergency transport service which now provides around 760 journeys each week.







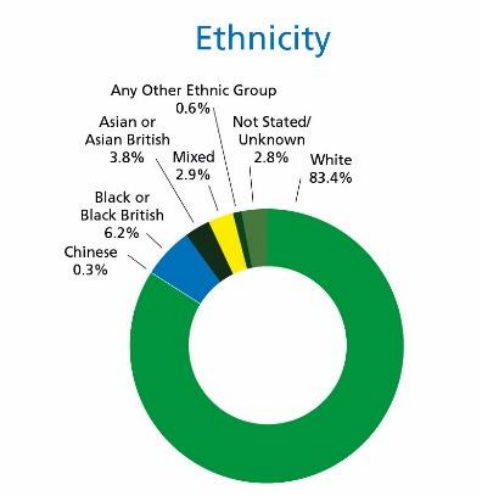
The majority of our people work full time and most are in clinical or support roles on pay band 6 and below. This balance presents a significant challenge around long-term career opportunities within the services, which we are working to address. See the career pathway section below for more information.



Respectful | Professional | Innovative | Collaborative

Building a world-class service for a world class city

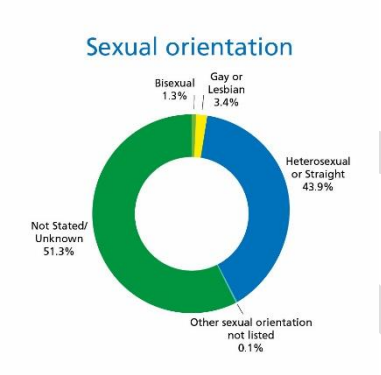
We have a considerably higher proportion of men working in London Ambulance compared to other NHS provider organisations; which often have a large majority of women. We also have a high proportion of younger single people.

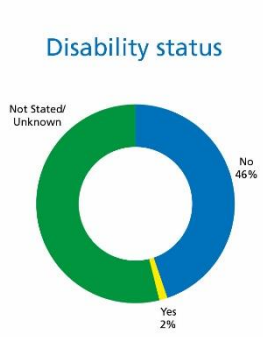


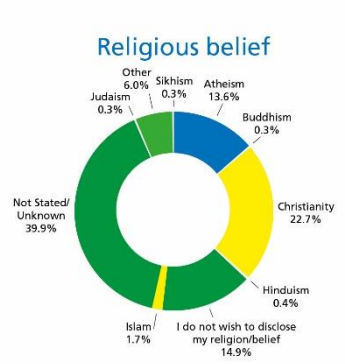
Diversity is an area where we are working hard; we need to recruit more people from black and minority ethnic backgrounds to more accurately reflect the diversity of London's population.

It is clear and well evidenced that diverse workforces perform better. Putting diversity at the heart of our strategy will support the transformation of our culture.

We are looking to improve our data recording of sexual orientation, disability and religion so we can have a fuller understanding of our workforce to effectively plan for the needs of all.







A career with the London Ambulance Service

We want to recruit the best new talent and retain the excellent staff we have; helping everyone to develop new skills and grow their careers.

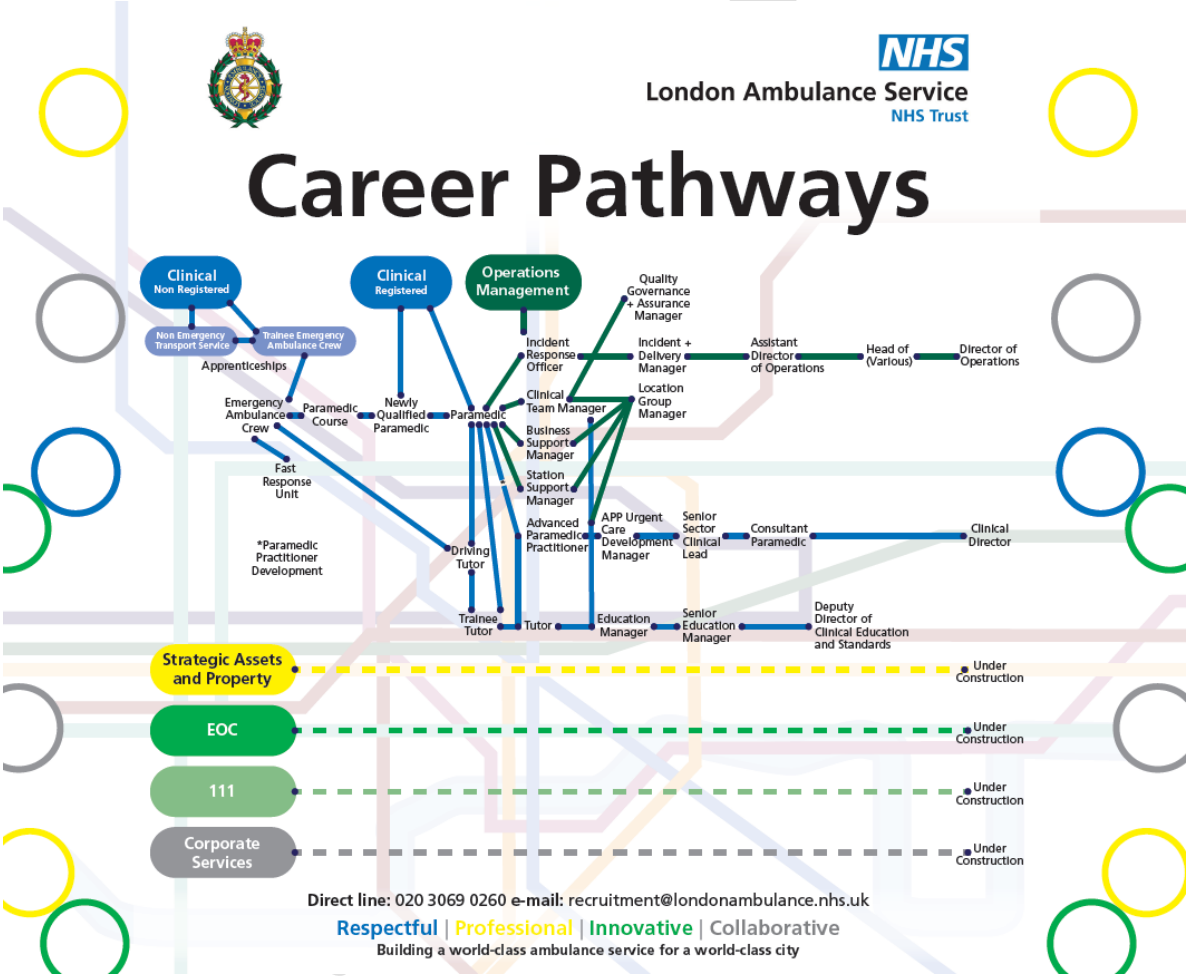
We want to establish a reputation as an employer of choice for long-term careers in the NHS; both for clinical and non-clinical roles. To build our new pioneer services we must promote the London Ambulance Trust brand and target our recruitment work on a wider range of clinicians.

To support recruitment and retention, we have created new career development pathways for people in all types of roles. The pathways show how people can join the Trust through different routes and, once with us, move into different clinical areas, management, education or our support functions. We will use these pathways in our continued work with universities to ensure potential recruits still in education, can see the opportunities for long-term careers with us.

We recognise that patient facing roles in our call centres and on the road can be high pressured and stressful and that we must provide options to move within the organisation if people no longer wish to work in frontline roles. Doing so will help retain vital experience which can support the next generation of patient facing staff. The pathways will make sure that people can see these options and how their careers can develop within the service.

Alongside the career pathways we will work with leaders across the Trust to ensure there is effective talent and succession management in all services. This will strengthen the resilience of our services as well as supporting individual staff to grow and develop.

Our clinical career pathways



People and culture themes

Within our strategy we have five people and culture themes with action plans against each. We have retained all the elements of the 2017 themes but have regrouped them. The ordering is not a prioritisation, all themes must be addressed simultaneously. Prioritisation will come within the action plans for each theme.

2017 – 2020 themes	2018 – 2023 themes
• Talent • Engagement • Rewarding and recognising excellence • Performance development and growth • Leadership and management • Inclusion • Healthy workplace	• Talent, development and growth • Engagement and recognition • Leadership, management and performance • Inclusion • Healthy workplace

In each theme we have set out a series of commitments which we will make as an organisation, and which we will expect managers and every individual in the trust to deliver against.

Importantly and providing the foundation stone of the work we do, we will continue to drive improvements in our data quality and to our workforce processes by maximising the functionality in ESR. Our next phase of work under our ESR Transformation Programme will streamline the way that information flows between workforce related systems and track and improve our understanding of the reasons why people leave the service, our development needs, our agency staff, our staff assets and our Employee Relation case management. We will also continue to make more available to all of our managers a much greater depth and richness of workforce intelligence and analytics so that they can optimise their day to day management of their teams and deliver improvements in Statutory Mandatory training compliance, PDR Appraisal rates, reductions in absence management and a staffing profile which is more balanced and reflective of the local population we serve.

Theme 1 – Talent, development and growth

This theme covers recruitment of new talent and the continuous development and growth of existing staff to ensure we have the right people and skills across all our clinical and non-clinical services with the capabilities, commitment and behaviours needed for current and future organisational success.

Moving forward our search for new and talented staff must expand to cover the new roles being introduced in our pioneer services alongside continuing to focus on filling vacancies in high priority areas. As these pioneer services develop through their pilot stages and into full roll out we will develop partnerships with other NHS providers to establish rotational models for nursing, midwifery, mental health and other roles which will encourage staff to maximise their potential.

We must develop the brand of London Ambulance Service and establish ourselves as a multi-disciplinary employer and an employer of choice within the NHS in London. In building our brand we will demonstrate that we are a learning organisation and focused on continuous improvement in everything we do. For our people this will mean on-going opportunities to learn and improve in order to reach their potential; both in terms of effective high-quality services, patient care and efficiency.

We want people to feel welcome when they join, experiencing a positive recruitment and induction; and we want that positive experience to be maintained year on year with effective appraisals and personal development plans linked to our career pathways.

We are going to improve the training and education that our staff receive by reorganising our education centres, improving access to electronic and mobile learning, and by increasing the amount of dedicated time that our operational staff have for training and education.

We must address short and medium-term recruitment issues but must also actively look at long-term strategic workforce solutions with a timeframe of 10 years plus. We will continue to build relationships with HEE and partners in education to tackle the long-term supply of paramedics and other roles and will seek to collaborate with other Trusts to support our work.

Key challenges we must address

- Recruit to priority roles including areas with high vacancy rates and our new pioneer services
- Retention of skilled and talented staff committed to deliver outstanding performance
- Improve the diversity of our teams to better reflect London's population
- Ensure consistency of access to learning with all our people given opportunities to develop and grow
- Implement a wide choice of apprenticeships across the service
- Establish the trust as an employer of choice with a strong brand and presence

Our commitments

- **Organisational commitments**
  - Deliver a responsive end-to-end experience for recruiting managers and candidates covering advertising, application, appointment and induction
  - Provide a broad range of clinical and non-clinical training opportunities accessible to all
  - Provide effective tools for development reviews and appraisals

- **Management commitments**
  - Ensure team level talent and succession planning is in place
  - Support individuals with personal development, ensuring everyone has time for training and development
  - Ensure fair and transparent processes are followed for appointment/promotion taking positive steps to improve diversity of teams where required

- **Individual commitments**
  - Proactively identifying learning and development opportunities
  - Maintaining core skills and keeping all mandatory training up to date
  - Supporting others to develop and grow by passing on skills and knowledge

Priority actions

Recruitment

- Targeted recruitment for priority areas including the new pioneer roles and existing areas with high vacancies e.g. call handlers in emergency operations centres
- Focused recruitment activity to increase the diversity of our workforce
- Support recruitment of volunteers in line with the trust's new volunteer strategy
- Introduce values-based recruitment processes
- Thoughtful and thorough induction/on-boarding for newly recruited and promoted staff
- Support managers to give candidates the best experience through recruitment and induction

Development & growth

- Supporting the organisational development needs of newly created teams/services including pioneer services and the integrated clinical assessment and triage service (iCAT London)
- Implement improvements to our education and training services
- Support the training and organisational development needs of individuals and teams adopting new technology in their work
- Implement sustainability and succession plans to ensure we attract/retain the right people with the right skills in the right roles

Theme 2 – Engagement and recognition

We can only deliver the ambitions in our trust strategy with widespread engagement at all levels across all services. We must work hard to listen and act upon the experiences of our people; and we must empower them, so they can drive change and improvement themselves.

Staff survey results have shown significant improvements in levels of engagement in recent years, however, this dipped slightly in 2017 and we must work hard to recover and maintain momentum. We must seize the opportunities that change brings by engaging our people in building the new services and driving the improvements outlined in the new trust strategy.

As a 24/7 service with mobile staff operating from over 70 sites across 620 square miles we must work hard to ensure everyone has opportunities to engage with operational management and the trust leadership team; and to get involved in projects beyond their immediate role.

Key challenges we must address

- Effective communication channels for a dispersed workforce
- Visibility of the executive team and senior management groups
- Involvement of our people in the direction of the trust and continuous improvement of their work
- Tackling bullying and harassment

Our commitments

- **Organisational commitments**
  - Provide an effective range of two-way communications and engagement channels to talk and listen to people across the trust
  - Recognise excellence and promote it across the trust to share achievements and spread good practice
  - Improve education and awareness of bullying and harassment and reinforce routes to tackle conflict at work constructively and proactively

- **Management commitments**
  - Attend regular bi-monthly management group meetings for the top 700 managers and ensure key messages and themes are communicated across teams
  - Hold regular team meetings to encourage strong lines of communication and continuous improvement planning
  - Commitment to tackling bullying and harassment across teams and building own skills and self-awareness

- **Individual commitments**
  - Proactively seek opportunities to shape and improve services within your team and across the wider trust
  - Proactively read trust and service level communications and alert managers/supervisors if you need more information on specific topics
  - Thank and praise colleagues for a job well done

Priority actions

- Welcoming and engaging the NHS 111 and Integrated Urgent Care service from North East London; joining the trust in 2018
- Improving communication across management groups and frontline employees
- Tackling bullying and harassment
- Pilot and evaluate the 'reverse mentoring' and 'sponsorship mentoring' schemes
- Maintain and facilitate regular Senior Management Meetings to support engagement and collaboratively tackle the management challenges

Theme 3 – Leadership, management and performance

The ambitions in our trust strategy will see new ways of working and changes that affect our people and external partners. Delivering these ambitions will need excellent leadership across the trust; both from people with existing leadership responsibilities and those taking on new roles. As a trust we must support our leaders of today and tomorrow by providing training and equipping them with effective tools to support team and line management. As individual leaders we must commit the time and resources needed to lead effectively.

We have created a development programme to offer a range of leadership training and education opportunities for staff across all functions and levels of the organisation from new aspiring leaders through to our executive team. Each level allows us to develop and map skills and knowledge alongside the trust's values and behaviours. The structure of the programme is shown in appendix 2.

Leadership must be inclusive and engaging across all our workforce. With our trust strategy, we will be developing a volunteer strategy and must ensure that volunteers and other temporary staff also feel part of the team, get the training they need and receive supportive and inspirational management.

Key challenges we must address

- Perceptions of unfairness in access to promotions and flexible working (identified through staff survey responses and feedback in staff meetings)
- Multiple systems for tracking training and development activities and achievements
- Clear organisation structures across the trust that set out management accountabilities and reinforce clear lines of communication
- Effective student management system for our clinical learners

Our commitments

- **Organisational commitments**
  - Provide a comprehensive leadership development and support programme covering all levels of leadership
  - Provide the tools, policies and processes needed for effective management to be delivered consistently and transparently
  - Complete the required changes to the organisation structures to empower fast effective decision making and clarity of responsibilities

- **Management commitments**
  - Make time to lead/manage individuals and teams effectively, with fairness and transparency
  - Identify personal development needs to improve leadership/management skills
  - Identify and support talented individuals to become our leaders of tomorrow

- **Individual commitments**
  - Be clear about performance expectations and priorities; and seek clarification if unsure
  - Respect fair leadership
  - Raise concerns if you experience or observe persistent poor management/leadership

Priority actions

- Visible Leader Programme delivered across relevant management group
- Unconscious bias training designed and delivered
- Equality and diversity training will be defined, sourced and planned and be included in Core Skills Refresher training for all employees
- Effective talent programme established and underway

Theme 4 – Inclusion

We want our workforce to be a diverse and inclusive community that celebrates difference and uses the strength diversity brings to drive performance. We know that our workforce diversity needs to improve to reflect the communities we serve. We will give particular focus to the Workforce Race Equality Standard (and Workforce Disability Equality Standard) which will help us embed inclusivity through the London Ambulance Service to create a truly remarkable place to work. However, this is just one aspect of our work and we will seek out best practice from other organisations in relation to their work across all protected characteristics and define and implement ways of working for the benefit of our people and our service.

Key challenges we must address

- Increase BME representation at all levels within the trust and particularly in leadership positions
- Address perceptions of bullying and harassment and inconsistent access to development and promotion
- Effective, timely and regular data rich analysis to support identifying inclusion interventions and activities

Our commitments

- **Organisational commitments**
  - Dedicate resources and efforts to recruiting and developing talented people from BME backgrounds so our workforce more accurately reflects the diversity of London's population
  - Improve data and reporting for BME and disabled employees to support planning of effective improvement interventions
  - Understanding and addressing the BME experience at London Ambulance with particular focus on equity through our discipline and grievance processes
  - Introduce a Trust-wide Code of Conduct in partnership with our networks, Trade Union partners and other stakeholders
  - Celebrate and promote the contribution of people from minority groups through our VIP Awards

- **Management commitments**
  - Commitment to engaging in 'big conversations' on race, disability, sexual harassment to bring forward employee-led improvements and initiatives and build an environment of Dignity at Work
  - Improving self-awareness of bias and supporting team development activities.
  - Commitment to meeting objectives set out in PDRs to take ownership of tackling diversity across local teams
  - Complete unconscious bias training and ensure fairness in recruitment and promotion decisions.

- **Individual commitments**
    - Proactively consider how the work you do could help improve diversity and inclusion.
    - Complete all training on diversity and inclusion relevant to your role.
    - Report any incidents of unfair treatment linked to diversity and inclusion.

Priority actions

- Pilot and evaluate the Sponsorship Mentoring programme for BME staff
- Support BME, EAC and EMT staff to progress to becoming paramedics, by providing access to additional bursary funding
- Introduce training for all staff across the organisation for dignity at work and unconscious bias
- Set targets for recruitment and promotion of BME staff and nominate leads for specific front line roles: EAC, Paramedic and EMD
- Address issues of BME staff being half as likely to be appointed to roles and twice as likely to be involved in formal disciplinary action

Theme 5 – Healthy workplace

We must place wellbeing and mental resilience at the heart of our people's experience of working at the London Ambulance Service. By engaging with our people we can support, encourage and inspire people to look after their health throughout the employee journey. We will offer high quality, prevention, support and timely therapeutic interventions to optimise health and wellbeing in the workplace. We know that our patient facing roles can be physically demanding, highly pressurised and at times traumatic, so we will give particular focus to prevention and management of musculoskeletal, mental health and stress management for this staff group.

Our aim is to make sure that all of our people can achieve a healthy balance between work and home life; are equipped to deal with the pressures and stress; and have safe and effective physical environments (vehicles and buildings) to work in.

Key challenges we must address

- The high levels of musculoskeletal problems and stress as reasons reported for sickness absence
- Evaluate and review our offering to staff prior to, during and following exposure to multiple major and serious incidents
- Proactive approach to resilience, health and wellbeing
- Address conflict at work, bullying and harassment
- High levels of reported abuse (physical and bullying) by patients (through the staff survey)

Our commitments

- **Organisational commitments**
    - Enhance data collection and reporting for health and wellbeing, including sickness absence to support planning of effective improvement interventions
    - Make a programme of support for physical and mental wellbeing accessible to all staff, with crisis support available at all times

- Proactively encourage individuals and teams to take positive steps to maintain/improve their physical and mental health
- Establish a proactive approach to health and wellbeing, through delivery of a co-created action plan which demonstrates commitment to health and wellbeing throughout the employee journey, with specific focus on musculoskeletal and mental health

Management commitments

- Make time for open conversations with individuals and teams about pressures affecting physical and mental health
- Prioritise actions that could, directly or indirectly, reduce pressures on individuals and teams e.g. engaging staff in decisions which affect them, creating clear well designed job roles, progressing recruitment to vacancies; reviewing rotas and the spread of workloads
- Proactively support staff on short or long-term sick leave to return to work within a reasonable time frame, with the right support in place

- **Individual commitments**
  - Take personal responsibility with regards to the health, safety and wellbeing of ourselves and others
  - Take positive steps to achieve a healthy work/life balance and maintain personal resilience, physical and mental health
  - Be open with managers/supervisors about pressures affecting physical and mental wellbeing; asking for help if needed

Priority actions

- Using data analysis improve our understanding of and actions to address Musculoskeletal and mental health issues in the workplace.
- Proactive approach to stress management with an effective toolkit for individuals and managers to support mental wellbeing
- Effective resilience training for managers and other groups of staff, including mental health first aid for relevant groups
- Proactive approach to addressing conflict in the workplace supported by an effective toolkit for individuals and managers
- Review, redefine and retender our wellbeing, musculoskeletal, mental health and occupational health service provision
- Conflict resolution training for all employees to support handling of patient abuse
- Effective and at point of need services for physio, counselling and OH

Delivering our strategy

This strategy sets the direction and pace of change over the next few years as we aspire to achieve excellence in all we do. It is not intended to be, nor should it be, prescriptive or cover every eventuality or new development that may emerge over the coming years.

Responsibilities

As identified in each of the people and culture themes, the responsibility for delivery is shared and we can only achieve our objectives through commitments from individuals, leaders of teams and services, and corporate wide actions led by the People and Culture team and the Executive Leadership Team/Trust Board.

It is an essential part of any people strategy that managers and leaders share responsibility for modelling the right behaviours and creating the environment we all need to succeed. The People and Culture team will support managers by providing the best tools, processes and structure to enable that to happen.

In addition, the People and Culture team have responsibility to make sure that they bring solutions to meet the needs of colleagues and teams across the trust, working collaboratively to remove barriers and blocks to delivery. The People and Culture team will seek both formal and informal feedback on their work and ensure they listen and learn from this. Service level agreements will be put in place where this is relevant and results against key performance indicators will be published. The Head of each function for the People and Culture team, will be responsible to the Director, through their individual objectives, for specific projects and associated performance indicators.

Resource implications

Delivering the ambitions set out in this strategy will have resource implications for the trust as summarised below:

- Increased staff participation in leadership development programmes and emerging systems for greater engagement in local service improvement will require people to be released from other duties with potential backfill requirements
- Higher completion rates for statutory and mandatory training and appraisal would mean more staff committing time to non-patient facing activities
- Increased recruitment activity with targeted work in publications reaching our priority audiences will require more investment in advertising, event attendance and recruitment materials
- Refocusing our wellbeing offering on prevention, and improvement will require changes in how we prioritise and allocate our wellbeing resources
- Increased engagement from staff in preventative musculoskeletal and mental health prevention and early interventions would mean more staff accessing therapy whist on duty
- Early resolution of workplace conflict requires our round table facilitators to be given protected time to support colleagues, continually develop and receive appropriate supervision
- Maximising technology to enable effective and efficient learning and engagement will require further investment in the ESR programme and other technology related solutions (ER case work, student management system, digitisation of records)

Long-term objectives

Medium to longer term objectives will be focused on key areas of embedding the work we have begun through this and our earlier strategies and seeking efficiency, value and best practice through collaboration with organisations across the health system, London GLA and our blue light colleagues.

The Carter Report on unwarranted variation in ambulance trusts has set a clear challenge to look at the way we deliver services and provides an ideal opportunity to collaborate with others to achieve better outcomes. Work has already started at a national level to develop strategic workforce planning across ambulance trusts and seek to influence UK higher education organisations and HEE funding for paramedics. We have also started a close collaboration with South Coast Ambulance Service to better understand variation of cost of deliver of people services and agree and adopt collaborative approaches that arise.

We will see the development of our estate to provide modern facilities that enhance the working environment for our teams and support collaboration and efficient workforce models.

Key Themes

- Collaboration across Ambulance and Healthcare Trusts
- Seek London partners to share best practice and achieve improved value
- Maximise use of technology to enable smarter working and learning
- Develop best in class data analytics to support strategic workforce planning
- Develop and grow strategic workforce planning capabilities

Measuring success

A key tool for understanding how people feel about working for the service is the national annual staff survey. We supplement this locally with three shorter surveys, so we capture quantitative feedback from our people on a quarterly basis. We will look to review the Friends and Family test use for 2019/20 to allow us to better use it to take pulse checks and monitor progress of our initiatives across different parts of the organisation.

A range of indicators within our monthly performance monitoring also tracks workforce related deliverables, including: vacancy rates, sickness absence, workforce ethnicity, mandatory training and appraisal compliance.

In addition, we gather rich intelligence on how people feel about working at the London Ambulance Service through meetings and internal communications channels including, trade union partnership meetings, our Learning into Action Facebook group, and executive roadshows.

Feedback from our regulators and auditors will also be used to confirm that people related risks are reducing.

Routine reporting against targets

From 2018/19 a detailed scorecard for People and Culture will be monitored by the Executive Leadership Team and the Board. The scorecard tracks performance against 49 indicators (31 monthly, 3 quarterly, 15 annually), covering all five themes. A summary of indicators linked to each theme is below. The full scorecard including baseline data and targets is attached as appendix 3.

Alongside the scorecard, overall progress against this strategy will be monitored through the People and Culture Committee and we will report to the Executive Leadership Team, People and Culture Committee and Board on specific projects as they are implemented.

Indicators by theme
Talent, development and growth
• Vacancy rate • Turnover (overall and international recruits) and exit interview completion • Time to hire (advert to conditional offer and conditional offer to pre-employment checks complete) • Performance against service recruitment plans (EOC, TEAC, Paramedic, 111) • Apprenticeships
Engagement and recognition
• Staff recommending London Ambulance Trust as a place to work and receive treatment • Staff survey response rates • Recognition and value of staff by managers and the organisation (Staff Survey)
Leadership, management and performance
• Average length of time to investigate, and complete disciplinary, attendance management, suspension and grievance processes • Appeals upheld and tribunal outcomes • Appraisal compliance and quality • Statutory and mandatory training compliance • Managers completing management essentials training • Staff agreeing they have supportive managers
Inclusion
• BME starters and leavers • Distribution of BME staff across all pay bands • BME staff survey response rate and specific scores on engagement, bullying and harassment, abuse, equal opportunities and discrimination • Trust Board reflection of workforce diversity
Healthy workplace
• Sickness levels (short-term, long-term and total) • Staff accessing counselling and physiotherapy over time • Staff exposed to body fluids • MSK injuries • Staff survey results on organisational health and wellbeing • Levels of staff immunisation • Levels and time to resolve workplace conflict, bullying and harassment.

Conclusion

We have made some good progress on the people and culture themes identified in the 2017-2020 strategy but there is still much to do. This updated strategy aligns our work to the priorities in the new trust strategy and identifies the key issues across five themes with detailed actions in each theme which we must now address to support delivery of the trust strategy.

Patricia Grealish
Director of People and Culture

November 2018

Appendix 1. Action plan by theme

Talent, development and growth	Timescale	Lead
1. Establish and maintain a detailed programme of recruitment events and activities to source new talent; including targeted proactive actions to attract recruits from BME communities.	Ongoing	Head of Talent
2. Create ambassadors, who are Londoners, who can use their reach to positively connect across communities and cultures and promote the service as an employer.	2019/20	Diversity Lead
3. Review and improve recruitment processes to ensure a responsive end to end experience for managers and candidates.	2019/20	Head of Recruitment
4. Maintain a robust and transparent approach to employment and capability checks such as DBS, Fit and Proper Person, professional registration and Qualification checks.	Ongoing	Head of Talent
5. Introduce a values-based recruitment process to ensure that our people are recruited not only for their competencies but also for their values and attitude in support of the core values of the service.	2019/20	Head of Talent
6. Develop a partnership with an external provider to deliver apprenticeships of all types.	Ongoing	Apprenticeship Lead
7. Continue to provide dynamic workforce modelling and planning to support recruitment.	Ongoing	Head of Workforce Analytics
8. Establish and maintain safe staffing levels in line with the strategic vision and establishment of iCAT London and pioneer services.	Ongoing	Head of Workforce Analytics
9. Establish and maintain talent and succession management planning to support the aspirations of our people and ensure our services are resilient and managing for the unforeseen.	2019/20	Head of Talent
10. Review and improve induction and on-boarding programmes covering the needs of permanent recruits; people joining on rotations; and volunteers.	2019/20	Head of Talent
11. Review and improve management of our temporary bank and volunteer workforce ensuring they feel part of the London Ambulance Trust team and are trained to the required standards.	2019/20	Head of Talent/Head of Engagement
12. Review and improve Statutory and Mandatory training content and methods of delivery.	2019/20	Head of Leadership and Performance
13. Introduce a Learning and Development Framework linked to our career pathways showing opportunities for all our people to develop their career and reach personal goals.	Ongoing	Head of Leadership and Performance

Talent, development and growth	Timescale	Lead
14. Review and refresh statutory and mandatory training content and delivery; shifting to deliver over maximum relevant online with a robust reporting function to ensure compliance and timely completion. Implement pre-employment completion of statutory mandatory training	2019/20	Head of Leadership and Performance
15. Implement processes to capture the effectiveness of training activities and record that required outcomes are met.	2019/20	Head of Leadership and Performance
16. Introduce annual review of all training activities to ensure all courses are fit for purpose and accessible to all; and that we respond to changing needs.	2019/20	Head of Leadership and Performance

Engagement and recognition	Timescale	Lead
1. Implement a best practice approach to staff engagement; following review of systems used in other organisations.	2019/20	Head of Engagement
2. Establish a clear internal communications strategy that enables dynamic two-way conversations with our people using different channels and approaches, recognising the challenge of talking with a dispersed workforce.	2019/20 and ongoing	Head of Engagement
3. Agree and embed the revised partnership arrangements with our trade union colleagues, ensuring that we meet regularly and work together to achieve the strategic aims of the London Ambulance Trust.	2019/20	Head of Engagement
4. Extend the use of "people stories" used at Trust Board to other committees and groups	2019/20	Head of Engagement
5. Review best practice and implement a model of staff led improvement methodologies (e.g. experience based design; a way of bringing patients and staff together in re-designing services).	2019/20	Head of Engagement
6. Design and deliver an annual 'innovation' event to celebrate the work of our people as they strive to make us more efficient, fit for the future and an exciting place to work.	2019/20	Head of Engagement / Head of Internal Communication
7. Review and revitalise the 'Total Reward Statement', emphasising the wide range of benefits available through working for the NHS and schemes local to London Ambulance Trust.	2019/20	Head of Engagement
8. Review and improve a programme of recognition schemes and awards covering annual awards and ways to recognise good work throughout the year and corporate and local levels.	2019/20	Head of Engagement
9. Introduce a simple thank-you tool/scheme allowing managers and colleagues to publicly recognise the good work of others.	2019/20	Head of Engagement / Head of Internal Communication

Engagement and recognition	Timescale	Lead
10. Introduce celebration of academic and development achievement, holding 'graduation' ceremonies to recognise the commitment to learning and professional development.	Ongoing	Head of Talent / Head of Engagement
11. Actively encourage and support our people to apply for external awards to gain recognition for the work that they do and to raise the profile of London Ambulance Trust.	2019/20	Head of Leadership and Performance/ Head of Talent
12. Seek external review of our staff recognition schemes and review best practice from elsewhere.	2019/20	Head of Engagement
13. We review the Friends and Family test use for 2019/20 to allow us to better use it to take pulse checks and monitor progress of our initiatives across different parts of the organisation.	2019/20	Head of Engagement / Director of People and Culture

Leadership, management and performance	Timescale	Lead
1. Review best practice and implement a Board Development programme that strengthens our position as a unitary board and enables the executive team to work effectively as a team and provides individual development and support as required.	Ongoing	Director of People and Culture
2. Establish a Leaders of Tomorrow programme, supported by the executive leadership team and Trust Board,that offers opportunities for our talented people to take part in challenging and stimulating learning programmes.	2019/20	Head of Talent / Head of Leadership and Performance
3. Work with groups and teams across London Ambulance Trust to embed the new trust behaviours in support of developing our culture for the future.	2019/20	Head of Leadership and Performance
4. Establish processes and events to draw on the talent of our leadership community to address organisational challenges and prepare the Trust for the future.	2019/20	Director of People and Culture
5. Establish clear role descriptions and accountabilities as part of internal restructures that empower people to take decisions at the appropriate level, ensuring robust governance, but giving the ability to 'just do it'.	Ongoing	Head of Talent / Head of Engagement
6. Establish a process for secondment to key projects as part of the Leaders of Tomorrow programme.	2019/20	Head of Talent
7. Introduce 'days' / 'weeks' focused on setting objectives for the year ahead and ensuring that PDR appraisals work collectively to focus the whole organisation on achieving the London Ambulance Trust overarching objectives.	2019/20 and 2020/21	Head of Leadership and Performance

Leadership, management and performance	Timescale	Lead
8. Set standards for our managers that demonstrate the importance in their roles on performance appraisal and review, challenging them to be the role model for others to follow.	2019/20	Head of Leadership and Performance
9. Implement a dynamic online tool to support PDR Appraisals and on-going conversations about performance and personal development.	2019/20 – 2020/21	Head of Leadership and Performance
10. Establish clear roles and accountability for supervision, ensuring that clear role descriptions provide clear lines of responsibility and reporting.	2019/20	Head of Talent / Head of Engagement
11. Continue to develop our information capability to provide timely and accurate information to managers about the people they are responsible for.	ongoing	Head of Workforce Analytics
12. Review and update the Performance Review Process to ensure that effective performance conversations are held across London Ambulance Trust at least annually.	2019/20	Head of Leadership and Performance

Inclusion	Timescale	Lead
1. Develop accurate and timely intelligence about the experience of people from across the diversity spectrum. Review practices of other organisation and develop and implement clear reporting that will support our work.	Ongoing	Head of Workforce Analytics
2. Develop action plans to hold ourselves to account and progress against all key indicators for Workforce Race Equality and Disability Standards.	Ongoing	Head of Workforce Analytics
3. Establish clear Equality Objectives across all nine protected characteristics.	2019/20	Diversity Lead
4. Maintain and develop staff networks/groups representing minority/special interest groups; ensuring there are channels for feedback and discussion with the trust leadership.	ongoing	Diversity Lead
5. Review and re-launch our equality and diversity training interventions to ensure they reflect the values of London Ambulance Trust and set clear expectations and standards.	2019/20	Diversity Lead
6. Train our managers and leaders to ensure they understand our approach to inclusion and are role models for diversity and inclusion.	2019/20 – 2020/21	Diversity Lead
7. Include modules on unconscious bias and inclusive leadership within our leadership development programme.	2019/20	Diversity Lead and Head of Leadership and Performance
8. Share best practice and engage with other employers and communities around diversity standards.	2019/20	Diversity Lead

Inclusion	Timescale	Lead
9. Actively identify and engage with influential groups external to London Ambulance Trust to improve our progress against inclusion benchmarks / criteria.	2019/20	Diversity Lead
10. Actively engage with our Blue Light colleagues on the inclusivity work stream of the Collaboration Project.	Ongoing	Diversity Lead
11. Establish ways of working with our Patient's Forum to ensure inclusion issues are addressed in our patient and public engagement work.	Ongoing	Diversity Lead
12. Implement a programme of 'lunch and learn' to support positive debate around all aspects of diversity.	Ongoing	Diversity Lead
13. Develop a calendar of events that celebrates a diverse London Ambulance Trust community.	2019/20	Diversity Lead
14. Establish processes and channels to encourage conversation and shift understanding of inclusion beyond the obvious towards meeting individual needs.	2019/20 – 2020/21	Diversity Lead

Healthy workplace	Timescale	Lead
1. Implement an externally accredited programme for health and wellbeing (Healthy Workplace Charter); providing a framework that promotes healthy working lives, helps reduce accidents and sickness absence; and ensures support systems are available for staff following incidents or sickness.	2019/20	Head of Healthy Workplace
2. Review and implement effective channels to ensure people have the best information on health and wellbeing through a range of sources appropriate to their role/working patterns.	2019/20	Head of Healthy Workplace
3. Introduce a programme of events and activities to help our people focus on their health linking them to key national health/wellbeing campaigns.	Ongoing and 2019/20	Head of Healthy Workplace
4. Develop proactive approaches to support the mental health and wellbeing of our people looking at assessments of roles and environments to identify stressors.	2019/20	Head of Healthy Workplace
5. Adopt a preventative approach to reducing sickness absence and proactively managing cases of ill health to keep our people at work or facilitate a more timely return.	2019/20 and ongoing	Head of Healthy Workplace and Head of Engagement
6. Established a proactive 'total health' approach to assessing the stressors affecting our people and provide support for people to achieve their potential, feeling enabled to do a good job and work productively	2019/20	Head of Healthy Workplace

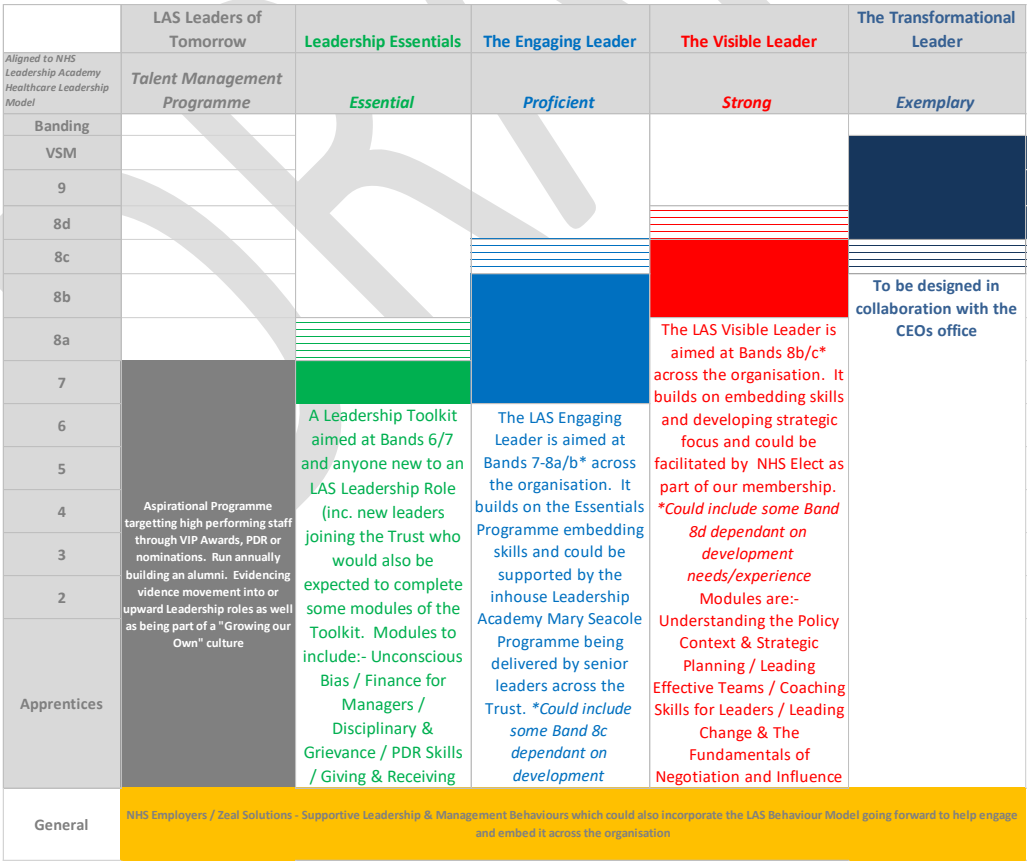
Healthy workplace	Timescale	Lead
7. Introduce learning events, such as Schwartz rounds, and other methods of resilience training and development that support continuous improvement and better patient outcomes	2019/20	Head of Healthy Workplace and Head of Staff Support
8. Maintain clear and transparent means for our people to speak up about their experiences.	Ongoing and 2019/20	FTSU Guardian and Bullying and Harassment Facilitator
9. Include health and wellbeing issues within the staff surveys carried out through the year.	2019/20	Head of Healthy Workplace
10. Establish a pre-employment health assessment to support strong early engagement around health and expectations	2019/20	Head of Healthy Workplace
11. Develop a framework for people, especially those in operational roles, to receive the necessary training, skills and knowledge on health and wellbeing at work to safely and competently perform their role.	2019/20	Head of Healthy Workplace and Head of Staff Support
12. Establish programmes and support networks that focus on tackling bullying and harassment in all its forms and seek to resolve disputes and differences in a proactive and positive way; strengthening our use of courageous conversations and mediation as methods of early intervention to resolve issues	2019/20	Director of People and Culture and Bullying and Harassment Facilitator

Appendix 2. Leadership development programme structure

We have created a leadership development programme to offer a range of training and education opportunities for our staff across all functions of the organisation. The leadership pathway is offered across five key areas:

- **Leaders of Tomorrow** for aspiring leaders to support skills development and progression of our identified future leaders
- **Management Essentials** is for bands 4–6 and as refresher sessions for all leaders and will form part of a management induction programme
- **The Engaging Leader** intended for bands 6–8
- **The Visible Leader** intended for bands 8–9
- **The Transformational Leader** intended for 'very senior manager'/executive leaders.

Each of the levels have been designed to allow us to develop and map skills and knowledge alongside the trust's values and behaviours. We will use our leadership development pathway to identify the training needs of our staff that we can support in order for them to develop their skills and competencies to lead our organisation now and in the future. The figure below identifies how our leadership pathway will be available to and targeted for all of our people, no matter whether they are apprentices or our most senior managers.



Appendix 3. People and Culture performance scorecard

Workforce Analytics

October 2018	Sept data				Historic Performance			2018/19	Reported in Month		Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class	Ranking against Best in Class	National Data
Agency spend v NHSi Agency Ceiling (£) (exc NEL111)	People		Monthly	(n)	N/A	N/A	734,000	5.99m	952,058	492,000	3,971,703	2,952,000	3,971,703	5,290,762*	5.99m	5.99m			
% of Subject Access Request overdue (8 received year to date)	People		Monthly	(%)	N/A	N/A	N/A	0%	20%	0%	12%	0%	12%	0%	0%	0%			

Not applicable | To be confirmed | Not readily available

Engagement

October 2018	Sept-18 data				Historic Performance			2018/19	Reported in Month			Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	No of Live ER cases	No of ER cases closed in month	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class	Ranking against Best in Class	National Data
Disciplinary - average days to complete - cases closed in month (process start to outcome)	People		Monthly	(n)					25	8	87		105		105						
Grievance - average days to complete (process start to outcome)	People		Monthly	(n)					11	1	12		83		83						
Managing Attendance Formal (MAP) - average days to complete (process start to outcome)	People		Monthly	(n)					51	8	187		142		142						
General User satisfaction score	People		Monthly	(n)					UNDER DEVELOPMENT - REPORTING FROM Q4												
Appeals - average days to complete	People		Monthly	(n)					8		0		163		163						
Number of Tribunals	People		Monthly	%					UNDER DEVELOPMENT - REPORTING FROM Q3												
Staff recommendation of the organisation as a place to work or receive treatment (KF1)	People		Annual	(n)	3.03	3.46	3.41	3.57			Q4										
Staff Survey Response Rates	People		Annual	%	35%	42.2%	53.6%	> 50%			Q4										
% of staff survey respondents (BME)	People		Annual	%	12%	12%	12%	14%			Q4										

Not applicable	To be confirmed	Current year	Not readily available

Talent

October 2018	Sept data				Historic Performance			2018/19	Reported in Month		Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class	Ranking against Best in Class	National Data
Vacancy rate	Public	People	Monthly	%		5%	5%	5%	6.1%	5%	6.1%	5%	6.1%	5%					
% of leavers with exit interviews	People	People	Monthly	(n)				100%	UNDER DEVELOPMENT - REPORTING FROM Q3										
Turnover	Public		Monthly	%	12%	10%	11%	<10%	11.9%	10%	11.9%	10%	11.9%				7.1%	7 of 11	7.1%
International 12 Month Turnover (iParas)	People		Monthly	%			20%	<10%	20.5%	10%	20.5%	10%	20.5%						
Length of time to hire - advert close to conditional offer (days)	People		Monthly	(n)			55	25	15	25	15	25							
Length of time to hire - conditional offer to unconditional offer (pre-employment checks completed)	People		Monthly	(n)			50	35	36.4	35	36.4	35							
Performance against recruitment plan 999 - EOC	People		Monthly	(n)			-106	194	29	34	192	194	192	-2					
Performance against recruitment plan TEAC	People		Monthly	(n)			-238	381	0	0	240	381	240	-141					
Performance against recruitment plan Paramedic	People		Monthly	(n)			-120	469	47	51	359	469	359	-110					
Performance against recruitment plan 111 - IUC	People		Monthly	(n)					UNDER DEVELOPMENT - REPORTING FROM Q2										

Not applicable	To be confirmed	Not readily available

Inclusion

October 2018	Sept data					Historic Performance			2018/19	Reported in Month		Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class Ranking against Best in Class National Data		
Number of BME Starters/Leavers (NET)	People	People	Monthly	(n)			+65		+21		+60		+60						
KF26 (Bullying and Harassment)	People	People	Annual	%	38%	32%	32%	27%			Q4						27.3%	46 of 56	28.4%
KF20 (Discrimination)	People		Annual	%	29%	25%	27%	24%			Q4						16.5%	43 of 56	17.6%
KF21 (Equal Opportunities)	People		Annual	%	60%	73%	59%	62%			Q4						76.3%	54 of 56	69.3%
Staff engagement score (BME)	People		Annual	%	3.22	3.53	3.43	3.47			Q4								
Percentage of BME staff	People		Quarterly	%	11%	13%	14%	15%	14.1%	15.0%	14.1%	15.0%			17.5%	20%	44.3%	65 of 70	4.4%
Relative likelihood of BME staff being appointed from short listing across all posts.	People		Quarterly	%		Half as likely	Half as likely	1:1			Q4								
Relative likelihood of BME staff entering the formal disciplinary process.	People		Quarterly	%		Twice as likely	Twice as likely	1:1			Q4								
Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. (higher % is worse)	People		Annual	%	35%	34%	39%				Q4								
Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. (higher % is worse)	People		Annual	%	40%	32%	38%				Q4								
Percentage of BME staff believing that the Trust provides equal opportunities for career progression and promotion. (higher % is better)	People		Annual	%	42%	57%	47%				Q4						65.1%	41 of 46	55.9%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / Team Leader or other colleagues	People		Annual	%	25%	18%	19%				Q4						16.5%	43 of 56	17.6%
Percentage difference between the Organisations Board voting membership and its overall workforce.	People		Annual	%	100%	100%	100%	15%			Q4								

Not applicable	To be confirmed	Not readily available

Healthy Workplace

October 2018	Sept data				Historic Performance			2018/19	Reported in Month		Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class	Ranking against Best in Class	National Data
Short-term sickness	People	People	Monthly	%	1.6%	1.8%	1.7%	2%	1.8%	2%	1.7%	2%	1.7%	2%					
Long-term sickness	People	People	Monthly	%	3.5%	3.3%	3.5%	3%	3.5%	3%	3.5%	3%	3.5%	3%					
Total sickness	People		Monthly	%	5.1%	5.1%	5.2%	5%	5.2%	5%	5.2%	5%	5.2%	5%			3.1%	7 of 11	3.1%
Number of staff accessing Counselling (CQUIN)	People		Monthly	(n)					138		877		877						
Number of staff accessing Physiotherapy (CQUIN)	People		Monthly	(n)					148		1011		1011						
Body Fluid Exposure (BFE)	People		Monthly	(n)					25		136		136						
Number of immunised staff (% of total required - not Flu)	People		Monthly	%					51%		51%	85%	51%	85%					
Number of immunised staff (% of total required - FLU)	People		Monthly	%				75%	21%		21%	75%	21%	75%					
Organisational Health & Well Being (Q9a)	People		Annual	%	11.0%	18%	14%		Q4										
PAM Net promoter score	People		Monthly	(n)					UNDER DEVELOPMENT - REPORTING FROM Q3										

Not applicable	To be confirmed	Not readily available

Leadership and Performance

October 2018	Sept data				Historic Performance			2018/19	Reported in Month		Year To Date			Full Year	Future Target		Benchmarking		
Indicator (KPI Name)	4Ps	Weighting	Frequency	Basis	2015/16	2016/17	2017/18	Target	Actual	Target	Actual	Target	Rolling	Forecast	2019/20	2020/21	Best In Class	Ranking against Best in Class	National Data
Appraisal compliance (PDR)	People		Monthly	%	16%	81%	86%	85%	83%	85%	83%	85%	83%	85%	85%	85%			
Statutory & Mandatory compliance	People		Monthly	%	N/A	N/A	87%	85%	87%	85%	87%	85%	87%	85%	85%	85%			
% of total managers who have completed the management essentials	People		Monthly	%					UNDER DEVELOPMENT - REPORTING FROM Q2										
Support from immediate managers (KF10)	People		Annual	%	3.19	3.52	3.54		Q4								3.91		3.77
Quality of Appraisals (KF12)	People		Annual	%	2.63	2.65	2.71		Q4								3.19		3.11

Not applicable | To be confirmed | Not readily available

London Ambulance Service NHS Trust

Report to:	Trust Board				
Date of meeting:	27 November 2018				
Report title:	Workforce Race Equality Standard Action Plan (WRES)				
Agenda item:	08				
Report Author(s):	Melissa Berry, Diversity Consultant				
Presented by:	Patricia Grealish, Director of People and Culture				
Status:	☐	**Assurance**	☒	**Discussion**	
	☐	**Decision**	☒	**Information**	

Background / Purpose:

The Trust's Workforce Race Equality Standard Action plan for September 2018 to August 2019.

Recommendation(s):

The Board is requested to review and discuss the content of 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	☐

OUR PLAN OF ACTION

Foreword by the Chief Executive

1. London Ambulance Service serves a diverse population across Greater London. Increasing the number of Black and Minority Ethnic staff that we employ is an organisational priority, and also reflects my strong personal commitment to ensuring that our service reflects the communities of London.

2. Given my commitment to achieving a step change in our approach, I will provide leadership on the work to deliver Race Equality in employment and service delivery. I will chair quarterly meetings to drive and monitor progress on our Workforce Race Equality Standard action plan.

3. The London Ambulance Service Action Plan is centred on three key themes. Our first theme is recruitment and development. Our second theme is workplace experience. Finally, our third theme is senior Trust leadership. These three areas were identified by staff across the Trust during a collaborative workshop including participants from both the Black and Minority Ethnic Network, and the Lesbian, Bisexual, Gay and Trans Network, together with Senior Leaders.

4. Each theme is supported by specific targets and initiatives that aim to ensure that our workforce reflects the population of London, and also create an inclusive culture in which everyone has a voice and an equal chance of success.

5. Our re-energised Diversity and Inclusion Committee will work within the framework of London Ambulance Service's Vision, Purpose, Values and Behaviours.

6. I am delighted that we will build on the efforts of staff who have contributed to our work to date, and also continue to progress a number of new, key initiatives.

Background

7. In July 2016 the London Ambulance Service commenced its journey towards having an inclusive and racially diverse workforce which is representative of the local populations the Trust serves. The starting point for this journey was to obtain a baseline understanding of the position of the Trust against the 9 Workforce Race Equality Standard (WRES) indicators. For each indicator data must be compared between non-BME and BME staff.

8. The baseline position revealed the Trust had a prolonged historical trend of its workforce under representing the Black and Minority Ethnic (BME) population which it serves, with the senior management team also under representing the BME workforce. In 2016, only 11% of the London Ambulance workforce was from a BME background; this is in stark contrast to the London picture where 41% of NHS staff in London are from BME backgrounds, and 45% of the London-wide population from BME backgrounds.

9. The London Ambulance Service is committed to working from a position of transparency, accepting that the current position for BME staff is a challenge which requires significant improvement in order to achieve better outcomes for BME staff and the communities we work with. We are committed to working with all staff, including BME staff groups, local unions and other organised staff groups in achieving improvements.

10. Over the 2 years the London Ambulance has focused its efforts to be more racially diverse and inclusive, the Trust has seen an increase in its BME workforce from (2016 to2018), in a 25% increase in numbers of BME Staff which is now at 14% (as at October 2018). There is still more the Trust can do to have a more diverse workforce and we have set ourselves bold targets of 15% BME staff representation by the end of March 2019 and 20% by 2020.

Background to WRES

11. The Workforce Race Equity Standard (WRES) was mandated through the NHS standard contract, starting in 2015 / 16. It was implemented to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

12. This is important because studies show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

13. It is national policy that NHS Trust Boards should be as representative as possible of the communities they serve and that this is likely to benefit the planning and provision of services (NHS Leadership Academy 2013). There is evidence (Salway et al 2013) that when Trusts commission services they often fail to cater for the most deprived communities including black and minority ethnic (BME) populations. One of the strategies that Trusts can use to mitigate this is to ensure that decision-makers are drawn from a diverse pool.

The next phase “The Big Conversation”

14. The next phase of the WRES for London Ambulance will focus on enabling people to work comfortably with race equality. Through communication and engagement, embedding unconscious bias training to help staff move to conscious action by taking personal responsibility and, delivering cultural awareness training we will work to change cultures of race inequality and focus on supporting our people to learn more about the importance of equity, building capacity and capability to work with race. Every employee in the organisation will feel empowered to take action and own the actions set out in our WRES plan.

15. We will also ensure embedding of accountability as teams are reorganised and roles are updated to reflect new responsibilities and ensuring key policies and practices have race equality built into their core.

Design of Action plan

16. For the WRES Action Plan October 2018 we have used co-production methodology which challenges the traditional approach of action plans. This plan was developed with all staff groups including BME colleagues and staff from the senior management group and was led by our Chief Executive. The approach is values driven and built on the principle that it will be owned across the organisation.

Progress against WRES Indicators 2015 to 2018

WRES Indicators:		2015 / 2016	2016 / 2017	2017/ 2018	
Workforce indicators	**Indicator 1:** Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	BME: 11%	BME 12%	BME 14%	
	Indicator 2: Relative likelihood of staff being appointed from short listing across all posts.	No data	1.7 times more likely to be appointed if white than BME	2 times more likely to be appointed if white than BME	
	Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	3 times more likely to enter the formal disciplinary process	2.7 times more likely to enter the formal disciplinary process	2 times more likely to enter the formal disciplinary process	
	Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.	No data	No data	No data	
National staff survey indicators	**Indicator 5:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White: 56% BME: 35%	White:56% BME: 34%	White: 57% BME:39%	
	Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White 38% BME 40%	White: 32% BME: 32%	White: 31% BME: 38%	
	Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progressing and promotion.	White: 62% BME: 47%	White: 74% BME: 57%	White: 63% BME: 42%	
	Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / Team Leader or other colleagues.	White: 13% BME: 25%	White: 9% BME: 18%	White: 11% BME: 19%	
Board representation indicator	**Indicator 9:** Percentage difference between the Organisations Board voting membership and its overall workforce. NB. Only voting members of the Board should be included when considering this indicator.	-11.9%	-12.7%	-14%	

Action Plan

Each of the actions in this plan will make a significant difference to improving the BME experience and representation within the London Ambulance Service

OUR PLAN OF ACTION (3 Key Themes)

THEME 1 Recruitment & Development We will.	Achieve representation of BME staff 15% by March 2019 17.5 by March 2020 20% by March 2021
THEME 2 Workplace Experience We will.	Use data to analyse the **BME experience** at London Ambulance and set challenging objectives for our managers to tackle inequality Launch a one year programme in 2018 to pilot Sponsorship Mentoring to support the progression of our talented BME employees and provide role models for others to follow
THEME 3 Senior Trust Leadership We will.	Develop and deliver extensive **unconscious bias and cultural awareness programmes** delivered across the employee journey over 3 years Set up a CEO/Director of People and Culture led WRES Action Plan Group to focus on tackling diversity on a '*grand*' scale.

Recruitment & Development

Not Applicable | Not Readily Available

Relates to WRES Indicator No.	Indicator Description	Historic Performance 2015/16	2016/17	2017/18	2018/19 Target	Reported in Month	Future Target 2019/20	2020/21	Benchmarking NHS London Average	LAS Ranking (NHS London)	Ambulance Trusts
1)	**% of BME Staff**										
	a) Trust Total	11.9%	12.7%	13.5%	15.0%		17.5%	20.0%	44.3%	65 of 70	4.4%
	b) Bands 1-4	19.2%	20.6%	21.4%	15.0%		17.5%	20.0%	51.4%	43 of 70	5.3%
	c) Bands 5-7	8.6%	9.0%	9.5%	15.0%		17.5%	20.0%	43.7%	60 of 70	3.5%
	d) Bands 8A and above	7.1%	9.7%	10.5%	15.0%		17.5%	20.0%	24.7%	63 of 70	4.8%
2)	**% of BME Appointed**										
	% BME Applications		47.8%	48.6%							
	% White Applications		49.3%	48.5%							
	% Unknown Applications		2.9%	3.0%							
	% BME Shortlisted		35.3%	34.7%							
	% White Shortlisted		61.8%	62.7%							
	% Unknown Shortlisted		2.9%	2.6%							
	% BME Appointed		20.2%	22.4%							
	% White Appointed		72.6%	73.4%							
	% Unknown Appointed		7.2%	4.2%							
	Relative Likelihood of appointment from shortlisting - BME		0.57	0.65							
	Relative Likelihood of appointment from shortlisting - White		1.18	1.17							
	Relative Likelihood of Appointment if White compared to BME		2.06	1.81							
4)	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff**		1.16	1.79							
7)	**% of Staff Believing the Trust provides equal opportunities (SSKF21)**										
	a) Trust Total	60.1%	72.6%	59.2%					76.3%	54 of 56	69.3%
	b) BME	42.2%	56.6%	47.1%					65.1%	41 of 46	55.9%
	c) White	62.9%	74.2%	61.8%					84.1%	54 of 56	71.0%
	d) Ratio (No. times more likely if White)	1.49	1.31	1.31					1.29		1.27

Theme 1: Recruitment and Development

Our pledge: We will increase the BME workforce and set specific targets over the next 3 years to recruit BME staff into front line roles

Theme 1: Recruitment and Development				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
1.1. To provide and promote opportunities / progression across the Trust for BME staff.	To roll out Visible Leader and Management Essentials training to Location Group Managers and all 8b and above leader's within the trust. The training will cover values unconscious bias, cultural awareness and aligned to the NHS leadership academy nine dimeson module. The training is co-facilitate with NHS Elect	1	April 2019	Julia Smyth Head of Leadership and Performance Melissa Berry Diversity Consultant.
1.2	To commission a detailed review external of the recruitment pipe line process. The outcome will be to understand where and why BME candidates fall out in the process	1, 2	February 2019	Patricia Grealish Director of People and Culture
1.3 To increase the LAS BME workforce to 15% by 2019, 17.5% by 2020 20% by 2020 / 21.	To ensure the Trust has diverse interview panels Bands 7 and above targeting corporate roles and TEAC panels with a monthly report provide to CEO in the performance review with how many interviews, panel make up and outcome.	2	Monthly	Averil Lynch Head of Recruitment Melissa Berry Diversity Consultant
	To provide data on a monthly basis to the CEO for performance review / recruitment. Data analysis will provide information on the differences between BME and white applications from shortlisting to appointment and address issues.	2	Monthly	Averil Lynch Head of Recruitment

Theme 1: Recruitment and Development				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
To increase the LAS BME workforce to 15% by 2019, 17.5% by 2020 and 20% by 2020 / 21.	To train BME interviewers twice a year to ensure diverse interview panels 2 cohorts with a minimum of twenty participates.	2	December 2019 / May 2019	Averil Lynch Head of Recruitment Melissa Berry Diversity Consultant
	Promote LAS roles to under represent BME Communities by identifying one Borough in each sector with a high BME representation from the Greater London authority data and engaging with and encourage individuals to apply. Engaging with a minimum of 5O potential candidates from local community groups	2	Run session every quarter 4 (2018/19)	Averil Lynch Head of Recruitment Melissa Berry Diversity Consultant
	Assign overall responsibility for BME recruitment targets to nominated senior managers. Senior Lead to take ownership of nominated areas to enable targets to be achieved and a Senior Lead assigned: Paramedics: 10% TEAC 10% EMD 50%	2	October 2018	Paramedics - Tina Ivanov TEAC - Peter Rhodes EMD Pauline Cramner /Jules Lockett

	Monitor and review the recruitment data monthly in the Chief Executives monthly performance review meetings.	2	Monthly reporting	Averil Lynch Head of Recruitment

Theme 1: Recruitment and Development				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
To increase the LAS BME workforce to 15% by 2019, 17.5% by 2020 and 20% by 2020 / 21.	The Trust to launch BAME Mentor Scheme for BAME Paramedic Students studying with our partner universities (all years) target of a minimum of 30 per year.	2	April 2019	Tina Ivanov Deputy Director Clinical Education & Standards.
	Devise programme to include awareness raising, application guidance and interview skills for front line roles in the Service to include Non-emergency transport, Emergency Ambulance Crew and Paramedic roles. 3 sessions for 25 participants February, March and April 2019	2	May 2019	Anna Byers, Apprenticeship Consultant Averil Lynch Head of Recruitment
1.5 To ensure that the next WRES submission has data for indicator 4	Data validation exercise to be undertaken to digitalise training records, and ensure it reports into the Oracle learning management system	4	December 2018	Chris Randall Head of Workforce Analytics
	To analysis the data for differences between White and BME staff accessing non-mandatory training and CPD based on the outcomes we will devise a separate action plan	4	February 2019	Julia Smyth Head of Leadership and Performance

Theme 1: Recruitment and Development				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
1.6 Develop Career pathways that are flexible and enable staff to progress	To develop a Career Map that shows all staff how their careers might progress at London Ambulance Service. The career map will be used to promote LAS Career days to be held twice a year, at CEO road shows, used at internal events and published on the pulse	7	September 2018	Julia Smyth Head of Leadership and Performance
	Publish successful staff stories (profile a minimum of one staff member a month) The staff will be included in the" big staff conversation". And profiles will be published on the Pulse and Rib and used within the organisation	7	Every month from September 2018	Melissa Berry Diversity Consultant Internal Communications
1.7 Introduce Talent Management and Succession Planning Programmes that include secondment and job shadowing opportunities	Job shadowing and secondment opportunities to be offered in areas where it is possible for the service to accommodate. As an initiative to further retain talent in the organisation. Identifying talent out of the PDR process, part of succession planning process, each directorate will identify a minimum of 1 person every quarter	3	March 2019	Patricia Grealish Director of People and Culture

Theme 1: Recruitment and Development				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
1.8 To develop and implement Sponsorship mentoring across the Trust.	To develop and run sponsorship mentoring training for a minimum of 30 BME staff in the next 12 months with a full evaluation of the programme -October for roll out for the first cohort of mentees -Evaluation of the sponsorship mentoring	6	October 2018 July 2019	Julia Smyth Head of Leadership and Performance. Julia Smyth Head of Leadership and Performance

London Ambulance Service NHS Trust

Workforce Experience

Not Applicable | Not Readily Available

Relates to WRES Indicator No.	Indicator Description	Historic Performance 2015/16	2016/17	2017/18	2018/19 Target	Reported in Month	Future Target 2019/20	2020/21	Benchmarking NHS London Average	LAS Ranking (NHS London)	Ambulance Trusts
3)	Likelihood of BME staff entering the formal disciplinary process compared to White		2.73	2.01	1.70		1.50	1.30			
5)	% of staff experiencing bullying from patients (SSKF25)										
	a) Trust Total	53.2%	52.1%	50.6%	TBC				23.2%	56 of 56	47.9%
	b) BME	34.4%	35.0%	38.9%	TBC				24.1%	49 of 56	38.4%
	c) White	55.6%	56.0%	56.6%	TBC				23.6%	56 of 56	47.5%
	d) Ratio (No. times more likely if White)	1.61	1.60	1.46	TBC				0.98		1.24
6)	% of staff experiencing bullying from staff (SSKF26)										
	a) Trust Total	38.4%	32.4%	32.0%	29.0%		26.0%	23.0%	27.3%	46 of 56	28.4%
	b) BME	40.1%	32.1%	37.7%	35.0%		33.0%	31.0%	30.8%	47 of 56	33.5%
	c) White	38.2%	32.4%	31.2%	29.0%		27.0%	25.0%	24.7%	50 of 56	27.6%
	d) Ratio (No. times more likely if BME)	1.05	0.99	1.21	1.21						1.21
8)	% of staff experiencing discrimination at work in the last 12 months (SSQ17b)										
	a) BME	24.6%	17.9%	19.1%	18.0%		17.0%	16.0%	16.5%	43 of 56	17.6%
	b) White	13.2%	9.3%	10.9%	10.0%		9.0%	8.0%	7.4%	52 of 56	10.8%
	c) Ratio (No. times more likely if BME)	1.86	1.92	1.76					2.23		1.63

Theme 2: Workplace Experience

Our pledge: We will use data to analyse the BME experience at the LAS and set challenging objectives for our managers to tackle inequality

Theme 2: Workplace experience				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
2.1 To prevent incidents going into formal disciplinary processes (where applicable) and resolve them informally wherever possible To decrease the percentage of BME staff going through the disciplinary process (where applicable).	Create and Implement Check and Challenge Panels to reduce numbers of BME staff going through disciplinary process. To include; 1. Triage process 2. Panel membership to include Head of Engagement 3. Investigation training and tool kit	3	October 2018	Lorna Campbell Interim Head of Engagement Melissa Berry Diversity Consultant
	Disciplinary data to be included in to the score cards and presented at the performance review meetings with CEO	3	September 2018	Chris Randall Head of Workforce Analytics
	Bullying & Harassment lead – training, coaching, triage to the 3 system approach of: Courageous conversations, round table and external mediation 8b and above 80 people	3	September 2018	Cathe Gaskell Bullying and Harassment Advisor
	To scope who should receive investigation training. Implement investigation training to improve the quality, consistency and equity of the process. Twenty per – cohort. Once trained this will be tracked through ESR. Target to train a sixty in a 12 month period. Managers will have to be trained in order to conduct an investigation	3	October 2018 January 2018	Julia Smyth Head of Leadership and Performance Lorna Campbell Interim Head of Engagement

Theme 2: Workplace experience				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
	All business partners and band 7 people and culture mangers and above managers will receive investigation training within the next 12 months. ()	3	Update provided every quarter until July 2019	Lorna Campbell Interim Head of Engagement
	Deep dive into a completed disciplinary case on a quarterly basis by external consultant.		Every quarter	Patricia Grealish Director of People and Culture
2.2 To decrease staff who experience harassment, bullying or abuse from patients or relatives by a minimum 3%	Undertake Thematic Analysis of supplementary questions on Staff Survey relating to discrimination, bullying, harassment, and abuse.	5	September to November 2018	Melissa Berry, Diversity Consultant Delia McMillan, Staff Survey Consultant
	Analysis of additional question from the staff survey and separate action plan developed for Health and Safety	5	March 2019	Martin Nicholas Sector Health & Safety Manager
	Commence the staff safety group as a sub group of the corporate Health & Safety committee for all staff 2. Verbal assaults 3. Physical assaults Look at key themes and support of staff	5	November 2018	Local Security Management Specialist

Theme 2: Workplace experience				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
2.3 Promote the Trust networks, BME networks and LGBT network with the aim of creating disability forum and women	BME staff network to be supported to have a work plan that aligns with WRES action plan	8	October 2018	Agatha Nortley – Mesh Chair BME Network Melissa Berry Diversity Consultant
	BME staff to have periodic meeting with CEO on a quarterly basis to hear concerns and enable two way communication and understand if action plan is having an impact on staff	8	Every quarter	Garrett Emmerson, CEO Melissa Berry Diversity Consultant
	As part of the offering of the BME network, BME Master class for BME staff network members (open to all staff) will be rolled out. Interview skills and techniques, motivational speakers, personal development session to include speed mentoring	8	November 2018	Agatha Nortley – Mesh Chair BME Network Melissa Berry Diversity Consultant
	Freedom to Speak up Guardian to work closely with Diversity consultant and Bulling and Harassment lead to share intelligence and meet every six weeks and flag theme's to Director of People and Culture	8	Every 6 weeks	Melissa Berry Diversity Consultant FTSU Guardian Bullying & Harassment Lead Patricia Grealish, Director of People and Culture

Theme 2: Workplace experience				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
2.4 "Big conversations"	To continue to use the Senior Managers forum annually to discuss the WRES and race. Using other methods of communication to "normalise" organisation discussion on race and related matters. Engagement with , ADO's, LGM's, Cultural awareness, Postcard to be sent out every month to managers to have conversations with their team with a different image each month, as part of the " Big conversation "each card will have questions on the back to be used by teams as part of team meetings Recruit Race Advocates "Ask me …." T-shirts to encourage staff to have the race conversation talk about the BME staff network all linked to the big conversation	2 6 6	Ongoing Monthly January 2019	Garrett Emmerson, CEO Patricia Grealish, Director of People and Culture Melissa Berry Diversity Consultant Melissa Berry Diversity Consultant
2.5 To improve our Trust wide communications and openness about race. "Big Conversation"	To develop and implement a Trust wide internal and external Communications plan called 'Lets talk about race'. - Promote success stories of BME staff. - The BME Staff network - The WRES - Equality delivery system	2	Plan Development: October/ November 2018. Implementation December r 2018	Alex Bass Head of Internal Communications Melissa Berry Diversity Consultant.

Theme 2: Workplace experience				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
2.6 Unconscious bias programme for all staff	Unconscious bias programme for 700 top leaders in the trust will be implemented as part of the management essential training Unconscious Bias training is to be commissioned by an external provider and to be delivered on CSR training over a four month period starting in April 2019. The training will focus on Bias, self awareness, Equity, Diversity.	1 1	April 2019	Melissa Berry Diversity Consultant Julia Smyth Head of Leadership and Performance Tina Ivanov Deputy Director Clinical Education & Standards. Melissa Berry Diversity Consultant

Senior Trust Leadership

Not Applicable | Not Readily Available

		Historic Performance			2018/19	Reported in Month	Future Target		Benchmarking		
Relates to WRES Indicator No.	Indicator Description	2015/16	2016/17	2017/18	Target		2019/20	2020/21	NHS London Average	LAS Ranking (NHS London)	Ambulance Trusts
9)	% difference between voting board members and total workforce										
	a) Trust Board BME %	0.0%	0.0%	0.0%							
	b) Workforce	11.9%	12.7%	13.5%							
	c) Difference	-11.9%	-12.7%	-13.5%							
Local Indicator	% difference between Exec Leadership Team and Workforce										
	a) ELT	0.0%	0.0%	9.1%							
	b) Workforce	11.9%	12.7%	13.5%							
	c) Difference	-11.9%	-12.7%	-4.4%							
Local Indicator	Overall staff engagement										
	a) Trust	3.11	3.39	3.36					3.80	55 of 56	3.45
	b) BME	3.22	3.53	3.43							
	c) White	3.10	3.38	3.36							
	d) Ratio (BME to White)	1.04	1.04	1.02							

Theme 3: Senior Trust Leadership

Our pledge: We will develop and deliver unconscious bias and cultural awareness programmes across the employee journey over the next 3 years

Theme 3: Senior Trust Leadership Inc 8C and above				
Objective	**Actions**	**What WRES indicator will this action contribute towards:**	**Timescale (delivered by)**	**Owner**
3.1 To influence leadership behaviours to drive a change in culture and move towards an inclusive way of working across the Trust.	TOP 65 band 8c and above in LAS to have specific objectives in PDR relating to race equality and contribution to the WRES	1	December 2018	Patricia Grealish, Director of People and Culture
3.3 To have a board that is reflective of the populations of which the LAS serve.	For Non-executive director - canvas through linked-in, Leadership academy, NHS diversity leads London and various channels to attract a more diverse candidate list	9	January 2019	Heather Lawrence Chair
	"Reject the list" To work with Head-hunters to ensure that shortlist are diverse 30% Gender and Ethnicity mix.	9	Ongoing	Patricia Grealish, Director of People and Culture
	Diversity lead to sit on all 8d and above post	9	Update quarterly	Melissa Berry Diversity Consultant
	Ensure a diverse selection panel for all executive appointments BME/Gender	9	Update quarterly	Melissa Berry Diversity Consultant
	CEO Commitment to delivery of the WRES Action Plan via annual objectives	9	Reviewed annually	Garret Emerson Chief Executive

Top 65

	Band 8C and above (inc non-exec)	
Gender Description	**Headcount**	**Percentage**
BME	8	12%
White	57	88%
Total	**65**	**100%**

Band 8C and above (inc non-exec)		
Gender Description	**Headcount**	**Percentage**
Female	34	52%
Male	31	48%
Total	**65**	**100%**

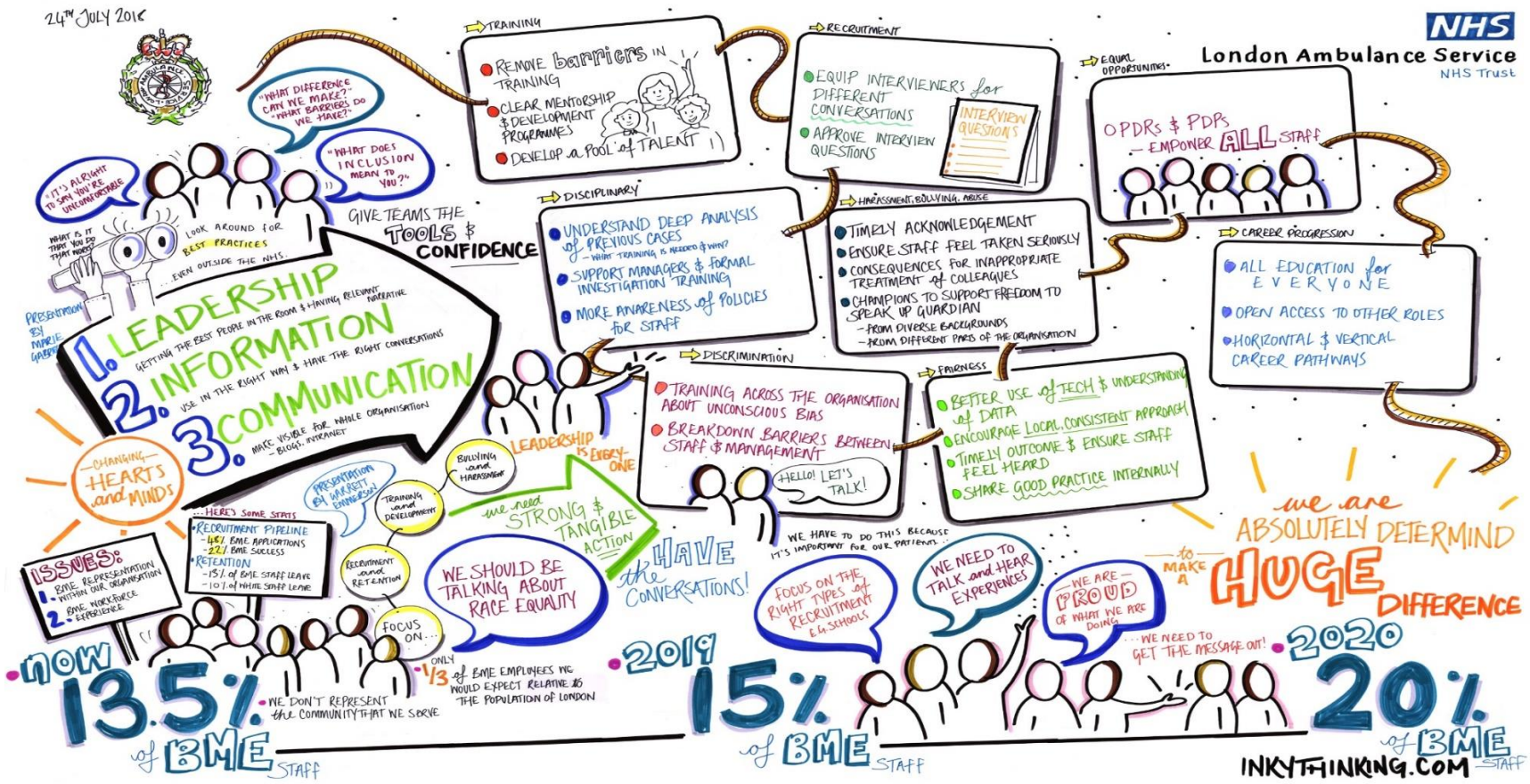
Conclusion

17. London Ambulance data demonstrates that if we want a better outcome for staff and patients, we will need to evolve our approach. This work is fundamental to the core values of London Ambulance and we are determined to meet the targets we have set.

18. The Trust is passionately committed to accelerating progress, ensuring our culture is supportive and equitable, having a workforce that is reflective of London, and doing so under the leadership of the Chief Executive.

Melissa Berry,
Diversity Consultant

Appendix 1


24TH JULY 2018
NHS
London Ambulance Service
NHS Trust
TRAINING
REMOVE barriers IN TRAINING
CLEAR MENTORSHIP & DEVELOPMENT PROGRAMMES
DEVELOP a POOL of TALENT
RECRUITMENT
EQUIP INTERVIEWERS for DIFFERENT CONVERSATIONS
APPROVE INTERVIEW QUESTIONS
INTERVIEW QUESTIONS
EQUAL OPPORTUNITIES
OPDRs & PDPs – EMPOWER ALL STAFF
DISCIPLINARY
UNDERSTAND DEEP ANALYSIS of PREVIOUS CASES – WHAT TRAINING IS NEEDED & WHY?
SUPPORT MANAGERS & FORMAL INVESTIGATION TRAINING
MORE AWARENESS of POLICIES for STAFF
HARASSMENT, BULLYING, ABUSE
TIMELY ACKNOWLEDGEMENT
ENSURE STAFF FEEL TAKEN SERIOUSLY
CONSEQUENCES FOR INAPPROPRIATE TREATMENT of COLLEAGUES
CHAMPIONS TO SUPPORT FREEDOM TO SPEAK UP GUARDIAN – FROM DIVERSE BACKGROUNDS – FROM DIFFERENT PARTS OF THE ORGANISATION
CAREER PROGRESSION
ALL EDUCATION for EVERYONE
OPEN ACCESS TO OTHER ROLES
HORIZONTAL & VERTICAL CAREER PATHWAYS
DISCRIMINATION
TRAINING ACROSS THE ORGANISATION ABOUT UNCONSCIOUS BIAS
BREAKDOWN BARRIERS BETWEEN STAFF & MANAGEMENT
HELLO! LET'S TALK!
FAIRNESS
BETTER USE of TECH & UNDERSTANDING of DATA
ENCOURAGE LOCAL, CONSISTENT APPROACH
TIMELY OUTCOME & ENSURE STAFF FEEL HEARD
SHARE GOOD PRACTICE INTERNALLY
"WHAT DIFFERENCE CAN WE MAKE? WHAT BARRIERS DO WE HAVE?"
"IT'S ALRIGHT TO SAY YOU'RE UNCOMFORTABLE"
"WHAT DOES INCLUSION MEAN TO YOU?"
WHAT IS IT THAT YOU DO THAT WORKS
LOOK AROUND FOR BEST PRACTICES
EVEN OUTSIDE THE NHS
GIVE TEAMS THE TOOLS & CONFIDENCE
PRESENTATION BY MARIE GABRIEL
1. LEADERSHIP
GETTING THE BEST PEOPLE IN THE ROOM & HAVING RELEVANT NARRATIVE
2. INFORMATION
USE IN THE RIGHT WAY & HAVE THE RIGHT CONVERSATIONS
3. COMMUNICATION
MAKE VISIBLE FOR WHOLE ORGANISATION – BLOGS, MANAGER
CHANGING HEARTS and MINDS
LEADERSHIP IS EVERY-ONE
we need STRONG & TANGIBLE ACTION
HAVE the CONVERSATIONS!
ISSUES:
1. BME REPRESENTATION WITHIN OUR ORGANISATION
2. BME WORKFORCE EXPERIENCE
HERE'S SOME STATS
RECRUITMENT PIPELINE
-46% BME APPLICATIONS
-22% BME SUCCESS
RETENTION
-15% of BME STAFF LEAVE
-10% of WHITE STAFF LEAVE
PRESENTATION BY MARIE GABRIEL
BULLYING and HARASSMENT
TRAINING and DEVELOPMENT
RECRUITMENT and RETENTION
FOCUS ON...
WE SHOULD BE TALKING ABOUT RACE EQUALITY
ONLY 1/3 of BME EMPLOYEES WE WOULD EXPECT RELATIVE TO THE POPULATION OF LONDON
WE DON'T REPRESENT the COMMUNITY THAT WE SERVE
WE HAVE TO DO THIS BECAUSE IT'S IMPORTANT FOR OUR PATIENTS
FOCUS ON THE RIGHT TYPES of RECRUITMENT E.G. SCHOOLS
WE NEED TO TALK and HEAR EXPERIENCES
WE ARE PROUD OF WHAT WE ARE DOING
WE NEED TO GET THE MESSAGE OUT!
we are ABSOLUTELY DETERMIND to MAKE A HUGE DIFFERENCE
NOW 13.5% of BME STAFF
2019 15% of BME STAFF
2020 20% of BME STAFF
INKYTHINKING.COM

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	London Ambulance Service Strategy – Six Month Review			
Agenda item:	09			
Report Author(s):	Adam Levy, Head of Strategic Development Angela Flaherty, Interim Director of Strategy			
Presented by:	Angela Flaherty, Interim Director of Strategy			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

Our new organisational strategy was signed off by the Trust Board in April 2018, which outlined our ambition to become a world-class ambulance service for a world-class city. This new strategy detailed how we want to change and improve the way in which we provide urgent and emergency care to the people who live, work and travel in London. It seeks to improve the care we provide for all of our patients and, crucially, to do so in the most cost effective way to generate savings for the NHS as a whole.

As part of our new strategy, we identified two key ways that we would deliver our strategy:

- The delivery of a number of strategic programmes to oversee the changes and service developments needed for implementation of our strategy
- Refreshing or writing a series of enabling strategies that examine the implications for all functional areas of our organisation

This paper provides an update on:

- Where progress on the key dependencies is primarily being monitored
- Progress on the implementation and aims of each of our six strategic programmes
- Progress on refreshing or writing all of our organisational enabling strategies
- How we are ensuring we have effective stakeholder engagement
- Where progress on our key dependencies is primarily being monitored

We will continue to drive forward progress on each of our strategic themes, sign off and implement our enabling strategies and build strong and effective relationships with our key stakeholders. Trust Board will receive regular oversight of all of these activities through delegated committees and the Integrated Performance Report. Additionally, a one year strategy update will be brought to Trust Board in May 2019 to provide assurance of continued progress.

Recommendation(s):
This report seeks to provide the Trust Board with information about and assurance on progress of delivery of our new organisational strategy. The Board is asked to note the report
Links to Board Assurance Framework (BAF) and key risks:
N/A

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

London Ambulance Service Strategy Six Month Review

Introduction and background

1. Our new organisational strategy was signed off by Trust Board in May 2018, which outlined our ambition to become a world-class ambulance service for a world-class city. This new strategy detailed how we want to change and improve the way in which we provide urgent and emergency care to the people who live, work and travel in London. It seeks to improve the care we provide for all of our patients and, crucially, to do so in the most cost effective way to generate savings for the NHS as a whole. It also targets a reduction in avoidable ambulance conveyance to Emergency Departments (ED) of around 10% over the next five years and identifies a potential saving to the NHS as a whole of between £12m - £36m a year.

2. Our strategy details how we intend to achieve this vision through three strategic themes:

Theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients

3. This theme introduces our desire to develop an integrated clinical assessment and triage service; iCAT London. This service would sit behind both 111 and 999 services across London with and expanded range of methods for patients to get in touch with us. Our strategy outlines our belief that by implementing iCAT across London as a whole we could provide a better service for patients and generate savings to the health system in London as a whole.

This theme is being taken forward through our iCAT strategic programme (outlined in section 3), supported primarily by our IM&T, Data and Digital strategy and Clinical strategy (outlined in section 4)

Theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients, a faster conveyance to hospital.

4. We will continue to provide high quality of care to everyone who needs us, especially those most critically ill and injured which for a number of our patients means identifying their needs, dispatching resources and conveying them to a specialist centre for treatment as quickly as possible. Our strategy also introduced our five pioneer services, specialised responses for specific patient groups:

Urgent care response	Mental Health	End of Life care
Falls	Maternity	

5. These pioneer services will change how we respond to these patient groups, placing emphasis on improving the quality of care they receive, improving their experience of being treated by the London Ambulance Service and, where possible and clinically

appropriate, treating them over the phone or in their own home thereby reducing the need to take them to hospital.

This theme is being taken forward through our Pioneer Services strategic programme (outlined in section 3), supported primarily by our clinical strategy (outlined in section 4)

Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

6. We want to play an increasingly pivotal role in the development of services across London, supporting patient outcomes and experiences whilst improving public value. Our strategy details that, using our insight as the only pan-London NHS provider, we believe that we can help NHS England, STPs and commissioners to identify those services that are best able to manage demand as well as where there are inconsistencies.

This theme is being taken forward through our commissioning and contractual form strategic programme (outlined in section 3) as well as changes to the structure of our stakeholder engagement functions (outlined in section 5)

How we said that we would deliver our strategy

We identified two key ways that we would deliver our strategy:

1. The delivery of a number of strategic programmes to oversee the changes and service developments needed for implementation of our strategy
2. Refreshing or writing a series of enabling strategies that examine the implications for all functional areas of our organisation

Strategic Programmes

7. We have six strategic programmes which are tasked with delivering the main changes that need to take place across our organisation to deliver our strategic ambitions. Each of these programmes has programme and project management resources and reports to a Portfolio Management Board (PMB) on a two monthly basis. PMB, a subset of the Executive Committee, is chaired by the Chief Executive and maintains oversight of delivery, risks and issues as well as resourcing implications. The six strategic programmes are:

iCAT London	Connecting Clinicians
Pioneer Services	Ready, set, go (medicine management)
Spatial Development	Commissioning and contractual form

Detail on progress against each of these programmes is included in section 3

Enabling strategies

8. Following the publication of our organisational strategy we embarked on a process of refreshing, rewriting or newly developing a suite of enabling strategies. Each of these strategies are being supported by the strategy team, ensuring that there is alignment across them all as well as to our Trust strategy. There are a number of key principles that have been adhered to through the development of these strategies:

9. Direction has been set by Trust Board as well as regular reviews, utilising the informal Board sessions and ad hoc briefings

10. Staff input at the appropriate level has been sought through a variety of means

11. Where appropriate we have engaged with external stakeholders to prevent developing in isolation

12. Where necessary analysis and modelling has been undertaken

13. The table below provides a status update for all of the organisational enabling strategies. Further detail on the strategies that have been progressed to drafting or sign off stage is provided in section 4

Strategy	Lead Director	Development stage	Board Engagement	Final sign-off
People & Culture (refresh)	Patricia Grealish, Director of People & Culture	Sign off	None (NED briefing session in July)	November 2018
IM&T, Data & Digital	Ross Fullerton, Chief Information Officer	Sign off	August 2018	January 2019
Clinical Strategy (refresh)	Fenella Wrigley, Medical Director	Drafting	October 2018	March 2019
Estates Strategy	Benita Mehra, Director of Strategic Assets & Property	Drafting	June 2018	March 2019
Fleet Strategy (refresh)	Benita Mehra, Director of Strategic Assets & Property	To be planned	To be planned	March 2019
Volunteering Strategy	Fenella Wrigley, Medical Director	Drafting	December 2018	March 2019
Patient Engagement	Trisha Bain, Chief Quality Officer	Drafting	At draft document stage	November 2018
Quality Strategy	Trisha Bain, Chief Quality Officer	Scoping Stage	To be planned	March 2019
Training & Education	Patricia Grealish, Director of People & Culture	Scoping Stage	December 2018 tbc	March 2019
Commercial Strategy	Lorraine Bewes, Director of Finance	Scoping Stage	February 2019 tbc	May 2019
Logistics Strategy	*Benita Mehra, Director of Strategic Assets & Property*	*Not Started*	*To be planned*	*Tbc*
Operational Transformation Plan	*Paul Woodrow, Director of Operations*	*Not Started*	*To be planned*	*Tbc*
Partnership & External Engagement	*Angela Flaherty, Interim Director of Strategy & Partnerships*	*Not Started*	*To be planned*	*Tbc*

Progress on strategic programme

14. Our strategic programmes all report into our Portfolio Board, chaired by the Chief Executive. This section provides a brief summary of each of those programmes and the main progress that has been seen over the last six months

iCAT London

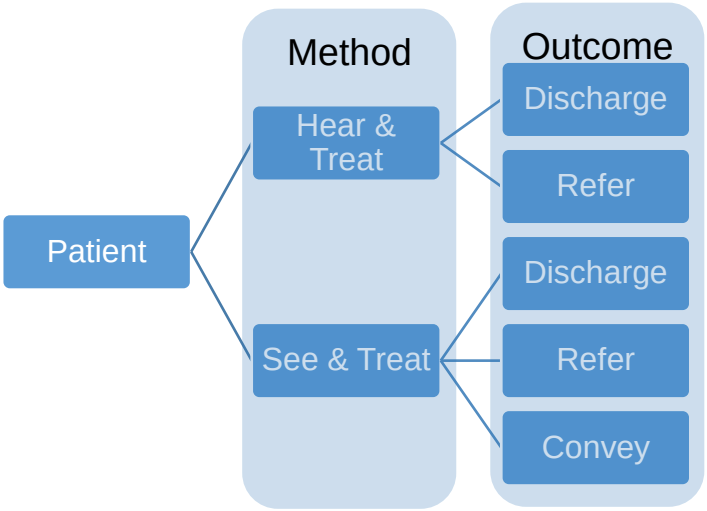
SRO Fenella Wrigley, Medical Director

15. The Integrated Clinical Assessment and Triage (ICAT) programme seeks to provide patients a single point of access to clinical assessment and triage. The objective is to improve clinical decision making and clinical care with resulting enhancements to patient care. The table below provides a summary of our proposed iCAT service model:

16.

Service delivery (patient-facing)	Service implementation (staff-facing)
• Improving the availability of high quality clinical information available to patients through a variety of digital means, utilising emerging artificial intelligence technology • Development of online self-triage systems linking to clinical self-care information, and connecting to the clinical queue where further assessment is required • Multidisciplinary clinical assessment service, utilising a broad range of clinicians, enabling the service to manage a high proportion of calls via 'hear and treat' using a clinical decision support system, reducing the number of unnecessary onward referrals • Well-governed referral pathways with smooth transfer of information between providers reducing the need for repetition • Post event messaging/discharge summary to a patient's GP to provide information about the assessment and management plan as well as recommendations for follow-up	• Full inter-operability between the 999 and IUC services facilitating seamless referrals and greater economic benefits of scale and scope • Shared access to clinical records supporting safe prescribing and tailored clinical management • A comprehensive directory of services populated with primary/secondary/community/voluntary sector services, facilitating appropriate referral • Electronic information transfer, prescribing and appointment booking in real-time with information following the patient • Central oversight of clinical queues with alert systems and a demand/capacity dashboard monitored to maintain patient safety • Opportunities for clinical workforce development/sharing clinical resources across the system

17. Once fully implemented, patients will be able to access ICAT services via 111 or 999 and be assessed by a single integrated assessment and triage team. With the exception of Category 1 and Category 2 ambulance situations, patients will fall into one of the following;



18. Utilisation of the principles of Integrated Urgent Care should result in patients receiving health advice, a face-to-face consultation, including ambulance attendance, or a prescription.

19. There are four key building blocks for the development of ICAT, on which a significant amount of work has already been undertaken;

iCAT building block	Achievements so far
Mobilisation of the North East London (NEL) Integrated Urgent Care Clinical Assessment Service (IUC CAS) for East London Health Care Partnership (ELHCP)	Successful mobilisation of our NEL IUC CAS to 'Live' on 1 August 2018
Transformation of the South East London (SEL) 111 to a SEL IUC CAS	Mobilisation commencement of the SEL IUC CAS for full service go live in February 2019
Merging the NEL and SEL IUC CAS into an integrated LAS IUC CAS	Working to enhance interoperability and resilience between our 111 and 999 services with ability to access each other's queue of calls by the end of the 2018/19 financial year. This is largely dependent on implementing the Adastra™ system within the 999 clinical hub. We are also working to see what elements of the integrated CAS could be achieved in advance of the timeline as detailed above to support our 111 and 999 services through the upcoming winter.
Transformation and merging of the 999 Clinical Hub into the LAS ICU CAS	

Pioneer services

SRO Trisha Bain, Chief Quality Officer

20. Our Pioneer Services programme has seen the establishment of a steering group to drive forward this work and oversee progress. This programme seeks to finalise the design specification, pilot and roll out new services for five patient specific patient groups.

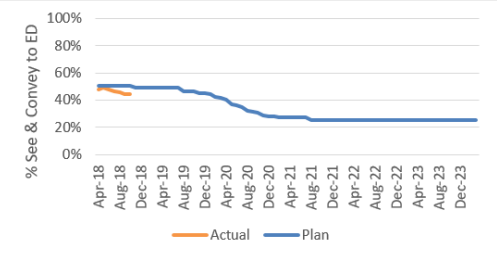
21. Whilst each of these services was described in our organisational strategy, the specifics of designing the services themselves has been the first task for the pioneer services programme. We now have completed project documentation for all of the five pioneer services and have allocated £24k per pioneer service to get the pilot established.

22. We have designed a pilot evaluation framework which will establish a strict set of evaluation criteria for each pilot before they start operating, so we have clarity about what we are measuring and what our baseline is, so that we are able to formally and accurately evaluate the benefits or challenges associated with the pilot. Additionally we have worked to identify a trajectory of ED conveyance reduction attributed to each pioneer service which is included below.

23. The five pioneer services and the progress made on each one is outlined below:

Mental health

24. The first pioneer service to be piloted is the mental health one, where a registered mental health nurse will respond alongside a paramedic to patients with mental health needs. We have successfully recruited paramedics to staff this pilot alongside our existing mental health nurses and the pilot will officially commence in November 2018 for a period of six months. The pilot will take place in South East London and we have had discussions with our partners within South East London accordingly. To support the development of our Mental Health service we are running a 'Whose Shoes' engagement event in February 2019.

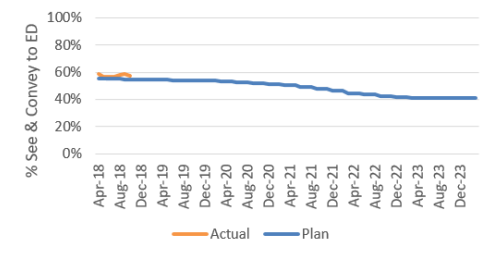


Mental Health

Definition: Card 25 during MPDS triage
Approx monthly incident + HT volume: 2,000
Plan caveats: Assumed initial pilot would run 18 hours; assumption less operationally feasible - busiest 12 hour period targeted instead

Urgent care

25. We have now recruited our third cohort of urgent care advanced paramedics practitioners (APP-UC), bringing the total to 21 across London. This will enable us to establish a fourth site, which will be at Brent, which is scheduled to be fully live from January 2019. In order to support our APP-UC programme we are now recruiting a clinical practice manager. We will continue to recruit additional APP-UCs in 2019, however we are also continually re-evaluating the programme to ensure that we have the optimal number of APP-UCs to provide the maximum efficiency and effectiveness.

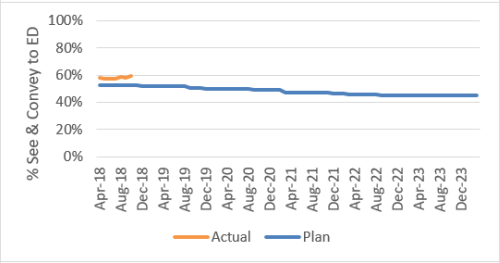


APP Urgent Care

Definition: C3, C4 and C5 incidents (or HT) that are not MH, Falls, Mat or EoLC. Please note this was the logic used during initial modelling so has been used here for consistency. UC APPs are able to attend a wider range of calls - logic to reflect this is still being developed.
Approx monthly incident + HT volume: 22,000
Plan caveats: Assumed Q3 2018/19 recruitment round; not the case.

Falls

26. Based on the high prevalence of fallers, we have identified North West London as our preferred location for the pilot to take place in. Additionally, we know that there is appetite within the STP for new service options to support their priority of responding to this patient group in a different way. Further service modelling, including whether it could utilise NETS staff, and conversations with the STP will need to take place before the pilot location is confirmed, but this should be completed soon and we will be able to advertise for paramedics who wish to staff this pilot by the end of November 2019. We intend for this pilot to launch in February 2019'

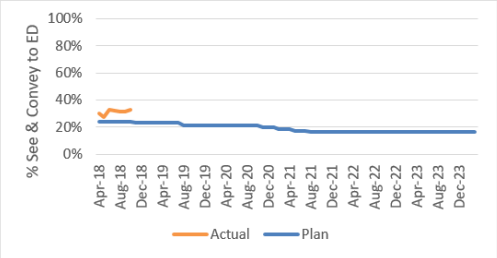


Falls

Definition: Card 17 during MPDS triage
Approx monthly incident + HT volume: 10,000
Plan caveats: Assumed Dec 2018 pilot start; Feb 2019 is updated plan

Maternity

27. Phase one of the maternity pioneer service is to introduce midwives into our control room clinical hub on a formal rostered basis. This will provide additional 'hear & treat' capacity to treat women over the phone who are experiencing maternity complications or worries. This will provide improved patient care as well as avoiding unnecessary ambulance dispatches when a face to face response is not required. A business case for this is being developed with the intention of having 24/7 midwifery cover in the control room by April 2019. We also held a patient and staff engagement event; 'Whose Shoes', and the outputs from that workshop are helping us to develop our maternity pioneer service.

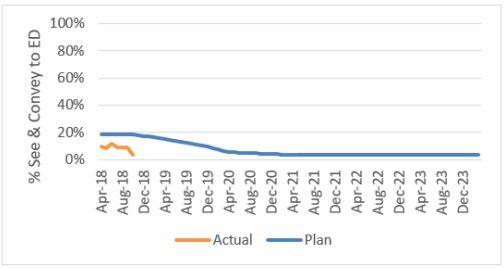


Maternity

Definition: Card 24 during MPDS triage
Approx monthly incident + HT volume: 1,000
Plan caveats: Assumed Nov 2018 pilot start; May 2019 is updated plan

End of life care

28. This pioneer service has the benefit of having received a pot of funding from MacMillan, which has allowed us to employ a team of 3 WTE for two years, to support the development of improved palliative and end of life care within our organisation. A major part of this work is engaging with stakeholders across London with the intention of strengthening our use of appropriate care pathways for these patients. The team is also communicating with and supporting our staff to improve their skills, knowledge and confidence when dealing with patients approaching the end of their life, as well as focussing on improving communications and interaction using electronic patient records via staff iPads. A pan-London conference is being organised for early 2019 to engage key stakeholders in discussing challenges facing for this patient population and considering possible solutions for the future.



End of Life

Definition: EoL MPDS card no longer in use - incidents defined using PRF illness code 25
Approx monthly incident + HT volume: 150
Plan caveats: -

Spatial development

SRO Benita Mehra, Director of Strategic Assets and Property

29. Our spatial development programme is looking at our entire estate and seeking to make best use of those resources, ensure our estate is fit for the future and provides a high quality working environment for our staff. As detailed in section 4 we are currently writing a new operational estate strategy, so the spatial development programme has been focussing largely on our Corporate Estate.
30. On 5th November, the first tranche of the corporate estates project was successful delivered on schedule. This comprised a refurbishment of the second floor Waterloo Head Quarters (HQ) Executive area. The result was an increase in existing occupancy by over 50%, and the provision of additional meeting room space. Crucially, the

redevelopment work has placed a large emphasis on promoting better working practices, reduced silo working and agile working.

31. Work is currently being undertaken to scope additional work at the HQ site, including the refurbishment and consolidation of the People and Culture offices onto the third floor, communal areas throughout the building and use of the space at Union Street. Work on the building frontage is also proceeding, with a specification for external works being developed and security and reception requirements being progressed.

32. Additionally to our operational estates strategy and this corporate work programme we will also be identifying improvements and efficiencies that could be seen in other areas of our estate including our control rooms, training estate and vehicle maintenance facilities.

Connecting clinicians

SRO Fenella Wrigley, Medical Director

33. We want to revolutionise the way that we treat our patients and we know that technology is the key enabler of this. This strategic programme aims to unlock Pan-London digital integration to enable the sharing and linking of LAS patient data with the London care community, as well as providing a gateway to other services. We will be able to sign post people to partner services facilitated by the digital technology and integration.

34. The first part of the Connecting Clinicians Programme has seen the successful deployment of a handheld mobile solution to 4000 patient facing staff changing the way we deliver world class patient care.

35. We are now working with clinical staff and collaborating with both internal and external stakeholders including NHS England, NHS Digital, the Pan-London community and the wider system to develop an electronic patient care record (ePCR). The ePCR will use the iPods that have been rolled out as the platform for improving the way that our crews record all interactions with patients. The ePCR will be designed to be intuitive to use and will not simply replicate the paper forms currently used, but actively help our crews to deliver improved patient care.

36. The Trust has also embarked on the journey to become a key player in London's bid to become a Global Digital Exemplar community. The Trust will act as a beacon to promote more interoperability across disparate systems for collaboration and sharing of key data to achieve better patient outcomes and clinical efficiency.

Ready, set, go (medicine management)

SRO Benita Mehra, Director of Strategic Assets & Property

37. The Ready Set Go Programme manages the development, implementation and roll out of the storage, management, distribution and audit of medicines and consumables with the aim to achieve:

    consistent patient quality
    standardisation of
    greater efficiencies in the use of medicines
    traceability of medication

We have made huge improvements to our medicine management arrangements over the past few years and this programme seeks to continue those improvements in these four areas:

Secure drug rooms

38. This project ensures the security of medicines at station by developing and building a purpose high spec secure drug room with CCTV and 'smart' key systems at 29 stations. This project is underway and 80% complete with 24 rooms already in use. Feedback from staff on the new rooms has been very positive and benefits are already being realised with any incident investigation time being reduced along with a clear and transparent audit system. The new processes also mean time savings for the band 7 APP clinicians and MRU/CRU whose packs are now routinely delivered to station. A full benefit realisation review will take place once all rooms are complete.

Multi-dose drug packs

39. Multi-dose drug packs of the "station based drugs" project brings together the currently loose drugs, which are either signed out by the individual clinician or vehicle into a pouch. These drugs are currently stored in containers on station and are not necessarily secure and are not carried in secure, appropriate or auditable ways. A pilot pack has been approved and pilot locations have been identified.

Primary response bags

40. This project is replacing the vehicle based equipment bags and will develop a modular restocking system for the equipment bags during a shift that eliminates the current inventory of loose consumables. We identified that the SCAS style bags were appropriate and a pilot is being prepared based on the LAS ALS design together with the SCAS primary response bags. Each bag content is modular with spare modules to be placed in the ambulances by VP.

Kit prep

41. The kit prep pack audit system has been in use for almost 2 years in stations. The Logistics packing app is integral to supporting the packing of drug packs with info being entered and printed of kit prep (pack list) and management of multi-dose drug packs. The next phase of roll out will provide crews with the ability to run the kit prep app on their iPads instead of hand writing the drug forms.

Commissioning and contractual form

SRO Lorraine Bewes, Director of Finance

42. Directed by Trust Board, we are developing an engagement plan and stakeholder impact assessment, to clarify the relative benefits and risks of new commissioning models. Since August 2018, there have been a number of consultations published on commissioning and contracting, together with the new planning guidance and a new framework for commissioning ambulance (999) services.

43. The Trust issued its Commissioner intentions on 28th September 2018. These set out the contractual approach and main issues for LAS, including how we start to move our strategy into the commissioning and contractual arena. It also flags the major national cost pressures that LAS faces and requires Commissioners to fund in order to deliver national performance standards consistently (Ambulance Response Programme). The Trust will shortly submit its case for retaining the funding originally set aside for growth of 1.7% (£4.6m) for 2018-19. Work is in train to complete the case for funding ARP for 2019-20 and securing LAS's share of the 3.4% real terms growth settlement. A review of ARP settlements for other ambulance trusts suggests that on average settlements of c£10m are being secured and LAS would therefore expect this to be a minimum estimate for the London context.

44. We have also been engaging with the consultation on the draft Integrated Care Provider contract with responses submitted to NHS Providers and AACE. We have challenged the omission of ambulance service/111 not being included within the scope of integrated provision on the basis that the contract should allow and support system wide integration and innovation and not impose restrictions on such developments.

45. Work also continues on developing the preferred options for future commissioning of 999/IUC services. A number of options have been developed and discussed at Trust Board and we are now working on articulating the benefits of each option taking account of different models of care, consideration of whom may be impacted by the changes and the potential risks of moving to a new model of care. An engagement plan for each option has been drafted identifying key system wide stakeholders. Building on the update previously provided on Manchester ICS, further information has been provided on other ICS plans including service integration details, governance etc. Finally, given the scale of planned change, consideration has been given to the potential resourcing requirements that would be required to deliver the various stages of transformation to a new model with a high level view of costs based on public disclosure by other emerging ICS systems.

46. Whilst we are working hard to progress our thinking and plans in relation to commissioning and contractual form, it is clear that there are still issues that are yet to be determined in the wider system. We will be looking to ensure that we are represented in any associated development programmes to help influence any national decision.

Progress of development of our enabling strategies

People & Culture Strategy

SRO Patricia Grealish, Director of People & Culture

47. The People and Culture Strategy aims to create a richer, more supportive working environment with greater opportunities for learning and career development, attracting and retaining the best people in the country from all walks of life.

Background to strategy development

48. In late 2017 we developed and published a People and Organisational Development (P&OD) Strategy (2017-2020). In response to the publication of our new organisational strategy, as well as the restructure of P&OD to People and Culture, this strategy has been reviewed to ensure it reflected the changes happening across the Trust and is aligned to the new Trust strategy.

Progress

49. In May 2018, work commence on the refresh of the People and Culture Strategy. A gap analysis was conducted initially to review the original People and Culture Strategy (2017) with the newly published Trust strategy (May 2018) to identify synergy and gaps. LAS staff were engaged with the development of the strategy during a workshop which focused on the Trust's new vision, values and behaviours and staff were asked their views on specific questions on areas to inform the refresh of the strategy.

50. Further engagement and input was sought from our Non-Executive Directors (Jayne Mee, Bob McFarland and Jessica Cecil) to gain insight and views on future direction of the strategy. We ensures that Unions were engaged with regularly throughout the development of this strategy with updates provide at Staff Council and feedback taken into account.

51. The draft final version of the Strategy was presented to ExCo in October 2018, and is planned to be presented to Trust Board in November 2018.

Key strategy development milestones

IM&T Strategy

SRO Ross Fullerton, Chief Information Officer

52. The IM&T, Digital & Data Strategy will develop a detailed technology roadmap to support our organisational transformation, including both the big strategic themes and day to day IM&T services that support our stations and offices. Our approach will be to support and influence NHS Digital's national urgent and emergency programme and to take nationally-developed solutions where they deliver the cost effective functionality that we require at the time that we will need it.

Background to strategy development

53. In September 2017, we set out our IM&T strategic vision in a slide pack presentation, presented to Trust Board. The LAS commissioned PA Consulting in May 2018 to assist with identify the LAS Digital Capability Opportunities within the local, regional and national context. With the publication of our new organisational strategy, we commenced the development of a new strategy to bring together the 3 strands of IM&T, digital (enablers and integration) and data (and analytics) into a single strategy aligned with our strategic vision and ambition.

Progress

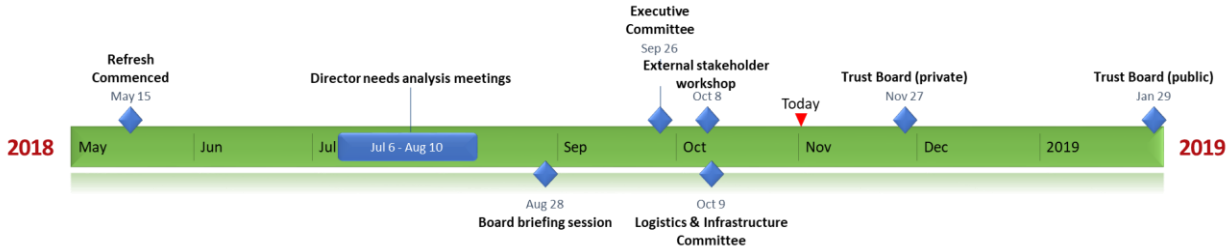
54. In May 2018, work commence on the development of a new IM&T, digital, data strategy with initial focus on understanding the external landscape / national context and its opportunities for the LAS. A gap analysis was undertaken focusing on what we knew from previous strategic work and cross-checking with the new Trust Strategy.

55. A significant amount of engagement has occurred to inform and support the development of the IM&T, data and digital strategy. Our Chief Information Officer met and engaged with the Pan-London Digital Governance Group, London CIO Council, National Chief Information Officers (CIO) and Chief Digital Officers (CDO), the Chief Digital Officer for London as well as with providers and Commissioners. There has also been significant 'user' engagement nationally for the elements of IM&T programmes which the LAS will be part of.

56. Specific project level engagement and workshops have informed the development of the strategy including the electronic patient care record (e-PCR) project. Needs analysis meetings were held with all Directors to understand their technological, data and digital needs arising from their strategies and work plans. Extensive input was sought from the IM&T Senior Managers through a series of workshops.

57. A Board briefing session took place in August 2018 for further engagement and input from Trust Board. The final version of the strategy was presented to ExCo at the end of September 2018, and the Logistics and Infrastructure Committee in early October 2018 and it is planned to be presented to Trust Board in January 2019.

Key strategy development milestones



Clinical Strategy

SRO Fenella Wrigley, Medical Director

58. Our clinical strategy describes describe the way in which we will deliver outstanding care to all of our patients. It outlines the overarching clinical leadership, accountability, responsibility and behaviours required to deliver clinical excellence in a changing NHS. It provides the framework against which developments in clinical practice will be made, and against which we will measure progress.

Background to strategy development

59. Our Clinical Strategy (2016-2021) was approved by the Board at the end of January 2017. It was developed with feedback from staff, the Patients' Forum and a significant number of external stakeholders. It sets out the Service's aim, commitment and expertise to be the provider of emergency and urgent care - with an integral role in the development and delivery of NHS 111 - for patients in London.

60. Whilst our clinical strategy was only signed off relatively recently, with the publication of our new trust strategy, as well as the changing nature of the NHS and other key enablers it is the right time to refresh this clinical strategy. This refresh will ensure that it is up to date, aligned with our overall strategy and ambitious is what it seeks to deliver.

Progress

61. In mid-July 2017, work commenced to review the Clinical Strategy. We ran a clinical strategy development workshop which included c.90 members of staff, non-executive directors, patient representatives, commissioners and other external stakeholders. The workshop focussed on our key challenges and opportunities to improve in both the urgent and emergency care spaces as well as the implications on our clinical training and education. The outputs of this workshop were used to inform a discussion at a board briefing session where Trust Board also considered the implications of the Carter Review on our future clinical response model.

62. At the time of writing this report, the strategy is being drafted and further conversations are being had to finalise the vision for our clinical response model and how we can improve the care we provide to our patients.

63. It is planned to present a final draft version to ExCo mid-January 2019, and to the Quality Assurance Committee in January 2019 and a presentation to Trust Board (private) 29.01.19 and Trust Board (public) March 2019.

Key strategy development milestones

Operational Estate Strategy

SRO Benita Mehra, Director of Strategic Assets & Property

64. Our estates strategy outlines the current state of play of our operational estate, sets out the expected requirements on that estate in the future and then how we plan to develop our operational estate to meet those requirements.

Background to strategy development

65. Over the past five years we have conducted a number of reviews into our estate, but have not finalised an estates strategy to outline what changes we need to make and how we will make them. The reviews that have taken place are:

    2018 Currie & Brown; Corporate estate – office accommodation review
    2017 Citrica & Knight Frank Estate strategy report following planning workshops
    2016 ORH station location optimisation report
    2012 '6-facet survey' looking at the quality of our estate

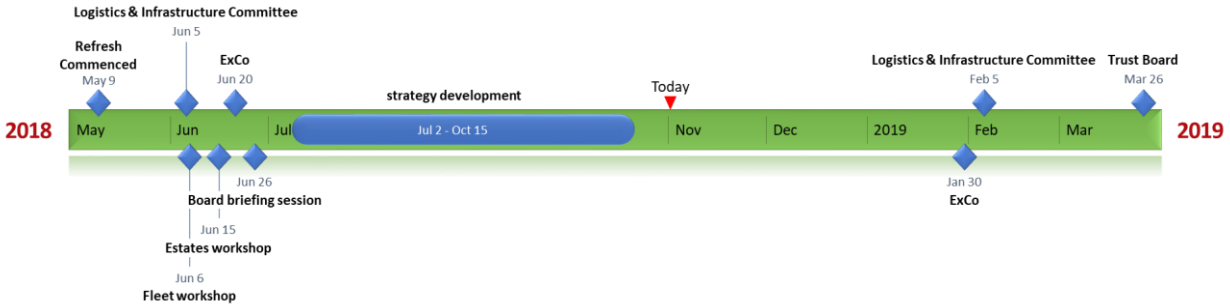
Progress

66. In May 2018, work commence on the development of a new Estates Strategy. A workshop took place in June 2018 for LAS senior managers to contribute to a shared vision for what our estate needs to be and do now and in the future. A separate workshop also took place focussing on our fleet which will be a key input for our estates strategy

67. At the end of June 2018 a Board briefing session took place focussing on estates which included a significant amount of modelling work which contributed to the Trust Board discussion about our future operational estate.

68. During July to September, the estates strategy has undergone iterative development shaped by the direction of the CEO. A draft estates strategy was presented to the CEO in early October for comment.

Key strategy development milestones



Fleet Strategy

SRO Benita Mehra, Director of Strategic Assets & Property

69. Our fleet strategy outlines the future requirements for our fleet and how our vehicles will support the delivery of world class patient care. Our fleet strategy needs to detail how we will ensure our fleet is best placed to meet our future needs, including being environmentally friendly, utilising modern technology and providing our staff with a high quality working environment.

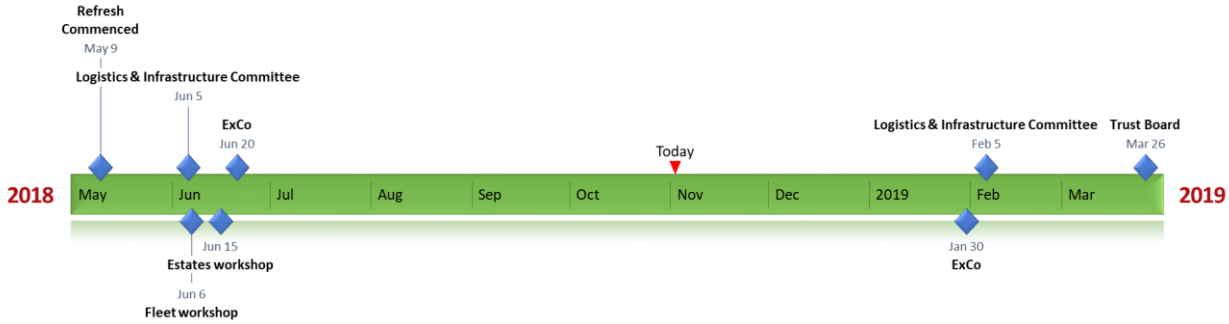
Background to strategy development

70. A Trust fleet strategy was written in 2016, however remained in draft form and did not receive formal sign off from Trust Board.

Progress

71. In May 2018 work was commenced to develop a joint estates and fleet strategy, with workshops taking place in June. However, following the Board session and further discussions with the CEO it was determined that they should not be developed as a single strategy, but done separately. Furthermore, rather than a standalone fleet strategy, it was decided that given then amount of work that is being done nationally on a standardised ambulance fleet, we should produce a lighter touch plan outlining our current fleet and the short term improvements.

Key strategy development milestones



Volunteering Strategy

SRO Fenella Wrigley, Medical Director

72. Our volunteering strategy will establish a volunteering scheme, identifying an expanded range of opportunities for members of the public to volunteer directly with us, or contribute to the health and wellbeing of their local community.

Background to strategy development

73. Whilst we have a number of existing volunteers, most notably Emergency Responders and Community First Responders, we have not previously had a strategy which outlined a broad vision for volunteering within the London Ambulance Service. Our ambition to expand on what we already do and set up a ‘community of life changers’ is outlined in our organisational strategy.

Progress

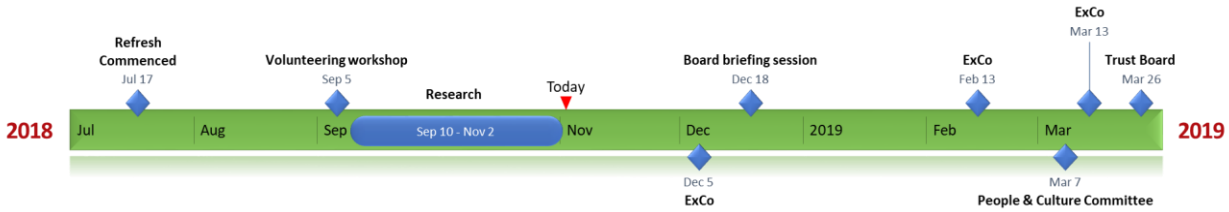
74. In August 2018, planning commenced to develop the Volunteering Strategy and a workshop was held in September 2018 to inform its development. This event was attended by a wide range of staff, some of our current volunteers, Heads of Volunteering from NHS Trusts and other key stakeholders including St John Ambulance, London's Air Ambulance and HelpForce. It was an energetic workshop which provided a large number of suggestions of what volunteering opportunities we could look to develop.

75. We know that there is a great deal of volunteering that already happens within the NHS and so we have contacted other NHS Trusts who are leaders in the field of volunteering, so that we can speak to their volunteering leads and learn from best practice

76. Additionally, we have carried our extensive research into what volunteering takes place within the NHS, within other Ambulance Trusts in the UK and abroad as well as in other organisations who we could learn from.

77. A Board briefing session will take place in December with the final strategy being presented to Trust Board at the end of March 2019.

Key strategy development milestones



Patient & Public Involvement & Engagement

SRO Trisha Bain, Chief Quality Officer

78. The Patient & Public Involvement and Engagement strategy builds on our existing strategy, to include additional involvement and engagement activities with our patients and the wider public. In particular, it seeks to identify the way in which we engage with individuals who experience our service first hand, specific patient groups as well as the wider London population, specifically looking at public perception and reputation.

Background to strategy development

79. We have an existing Patient & Public Involvement strategy which was produced in 2017. We also have a significant amount of patient and public engagement work that takes place around the Trust which is reported in the PPI annual report

Progress

80. In September 2018 a meeting was held with the CEO where he outlined his vision for an expanded patient and public involvement and engagement strategy. The key changes to the current strategy is that it should include all aspects of how we engage with patients and the public, which currently sits within the communications team and the Patient Experiences team.

Key strategy development milestones

Effective stakeholder engagement

81. One of our three strategic themes as outlined in our new organisational strategy is that we want to have a stronger working relationship with our key stakeholders across London, particularly NHSE, NHSI, the five STPs and London's CCGs. In order to achieve this we have restructured and expanded our stakeholder engagement function with the aim of being able to focus this engagement work on the key strategic issues. The main changes that we have made are:

82. Our Stakeholder Engagement Managers have transferred from the Operations Directorate to our Strategy team. Whilst they will still maintain close links with operational colleagues, this move will seek to ensure that they are able to focus more substantively on the key strategic issues which will help us to deliver our strategic ambition. One of the key responsibilities for the SEMs will be to ensure that we have consistent and equitable alternative care pathways available at the right times for our crews to refer patients into. This is a key enabler of our ambition to reduce ED conveyances.

83. We have established a Strategic Partnerships function, into which we are recruiting a Head of Partnerships. This function, in which the SEMs will sit, will be responsible for strategic oversight of all partnership working. Whilst we know that there is a significant amount of partnership working across the Trust, the information and intelligence gathered by individuals is not always circulated to others. We will ensure that this information that colleagues gather is used in a strategic way to help us influence service development going forward.

84. Our STP engagement CQUIN has been refocussed to ensure that we are working at a local level on shared priorities. These priorities have been discussed and agreed in each sector as follows:

North West London – Requiring final sign off from STP, low risk of issues arising. High level priorities are: **Priority 1 – Increasing ACP usage throughout North West London through education of LAS staff and promotion of pathways** **Priority 2 – Working with commissioners to refer non-injured fallers in Hillingdon and referrals to rapid response** **Priority 3 – Working with commissioners/providers to 'fix' mental health intermediate care pathway**
North Central London – Requiring final sign off from STP, low risk of issues arising. High level priorities are: **Priority 1 – Increasing ACP utilisation in across North Central London** **Priority 2 – Reduce ED calls and conveyances through Demand Management** **Priority 3 – Improve ED flow and handover across NCL**
North East London – Fully agreed. High level priorities are: **Priority 1 – Increasing ACP utilisation in the community and reducing ambulance conveyance to the ED** **Priority 2 – Reducing patient handover delays at acute hospitals** **Priority 3 – Management of High Intensity Users (Frequent Attenders/Callers)**

South East London – Fully agreed. High level priorities are: **Priority 1 – Deep dive into demand growth in Greenwich** **Priority 2 – LAS to Assist with SEL Demand Management by Providing More Data** **Priority 3 – LAS to share best practice about successful demand management initiatives**
South West London – Not agreed, we have submitted a response outlining the areas we cannot agree to. High level priorities are: **Priority 1 – Meeting attendances** **Priority 2 – increasing ACP usage across SWL** **Priority 3 – Working with STP to develop in-year demand management schemes** **Priority 4 – Working with STP on winter planning** **Priority 5 – Working with system partners to deliver improvements to hospital handover times**

85. Whilst improved partnership working is a priority in and of itself, it is also a key enabler of all of our other priorities and the changes we have made to this function will seek to support all the work we do as part of our strategy.

Key dependencies

86. Within our strategy we identified four key dependencies that would impact on our ability to successfully deliver our strategy. The table below outlines what those dependencies are and where they are being monitored and progressed:

Dependency	What that means	Where progress is primarily being monitored
Closer clinical working with partners	1. For iCAT London, we will need to be able to access specialist advice from staff at other providers 2. We need to be able to access shared care records 3. We need to be able to refer to local community teams & partners populate shared records	1. iCAT strategic programme 2. Connecting Clinicians strategic programme 3. Connecting Clinicians strategic programme
Digital interoperability	1. Technical ability to access shared records in EOC and on the road 2. Support NHS Digital & influence national initiatives	1. IM&T enabling strategy 2. IM&T enabling strategy
Approach to commissioning	1. Ensure we have the right incentives in place through our contracts with commissioners 2. Contracts and payment mechanisms will need to reflect savings that we make for the wider system 3. We need to develop our strategy in collaboration with commissioners	1. Commissioning & contractual form strategic programme 2. Commissioning & contractual form strategic programme 3. Changes to stakeholder engagement function
Funding from commissioners	1. We are likely to need additional funding to roll out our pioneer services once they have been piloted	1. Pioneer services strategic programme 2. Commissioning & contractual form strategic programme

Next steps

87. We will continue to drive forward progress on each of our strategic themes, sign off and implement our enabling strategies and build strong and effective relationships with our key stakeholders. Trust Board will receive regular oversight of all of these activities through delegated committees and the Integrated Performance Report.

88. We will ensure that there is alignment between our strategic intentions and our Business Planning which will detail how the specific initiatives will continue to be delivered each year.

89. A one year strategy update will be brought to Trust Board in May 2019 to provide assurance of continued progress and where each of the strategic themes sits within our 2019/20 Business Plan

Angela Flaherty
Interim Director of Strategy

London Ambulance Service NHS Trust

Assurance report:	Logistics & Infrastructure Committee	Date:	09/10/2018

Summary report to:	**Trust Board**	**Date of meeting:**	**27/11/2018**
Presented by:	**Theo de Pencier, Non-Executive Director, Chair of Logistics and Infrastructure Committee**	**Prepared by:**	**Theo de Pencier, Non-Executive Director, Chair of Logistics and Infrastructure Committee**

Matters for escalation:

- In regards to Cyber-security, the Committee acknowledged that the Trust did not necessarily have the resources needed to improve the robustness of its network and was therefore unable to provide assurance to the Committee regarding cyber risks. The Committee agreed that additional funding should be sought externally if the Trust escalated this issue and presented its service as part of national infrastructure which needed additional resource.

Other matters considered:

- In regards to the draft Digital Strategy, the Committee suggested that it was to be development to not only describe the issues facing the Trust but also provide answers. The Committee also advised that it was important to have finances expressed at the early draft stage.
- In regards to the status of the Vehicle Preparation (VP) Contract, it was noted that discussions regarding the possibility of a combined contract had taken place with South East Coast Ambulance Service NHS Foundation Trust (SECAMB) and South Central Ambulance Service NHS Foundation Trust (SCAS).
- In regards to the Uninterruptable Power Supply (UPS) upgrade work at the Trust's Bow site, it was noted that the planned shutdown and work was provisionally scheduled to take place on 11 November 2018 and that the planned work, including testing, could take up to six days.
- The Committee was advised that the IM&T capital programme was behind schedule and that a new interim Head of Business Engagement & Change had been appointed to address the issues.

Key decisions made / actions identified:	• The Committee discussed the robustness of key suppliers and business continuity in regards to the ambulance fleet supply chain. The Committee agreed that checks should be undertaken to provide assurance on the financial robustness of key ambulance fleet suppliers. It was also agreed that contingency suppliers should be identified in the event that current box body and chassis suppliers were unable to fulfil the Trust's orders. • It was agreed that a UPS event plan would be provided to the Committee a week in advance of the scheduled work. • The Committee noted that planned Distributed Denial of Service (DDoS) protection was behind track and was scheduled to be completed by January 2019. The Committee requested that progress should be provided to the Committee in correspondence. • The Committee resolved to recommend to the Board that the amended Terms of Reference should be approved.
Risks:	• It was noted that BAF Risks 45 and 50 should be updated to reflect both the UPS and cyber-security discussions. • It was anticipated that BAF risk 50 would be proposed for closure at the Trust Board meeting in November 2018 following the successful completion of the scheduled UPS work. • Committee members were content to recommend that BAF Risk 51 should be de-escalated in light of the assurances provided by the Cabinet Office. It was noted that a corporate risk remained with regard to ensuring the continuity of services provided by third party suppliers and indicated that this should be recorded on the corporate risk register. • The Committee also acknowledged a related risk regarding the implications of the impact of the UK's exit from the European Union. It was noted that a potential BAF risk regarding Brexit would also be brought to the Board in November 2018.
Assurance:	• With regard to the procurement of Double Crewed Ambulances (DCAs) the Committee noted that slots had been secured for the completion of 20 box bodies with 10 further slots to be confirmed. • In regards to the Uninterruptable Power Supply (UPS) upgrade work at the Trust's Bow site, the Committee noted that the Trust had discussed the project regularly with NHS England (NHSE) and NHS Improvement (NHSI). The Committee was informed that third party specialists had been sought to provide input and that the Trust's

project teams had developed a plan detailing the cost, dates, resilience and movement of staff associated with this work.

London Ambulance Service NHS Trust

Logistics and Infrastructure Committee

Terms of Reference (effective December 2018-March 2019)

1. Purpose

1.1 The Logistics and Infrastructure Committee has been established principally in order to provide assurance on and oversee strategic development and investment in Fleet, Estate and IM&T whilst ensuring compliance with all regulatory and statutory duties as appropriate.

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 Committee of the Trust (including the Director of Finance and Performance, the Chief Information Officer and the Director of Strategic Assets and Property) and shall consist of not less than six 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 Director of Corporate Governance and senior representatives of the Operations and Medical Directors should normally attend all Logistics and Infrastructure Committee meetings.

7.2 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 Director of Finance and Performance, the Chief Information Officer or the Director of Strategic Assets and Property.

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 A minimum of three meeting will be held per year, 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

12.1 To take assurance on the executive oversight of the Fleet, Estates and IM&T functions of the Trust.

12.2 To seek assurance that effective strategies are in place that enable the achievement of the overall Trust strategy.

12.3 To have oversight of the regulatory and compliance framework for each function ensuring that all requirements and reporting requirements are being met.

12.4 To consider and review key risks to delivery of strategic objectives within each function and to confirm the risk appetite accordingly, escalating key risks to the Trust Board.

12.5 To consider the capital and investment plans for each function within the overall Trust financial plan and to inform/advise the Trust Board as appropriate.

12.6 To review and approve for recommendation to the Trust Board and Finance Investment Committee as appropriate any outline and full business cases for development and investment within each of the functions.

To receive assurance that all policies relating to each function are up to date and remain relevant and complied with.

12.7 To receive assurance with regard to the Trust's Data Quality activities.

12.8 To receive reports on key performance indicators for each function at each meeting, escalating any concerns to the Trust Board as appropriate.

12.9 To receive any external and internal assurance reports on the functions, and to take assurance from these or escalate concerns to the Trust Board.

12.10 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 November 2018

London Ambulance Service NHS Trust

Assurance report:	Audit Committee	Date:	05/11/2018

Summary report to:	Trust Board	Date of meeting:	27/11/2018
Presented by:	John Jones, Non-Executive Director, Chair of Audit Committee	Prepared by:	John Jones, Non-Executive Director, Chair of Audit Committee

Matters for escalation:	Two Board Assurance Framework (BAF) Risks need to be escalated for Board attention: BAF Risk 45 Cyber Security. Plans to mitigate cyber-security risks require faster implantation; this will have financial implications and additional funding is being sought. BAF Risk 50 Power supply to Bow EOC. This risk was to be controlled by November/December 2018, and is now planned for February 2019. General Data Protection Regulation (GDPR) - An update report revealed expected progress had not been made resulting in delay to the internal audit review. Additional resources have been agreed to make real progress over the next few months.
Other matters considered:	The BAF, which shows five red risks, was reviewed. These are also subject to monitoring by respective Board Assurance Committees. It is proposed that two red risks are de-escalated from the BAF and a new BAF risk added (regarding the risk of delivering the Trust control total). This is supported by the Audit Committee. A proposed framework for a review of the Trust's corporate governance structures was considered, leading to the review being undertaken in the final quarter of the financial year, and presented to the Trust Board at its March meeting. The 2018/19 Year End timetable for the annual accounts was noted - key dates for the Audit Committee are 18 April 2019 draft unaudited accounts and 23 May 2019 audited annual accounts.

A report on the Losses and Special Payments to 30th September 2018 was reviewed by the Committee. Expenditure on vehicle accidents continues at a high level.

A report on progress on overdue internal audit recommendations was received showing 22 high priority overdue items. It is intended to invite the appropriate Executive to the next meeting of the Audit Committee (Feb. 2019) to discuss any remaining overdue recommendations.

An update on the internal Audit plan and counter fraud activity to date was presented by Grant Thornton and reviewed by the Committee. Three internal audit studies had been completed –

- a review of the set-up of the Programme Management Office has been undertaken,
- an audit of the Performance and Development Review (Staff) Process,
- an audit of Safeguarding in the Trust.

It was proposed that the audit report of the Performance and Development Review be referred to the People and Culture Committee in view of the goal in improving the quality of appraisals, the rating of the review and the recommendation's made.

In order that more meaningful discussions at the Audit Committee are held regarding new internal audit reports consideration will be given to invite the appropriate Executive lead for reports that are rated 'partial assurance' or less.

An approach to the preparedness of the Trust to the UK's departure from the European Union was discussed and will be reported to the November Trust Board.

Key decisions made / actions identified:

The Committee agreed

- the framework and objectives of the Corporate Governance Review
- the methodology for the effectiveness review of the internal audit and counter fraud service
- the approach to evaluation of preparedness of the Trust to the UK's departure from the European Union.

Risks:	No new risks were highlighted but the Committee reviewed two areas (in addition to GDPR) which are highlighted as high risk.
Assurance:	The assurance rating for the internal audit reviews were: The audit of the Performance and Development Review (Staff) Process, was **Partial Assurance** with improvement required. Nine recommendations were made. The audit of Safeguarding in the Trust was **Significant Assurance** with some improvement required. Six recommendations were made. Review of the set-up of the Programme Management Office was not rated as this is an advisory/improvement report for a new service but it provides assurance that the current approach is proceeding in line with expected good practice. Both representatives of the internal (Grant Thornton) and external (Ernst and Young) auditors were present at the meeting.

London Ambulance Service NHS Trust

Assurance report:	**People & Culture Committee**	**Date:**	**08/11/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**27/11/2018**
Presented by:	**Jayne Mee, Non-Executive Director, Chair of People and Culture Committee**	**Prepared by:**	**Jayne Mee, Non-Executive Director, Chair of People and Culture Committee**

Matters for escalation:

- The Committee noted that the Trust's recent internal audit on safeguarding had raised the following issues: The Trust did not provide a 24/7 telephone line for safeguarding referrals. There was not a rolling DBS programme at the Trust. The Committee clarified that if a 24/7 safeguarding provision was needed at the Trust that a business case would have to be submitted and funding sought. It was clarified that there was a DBS rechecking programme in place that began in September 2016 and was due to end in September 2019. It was noted that the Trust had completed around 2000 of the checks and had 1700 left with a year left to complete them. All new recruits undertake DBS checks and all staff who change roles are required to undertake a DBS check. It was additionally noted that there was not a legal requirement for the Trust to have rolling DBS checks. It was agreed that a paper be brought to the Committee outlining the Trust's legal requirements, options and costs for a future rolling DBS programme.

Other matters considered:

- The Committee was advised that, as a result of actions taken in order to reduce agency, the current forecast position identified a reduced gap of £289,302 against the agency ceiling. The Committee was informed that the Trust had made a case to NHS Improvement (NHSI) to amend its agency cap due to the extenuating demands of resourcing the North East London (NEL) 111 services. It was noted that the Trust's case would be considered and decided upon in December 2018.
- The Committee was informed that the WRES action plan was co-produced by approximately 60 staff members including BME colleagues and senior management staff. It was noted that the action plan centered around three key themes: recruitment and development, workplace experience, and trust leadership. The Committee commended the approach taken to building the plan, and whilst recognising there was still much to do appreciated the work

	that had been done in the last 2 years by the team to provide a firm foundation on which to build.
Key decisions made / actions identified:	• The Committee agreed that the implementation of drugs testing at the Trust would require a robust mechanism but that the dignity of staff whilst undergoing testing was paramount. The Committee agreed that further discussions would be needed and that the phraseology used in the policy required sensitivity. It was agreed that the Drugs and Alcohol Policy action plan would be provided at the People & Culture Committee meeting in January 2019. • The Committee was advised that a significant amount of work would be needed to meet the requirements outlined by the draft Workforce Disability Equality Standard (WDES) and that it would be reported on for the first time in August 2019. It was noted that upon implementation of the standard, it was required that the Trust provide both the relevant data and an improvement plan against this data. The Committee agreed that an update on the WDES would be provided to the Committee once more information was established.
Risks:	• The Committee was informed that a risk was being written about PAM, the Trust's occupational health provider, and would be submitted to the Trust's Risk Compliance & Assurance Group (RCAG) for consideration. In addition, a letter of concern had been written to PAM outlining poor performance against key performance indicators. • The Committee acknowledged that BAF Risk 47 regarding low EOC staffing levels at Bow and Waterloo remained a risk and that this would be reviewed and considered by the Committee in January 2019. • Regarding the corporate risk register risk relating to musculoskeletal injuries to frontline staff, the Committee was informed that in light of a number of mitigations, injuries at the Trust were expected to decrease in the near future and that the risk could potentially be de-escalated pending a further improvement.
Assurance:	• The Committee acknowledged the efforts of the team in achieving an EMD recruitment gap of 2fte against the 2018/19 recruitment target of 171fte. The Committee also noted the forecasted 105 paramedic vacancies at the end of the year, and were informed that

	this would likely be lower with higher than expected numbers of international paramedics agreeing to stay at the Trust.

London Ambulance Service NHS Trust

Assurance report:	**Finance & Investment Committee**	**Date:**	**13/11/2018**

Summary report to:	**Trust Board**	**Date of meeting:**	**27/11/2018**
Presented by:	**Fergus Cass, Non-Executive Director, Chair of Finance & Investment Committee**	**Prepared by:**	**Fergus Cass, Non-Executive Director, Chair of Finance & Investment Committee**

Matters for escalation:

- The deficit for the first six months, at £4.4m, is in line with budget. The latest full-year forecast shows a surplus of £0.3m, which improves on the previous forecast deficit of £1.5m. The revised control total takes into account: conservative assumptions on activity levels; cost savings; and funding requested from commissioners to cover the cost of delivering the ARP targets. Achieving it would attract additional Provider Sustainability Funding (PSF) of £3.8m. The Committee has reviewed the assumptions and risks; delivery of the revised forecast is proposed as a BAF risk.
- The Committee discussed a summary assessment of the Carter review "Operational productivity and performance in English Ambulance Trusts: unwarranted variations", published on 27th September 2018. The Trust is required to respond formally to the review. The comparative data underlying the review points to issues for detailed examination and to potential opportunities across a range of areas, including: conveyance rates; job cycle and handover times; fleet; and corporate costs. Work is proceeding to clarify the factors affecting the data reported in respect of LAS and to develop a prioritised action plan which will be reflected in financial plans.
- The Committee endorsed the processes and modelling that support the development of the five-year financial plan and the business plan for 2019/20. A draft of the business plan has to be submitted by 14th January 2019; arrangements will be made for review of the figures. Factors relevant to assurance of the plans were noted.
- The Committee recognised that, notwithstanding the projected surplus for the year, there is an underlying deficit of £5.5m which will be addressed as part of the financial planning exercise

Other matters considered:

- The Committee received an update on Procurement. All actions from the KPMG Procurement Maturity Plan have either been completed or are on track. The Committee noted that work is in

	hand to strengthen control over contract management, a critical area. It also noted that procurement savings in the current year are expected to reach £792k, ahead of the £550k target and that a number of saving opportunities are being investigated in collaboration with SCAS. The Committee looked forward to receiving the plan to save 10% of purchases. • The Committee reviewed progress in implementing Internal Audit recommendations related to finance and procurement, and noted the Executive Team's commitment to conclude the outstanding actions. • In reviewing the latest Technical Releases, the Committee noted the potential impact of the updated UK Corporate Governance Code.
Key decisions made / actions identified:	• Capital expenditure, at £5.8m, is £3m behind plan. Measures to achieve planned expenditure were noted, including action to secure the production slots needed to obtain all of the double crewed ambulances approved for purchase in 2018/19 and 2019/20. • Progress with the Cost Improvement Programme (CIP) was noted. The year's target of £12.3m is expected to be delivered with the help of non-recurrent savings of £3m; savings of £1.1m are reported as "yet to be identified" but are expected to be covered by a non-recurrent underspend on pay. • Timings for submission of some business cases have yet to be determined.
Risks:	• The principal financial risk relates to the achievement of the control total, where a number of uncertainties remain, including: activity levels; cost savings; and additional funding to cover the resources required to achieve the ARP targets. • The Committee was briefed on the contracts review exercise that is being undertaken under DHSC guidance in order to identify supplier risks and mitigations potentially associated with the UK's departure from the European Union.
Assurance:	• The Committee reviewed financial performance to the end of September and projections for the remainder of the financial year, including: activity levels; variances against budget; CIP delivery; and other critical areas. Appropriate explanations and background information were provided. Key figures were noted above. • The Committee reviewed the action plan relating to expenditure on agency staff. This plan has already been reviewed in depth by the People and Culture Committee. The Committee noted the steps

already taken and the projections indicating management's commitment to deliver a final spend that is within the NHSI ceiling.

- Cash flow performance and projections were also reviewed. At the end of September, cash was £13.4m ahead of plan, reflecting a variety of positive and negative factors that mainly relate to the timing of receipts and payments; the capital underspend of £3m also contributed. Cash flow is forecast to remain positive over the next twelve months and will stay above the agreed £6.5m buffer.

London Ambulance Service NHS Trust

Assurance report:	Quality Assurance Committee	Date:	20/11/2018

Summary report to:	**Trust Board**	**Date of meeting:**	**27/11/2018**
Presented by:	**Robert McFarland, Non-Executive Director, Chair of Quality Assurance Committee**	**Prepared by:**	**Robert McFarland, Non-Executive Director, Chair of Quality Assurance Committee**

Matters for escalation:

- For acutely ill patients with cardiovascular and cerebrovascular disease the Trust has maintained a high standard of care (see reports).
- There has been an increase in the number of defibrillator downloads (when APPs are involved). However, although we have the technology, this facility has not been extended to all frontline staff. As well as a learning opportunity the availability of these records informs ongoing treatment by specialists as well as legal proceedings.
- There has been no improvement in the estate in NE London sector – It is difficult to instill a professional culture in staff working from scruffy and inadequate stations.
- The Wi-Fi at Deptford is inadequate to support the Kit Prep project which is necessary to track medicines. The Committee were not assured that this issue is being given appropriate priority.

Other matters considered:

- **CIP Quality Impact Assessment:** In July three items were listed as having a high risk to safety (ending overtime incentives for EOC and Frontline staff; reduced use of private ambulances) and one of significant risk (revising vehicle movements). The Committee had asked for information on how these high risks were mitigated and was assured that regular and frequent management meetings ensured that any risk would be recognised and contained. It was now also possible to assure us that there had been no detriment to performance over the nine months. We will review next year's CIP in March with a clear explanation how any risk identified is to be mitigated.
- **NE London Sector Report:** Kevin Bate has only been in post a short time and already has a good understanding of the opportunities and difficulties in this sector. He has a new enthusiastic and energetic managerial team and feels most staff (many only appointed within the last three years) are open to improved ways of working. Performance and quality measures are good and investigative work is underway to

improve the use of Alternative Care Pathways. However, vacancies are high, there are some long hospital handover times, and there has been no improvement in the estate since the last report. It is difficult to instill a professional culture in staff while working in inadequate stations.

- **Serious Incidents:** There has been a reduction in clinical treatment SIs. Following the thematic review of delays a change in protocol for some incidents has been introduced (i.e. if no DCA available in 8min. an FRU is dispatched to assess) and there has been a notable reduction in this type of incident. There has been an increase in the number of actions not completed which is being actively managed to regain previous good performance.
- **Health and Safety Report:** Steady progress was noted with 60/69 actions completed and the others in progress. The risk rating for Manual Handling has been downgraded. The number of equipment related incidents is down and, although the total number of incidents is higher this is due to improved reporting and on analysis there are fewer serious injuries.
- **Deep Dive Patient Experience Review:** as prepared for the CQRG. All aspects of our extensive patient and public involvement programme were included. There has been a detailed review of the Complaints process, including the letters to patients, and there is a subsequent action plan. The Patient Experience strategy is currently being refreshed. It was felt that patient experience should be aligned with the evaluation of the pioneer initiatives.

Key decisions made / actions identified:

- **Cardiac Arrest Annual Report, STEMI Annual Report, Stroke Annual Report:** Our current outcomes for these serious life-threatening conditions remains excellent and comparable with the best centres. Further improvement will depend on several factors including increasing the availability of public defibrillators. Regarding Stroke - there are plans to transfer appropriate stroke patients to specialist centres for thrombectomy rather than thrombolysis.
- The Committee is pleased to commend to the Board the full reports which were presented to the Committee in summary.
- **Internal Audit:** There are two outstanding recommendations from previous audits by KPMG: the archiving of paper records of training and records of attendance at teaching sessions. Both issues will be addressed by the Rethink training review action plan in January 2019.
- **Safeguarding Internal Audit:** significant assurance with some improvement required. There were two recommendations which had already been raised by NEDs at the People and Culture Committee.
- Telephone safeguarding referrals by crews are not available 24/7 – Paul Woodrow is taking action on this longstanding deficiency.
- DBS checks on all staff are due to be completed by September 2019. There is currently no plan to maintain regular three-year rolling DBS

	checks. Members of this Committee understood a rolling programme of DBS checks on all staff was agreed in 2016.
Risks:	• There are no new BAF risks allocated. • The Rethink Training Review identified systemic issues across all areas of Training and Education. An action plan will be presented to the People and Culture Committee in January 2019.
Assurance:	• **Cardiac and Stroke:** Our current outcomes for these serious life-threatening conditions remains excellent and comparable with the best centres. • **Safeguarding Internal Audit:** Overall conclusion -significant assurance – the main processes are good with some detailed improvement required.

London Ambulance Service NHS Trust

Report to:	**Trust Board**			
Date of meeting:	27 November 2018			
Report title:	Integrated Quality and Performance Report			
Agenda item:	11			
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:

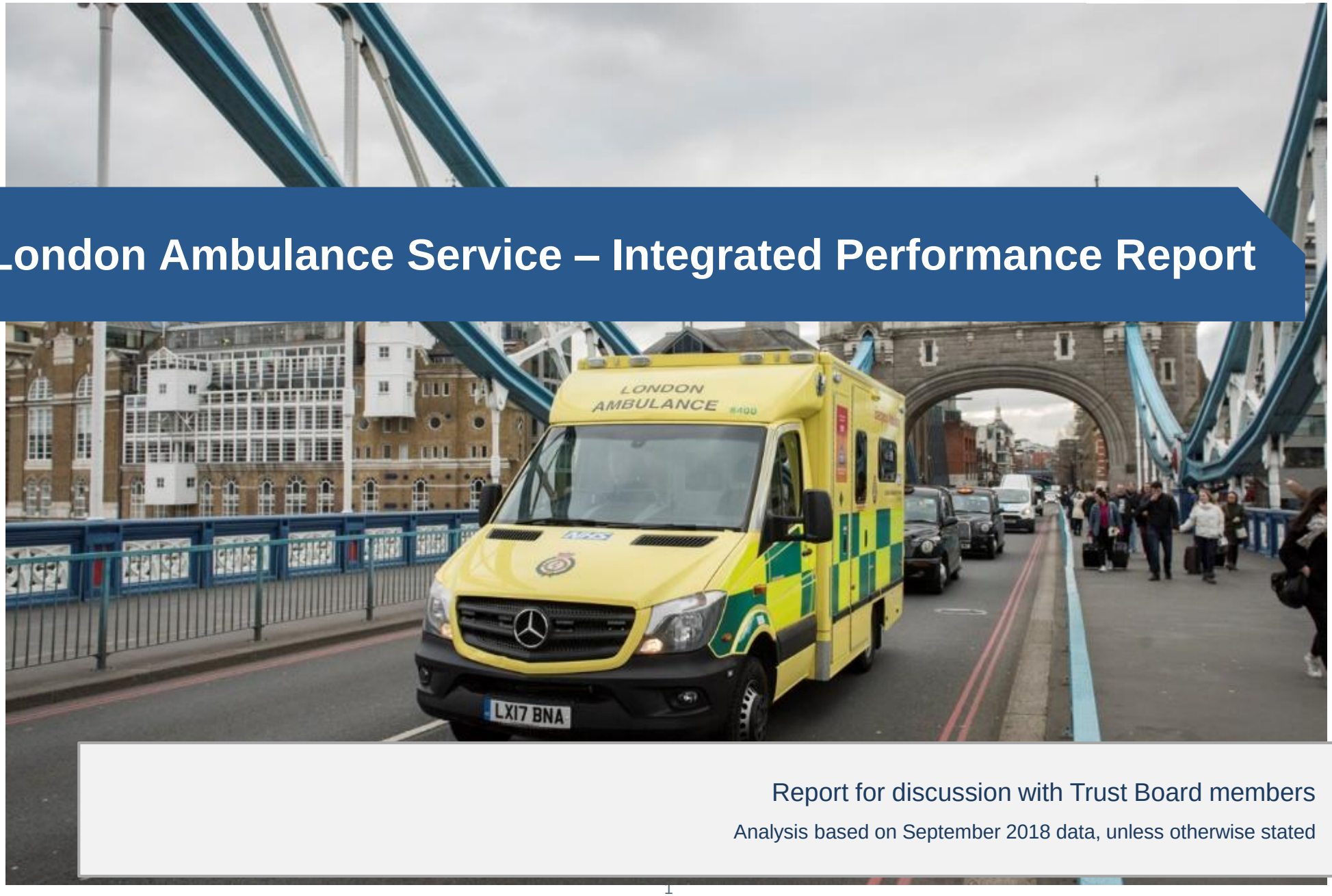
This report contains an overview of Trust Risks directly linked to the BAF but does not itself raise any risks.

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	☒

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Integrated Performance Report



Report for discussion with Trust Board members

Analysis based on September 2018 data, unless otherwise stated

Contents Page

Overview

We have structured our management of performance and business plan around our organisational goals: **our patients, our people, our partners and public value**:

	Update on performance:	**Achievements since the last board** (incl. reference to Business Plan deliverable):
Provide outstanding care for **our patients**	In September challenges continued with meeting Category 2 and 3 response standards but due to initiatives being implemented, we anticipate performance to improve from next month. However, the latest nationally published data shows that the Trust is ranked 1st in the Category 1 mean measure as well as the Category 1 90th centile measure when compared to all Ambulance Trusts across England showing that our most critically ill patients are being responded to quickly.	*Refreshed action plans have been published which relate to reducing unnecessary conveyances to emergency departments, reducing the number of hours lost to handover to green, improving hear and treat rates and improving call answering times. This includes visits by senior management to other ambulance services to share, learn and adopt best practice. (BP.16)*
Be a first class employer, valuing and developing the skills, diversity and quality of life of **our people**	Sickness rates remain consistent with previous months and we continue to make good progress on our recruitment and training plans across the organisation. Work is underway to remodel workforce profile for 19/20 and next 5 years Whilst vacancy rates continue to remain lower than in FY17/18 and we are close to our target of 5%, the Trust continues to experience higher than average turnover rates at over 11%.	• *All business plan deliverables on track with no significant milestones reached during the period since the last board*
Provide the best possible value for the tax paying **public**, who pay for what we do	September's financial performance continues to align with our financial plan for FY18/19 with a strong current cash position for the Trust, however income continues to be behind planned levels and our capital plan is not progressing as quickly as anticipated. The majority of business plan deliverables are on track with the exception of capital and CQUIN.	• *The Trust has improved its outturn by £1.8m which will enable access to additional PSF funding in 2018/19* • *The financial risk relating to delivery of the CIP has been de-escalated and replaced with a risk regarding funding required to deliver ARP performance and management of our agency control cap and potential IT licence cost pressures.*
Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London	SE111 call answering within 60 secs was at 91.5%, below the 95% standard but in line with the 17/18 average. NE111 call answering within 60 secs, which went live in August, is still to achieve the national standard. We are engaging well with our NHS partners on a variety of local and pan-London boards and working groups to ensure shared focus on key issues such as demand management and ACP usage. We are also working at a local level to understand and help solve issues that arise. Our STP engagement CQUIN has been refocussed to ensure partnership working to achieve shared local priorities.	• *Successfully awarded full payment for Q2 of the STP engagement CQUIN*

Patients Scorecard

September 2018

Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Current Perfomance: Target	Current Perfomance: Latest Month	Current Perfomance: Year To Date (From April 2018)	Current Perfomance: Rolling 12 Months	Trajectory: FY18/19 Trajectory	Benchmarking (Month): National Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (out of 10)
Category 1 response - Mean	mm:ss	Sep-18	G		07:00	06:57	07:01	N/A	07:00	07:20	06:12	4
Category 1 response - 90th centile	mm:ss	Sep-18	G		15:00	11:27	11:31	N/A	11:18	12:46	10:52	2
Category 2 response - Mean	mm:ss	Sep-18	A		18:00	19:29	18:56	N/A	18:30	21:41	11:58	5
Category 3 response - 90th centile	h:mm:ss	Sep-18	R		2:00:00	2:16:25	2:12:05	N/A	2:10:30	2:26:09	1:12:40	4
Category 4 response - 90th centile	h:mm:ss	Sep-18	G		3:00:00	2:14:12	2:19:27	N/A	2:14:06	3:16:33	2:05:38	2
ROSC at Hospital	%	Jun-18	G		30.0%	38.3%	38.1%	33.5%	N/A	31.8%	38.3%	1
STEMI call to angiography - Mean	h:mm:ss	Jun-18			TBC	2:18:00	N/A	N/A	N/A	2:11:00	1:44:00	6
STEMI call to angiography - 90th centile	h:mm:ss	Jun-18			TBC	2:58:00	N/A	N/A	N/A	N/A	N/A	N/A
Stroke call to door - Mean	h:mm:ss	Jun-18			TBC	1:13:00	1:09:00	1:14:00	N/A	1:13:00	1:06:00	7
Stroke call to door - 90th centile	h:mm:ss	Jun-18			TBC	1:44:00	N/A	N/A	N/A	N/A	N/A	N/A
Re-contact rates in 24 hours (ONLY S&T and H&T)	%	Sep-18	G		7.0%	5.6%	5.8%	5.8%	N/A			
Positive compliments received	Per 1000	Sep-18	R		1.50	0.90	1.31		N/A			

The performance of our **111 services** is measured in the **Our Partners** section of this report

G — KPI on or ahead of target

A — KPI off target but within agreed threshold

R — KPI off target and outside agreed threshold

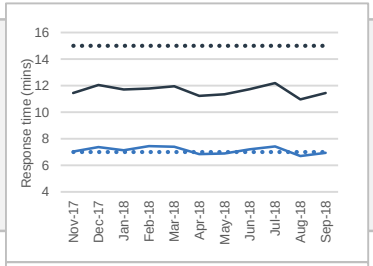
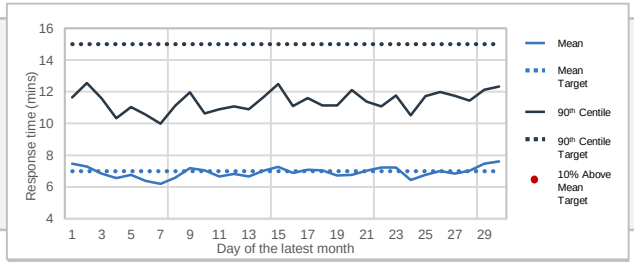
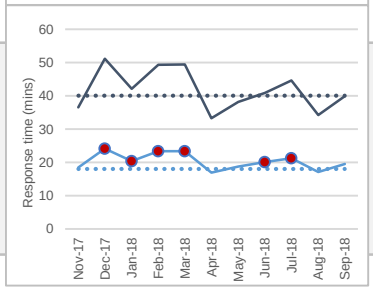
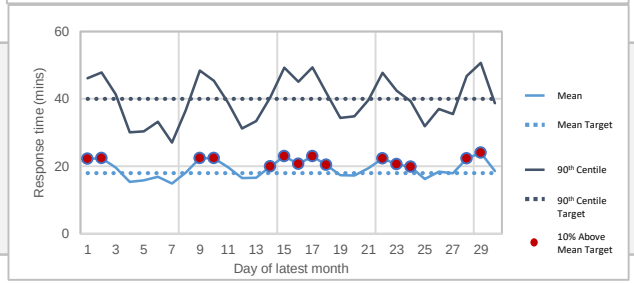
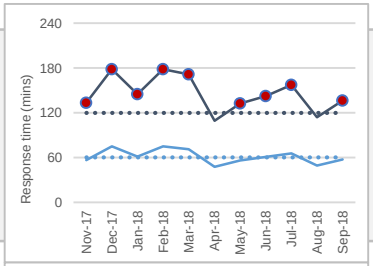
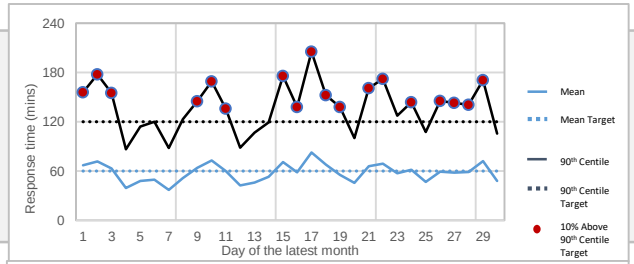
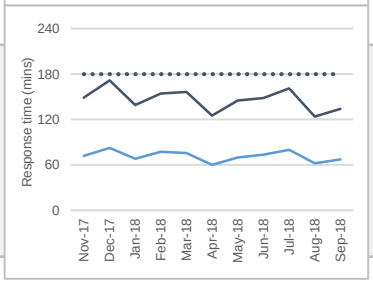
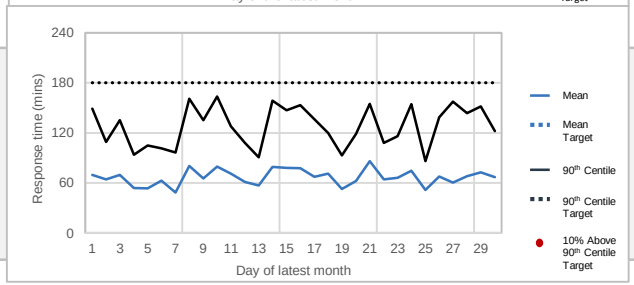
KPI not reported / measurement not started

Variation Indicators

*Note: **ROSC at Hospital** is measured quarterly*

Response Time Performance

The September Category 1 mean returned 6 minutes 57 seconds while the Category 1 90th centile was 11 minutes 27 seconds. The Category 1 90th centile has remained within the standard each week since the implementation of the Ambulance Response Programme (ARP) and shows that our most critical patients are being responded to quickly. The latest nationally published data shows that the Trust is ranked 1st in the Category 1 mean measure as well as the Category 1 90th centile measure when compared to all Ambulance Trusts across England.

		Monthly Trend	Daily Analysis	
C1	**Mean: 6:57** **Target: 7:00**			Month of September's Category 1 mean returned 6 minutes 57 seconds while the Category 1 90th Centile was 11 minutes 27 seconds. Both the Category 1 mean and 90th Centile remained within the National Key Standards (NKS) meaning our most critical patients are being responded to quickly.
C2	**Mean: 19:29** **Target: 18:00**			September's Category 2 mean continued to be off target with 20 out of 30 days achieving the NKS of 18 minutes or less. The weekend of the 15th / 16th was particularly challenging which continued into the early part of the following week, exacerbated by high temperatures.
C3	**90th Centile: 2:16:22** **Target: 2:00:00**			Category 3 90th Centile was not achieved in the month of September, missing the NKS 9 of the 11 months since post ARP implementation. Category 3 90th Centile performance remained challenged mirroring similar trends as Category 2, with 20 of the 30 days breaching the NKS, with the maximum 90th Centile time being 3 hours 26 minutes and 50 seconds
C4	**90th Centile: 2:14:07** **Target: 3:00:00**			The Category 4 90th Centile Target continues to be met on a monthly basis. There were no days in the month where this target was not met by the Trust.

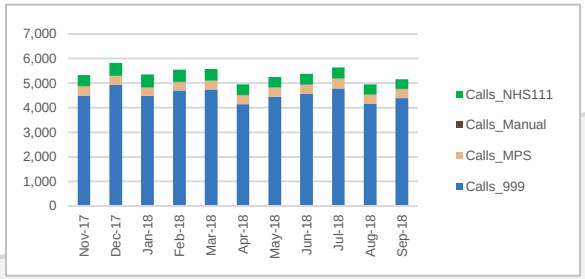
The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: **1)** Calls Received, **2)** Incidents and Response Type (incl. Hear & Treat, See & Treat, See & Convey), **3)** Incident Category

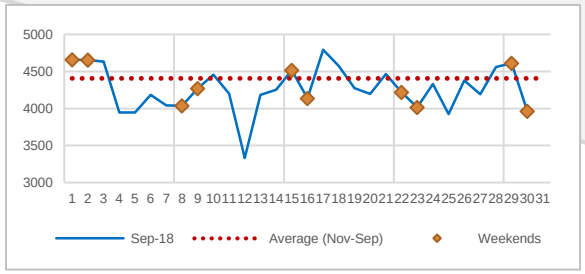
999 Calls Received

The level of total contacts per day in September was 5.6% greater than the previous month. This was driven by the sustained hot weather and large scaled summer events.

Average Calls Per Day



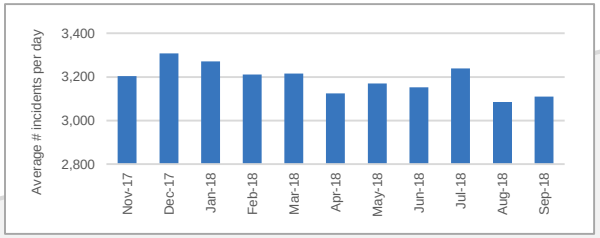
Daily Calls Answered



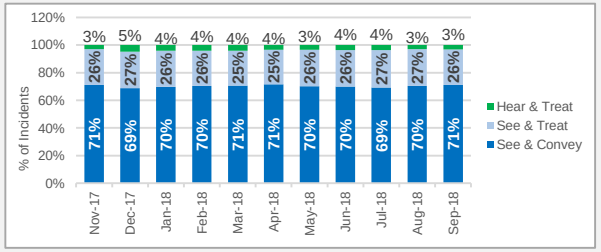
Incidents and Response Type

This resulted in 1% more incidents per day on average when compared to August. Our responses remained inline and consistent with previous months.

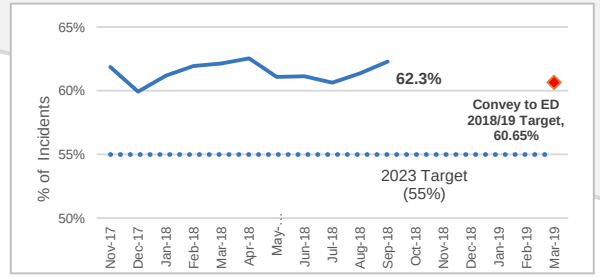
Incidents



Response Type



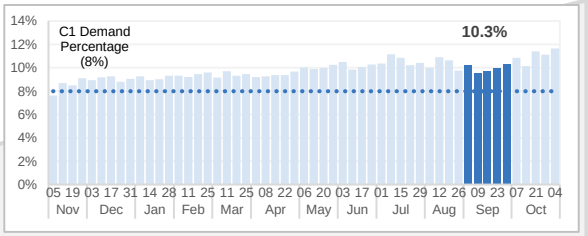
Convey to ED



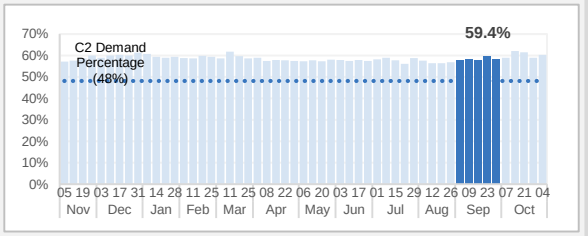
- ***Total incidents now include those without a face to face response***
- ***Nationally Convey to ED is reported as % of total incidents (not just face to face incidents) Sep = 62.3%***

Incident Category (By week)

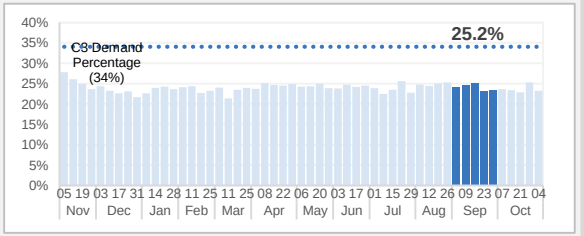
C1



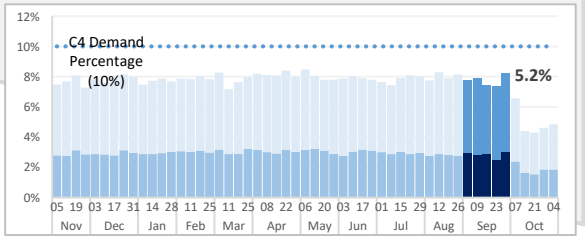
C2



C3



C4



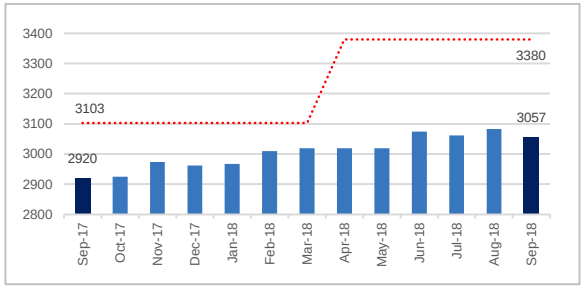
Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

Frontline Operational Staff

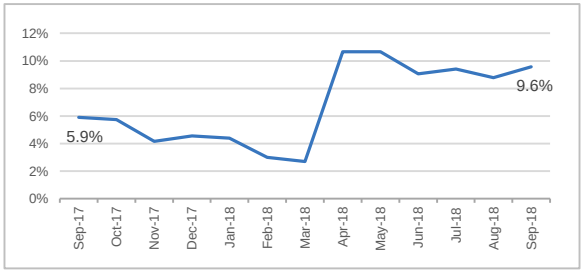
The number of filled operational FTE **has increased by 5% since September 17** and we continue to place considerable effort into our recruitment and retention activity

(See Our People section of this report for further detail across the organisation)

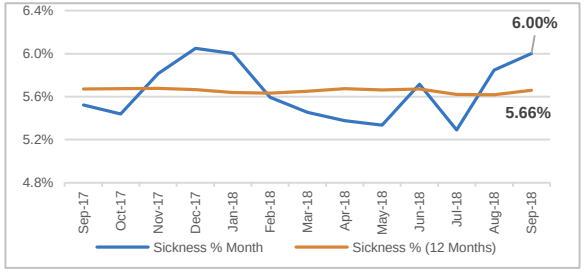
Filled FTE



Vacancy Rate



Sickness Rate



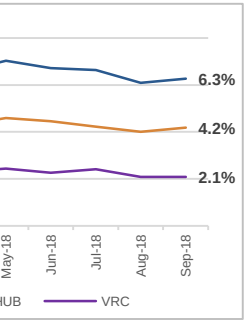
Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate remains close to 6%, which is consistent with performance this calendar year.

High numbers of vehicles going out of service in the evening and early hours (after workshop closure) continue to create shortages for Vehicle Preparation teams.

Average vehicle hours per day increased by 3.3% in September compared to August mirroring the increase in November 17 increase.

Out Of Service %

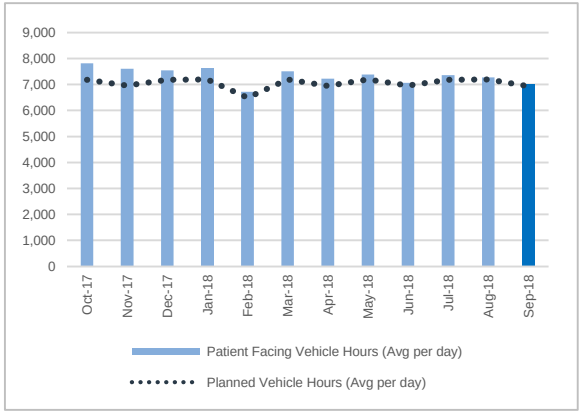


Note:

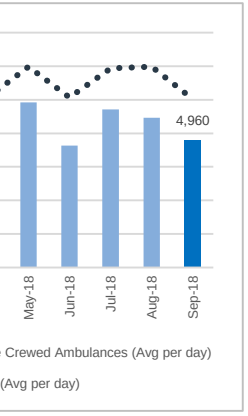
OOS HUB *- This account for out of service codes related to people/crew reasons for out of service hours*

OOS VRC *- This account for out of service codes related to vehicle reasons for out of service hours*

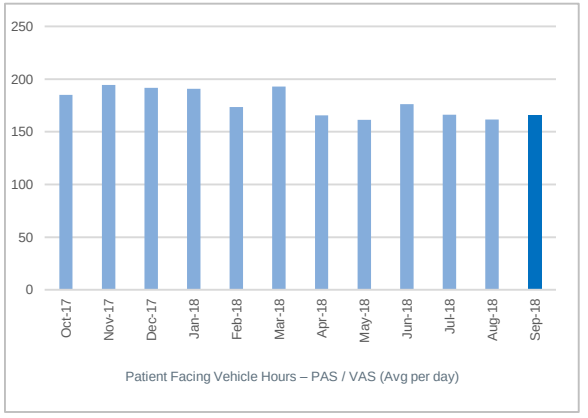
All Vehicles



Ambulance Hours



PAS / VAS



Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.

Arrival at Hospital to Patient Handover

In September over 4,700 hours were lost due to handovers exceeding the 15 minute threshold.

There are 6 hospitals where the proportion of handovers exceeding 15 minutes was greater than 70%. Queens Romford hospital had the greatest number of minutes lost per breached handover with an average of 15.9 minutes lost.

STP	Hospital	Total conveyances	Handovers	Handovers exceeding 15 mins	% over 15 mins	Total time lost (hours)	Avg mins lost per breach
North Central	Barnet	1,512	1,464	496	34%	85.9	10.4
	North Middlesex	2,461	2,369	1,459	62%	241.7	9.9
	Royal Free	1,460	1,362	873	64%	171.9	11.8
	University College	1,804	1,725	937	54%	130.2	8.3
	Whittington	1,495	1,442	570	40%	57.0	6.0
North East	Homerton	1,261	1,211	359	30%	28.4	4.7
	King Georges	1,253	1,212	1,091	90%	214.1	11.8
	New ham	1,940	1,855	1,387	75%	228.5	9.9
	Princess Royal	1,822	1,712	818	48%	240.7	17.66
	Queens Romford	3,029	2,927	2,458	84%	652.2	15.9
	Royal London	2,240	2,153	1,245	58%	160.7	7.7
	Whipps Cross	1,865	1,776	1,433	81%	292.6	12.3
North West	Charing Cross	1,233	1,181	724	61%	75.7	6.3
	Chelsea & West	1,346	1,276	404	32%	39.2	5.8
	Ealing	1,365	1,319	474	36%	48.7	6.2
	Hillingdon	1,807	1,750	1,163	66%	240.7	12.4
	Northw ick Park	3,111	2,986	922	31%	175.1	11.4
	St Marys	1,892	1,811	1,234	68%	202.1	9.8
	West Middlesex	1,836	1,793	792	44%	85.4	6.5
South East	Kings college	2,067	1,935	1,418	73%	235.4	10.0
	Lew isham	1,558	1,449	862	59%	124.8	8.7
	Queen Elizabeth II	2,306	2,216	703	32%	150.7	12.9
	St Thomas'	2,353	2,195	1,345	61%	154.6	6.9
South West	Croydon	2,094	1,996	1,500	75%	278.7	11.1
	Kingston	1,574	1,510	973	64%	86.3	5.3
	St Georges	2,040	1,937	1,363	70%	212.7	9.4
	St Helier	1,295	1,243	867	70%	118.6	8.2
	TOTAL	50,019	47,805	27,870	58%	**4,733**	10.2

Max average breach value
Value >10 mins per breach

Patient Handover to Green

In September, over 2,400 hours were lost due to patient handover to green exceeding the 14 minute threshold.

The average for this measure was exceeded by 11 station groups, with the whole of North Central and North East sectors exceeding the 14 minute target.

Sector	Station Group	Handovers to Green	Handovers Exceeding 14 mins	% over 14 mins	Total Time Lost (hours)	Avg Time PH to Green	90th Centile PH to Green	Avg mins lost per breach
North Central	Camden	2,523	1,471	58%	195.7	16.0	28.1	8.0
	Edmonton	2,984	1,365	46%	156.4	14.1	24.6	6.9
	Friern Barnet	1,892	1,039	55%	101.3	14.7	24.2	5.8
North East	Homerton	2,504	1,504	60%	198.8	16.3	27.4	7.9
	New ham	3,791	2,032	54%	228.4	14.5	25.7	6.7
	Romford	3,729	2,010	54%	199.4	14.7	23.9	6.0
North West	Brent	3,697	1,915	52%	201.9	14.4	23.8	6.3
	Fulham	2,046	1,046	51%	110.0	14.3	24.1	6.3
	Hanw ell	2,763	1,346	49%	97.5	13.5	21.1	4.3
	Hillingdon	1,516	708	47%	57.2	13.7	21.3	4.8
	Westminster	1,203	667	55%	71.0	14.7	24.6	6.4
South East	Bromley	2,418	1,176	49%	99.6	13.6	21.7	5.1
	Deptford	4,477	2,275	51%	228.1	14.2	23.8	6.0
	Greenw ich	2,315	1,024	44%	55.5	13.4	18.4	3.3
South West	Croydon	1,769	962	54%	83.8	14.2	22.2	5.2
	New Malden	1,258	647	51%	54.1	14.0	21.5	5.0
	St Helier	1,622	762	47%	50.3	13.3	20.1	4.0
	Wimbledon	1,809	947	52%	85.8	14.0	22.9	5.4
Other	IRO	8	5	63%	3.0	27.5	81.3	36.0
	NETS	869	208	24%	27.3	4.5	20.0	7.9
	Other	1,319	642	49%	72.0	13.6	23.2	6.7
	Training	1,307	476	36%	38.9	12.2	19.7	4.9
	TOTAL	47,819	24,227	51%	2416.0	**13.9**	**23.6**	**6.0**

Max average breach value
Value >7 mins per breach

Ambulance Quality Indicators (Latest Reported Month) and Recontact Rates

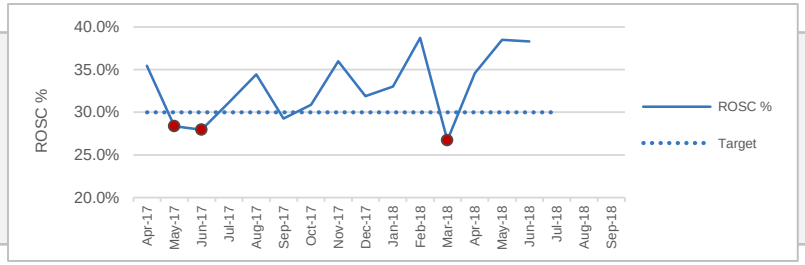
Our Trust-wide scorecard covers 3 of the key Ambulance Quality Indicators: Return of Spontaneous Circulation (ROSC) at Hospital, STEMI call to angiography and Stroke call to door.

The data presented is from June 2018, which is the most recent month published by NHS England. During this period, the average response times for cardiac arrest patients was 10 minutes, with patients receiving an average response of 7 minutes when allocated a C1 response. CPR was commenced on average 1 minute from arrival at the patient and a defibrillator used on average 3 minutes from arrival at the patient. For STEMI patients, the average response time was 21 minutes, the on-scene time was 37 minutes and the overall call to arrival at hospital time was 74 minutes. For stroke patients, the average response time was 23 minutes, the on-scene time was 30 minutes and the overall call to arrival at HASU time was 70 minutes.

ROSC at Hospital

Month: 38.3%

Target: 30%



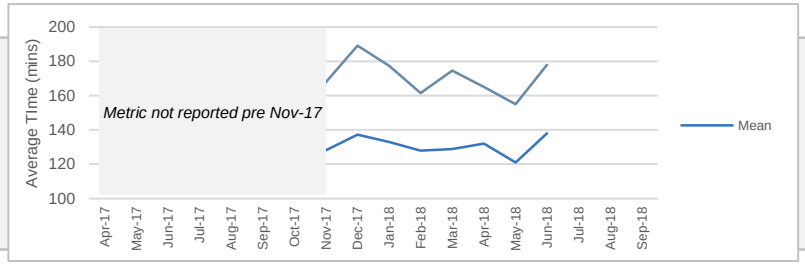
Overall Return of Spontaneous Circulation (ROSC) at Hospital indicator is above the target of 30%.

Of note in June, the Utstein comparator group achieved 70% ROSC, the highest rate observed over the last 12 months.

STEMI call to angiography

Mean: 2:18:00

Target: TBC



Targets currently not available for this metric to support performance assessment.

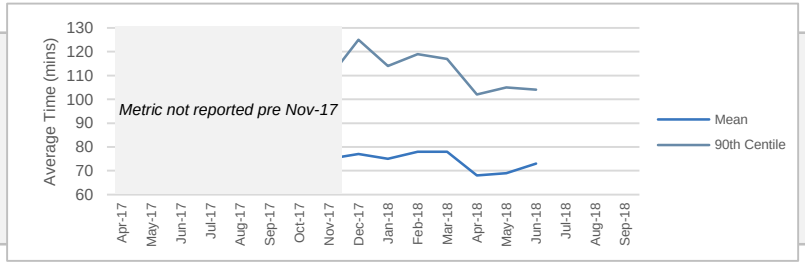
In June **ranked 6th for the mean** when compared to other Ambulance Trusts and performance is above the national average. The 90th centile is 2:58 and the LAS falls below the national average.

Data is sourced from national systems based on hospital entered data that may not be accurate or complete.

Stroke call to door

Mean: 1:13:00

Target: TBC



Targets currently not available for this metric to support performance assessment.

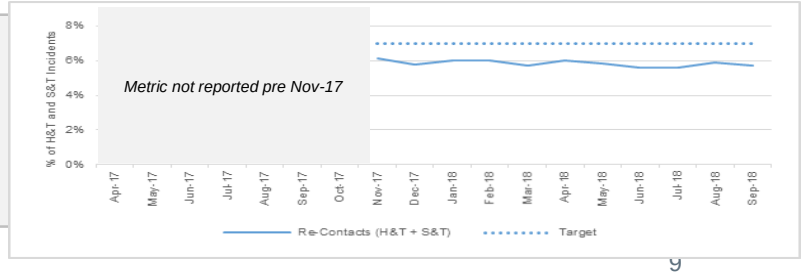
The median response time is 1:03 and 90th centile is 1:48. This is in line with the national average.

In June **ranked 7th for the mean and 3rd for the median** when compared to other Ambulance Trusts.

Recontact Rates

Month: 5.6%

Target: 7%



Recontact rates remain below 6% and therefore continue to be below the 7% target

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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	Trisha Bain	G	On track, four deliverables being escalated related to use of resources with recovery plans in place. Refresh of the Quality Account and Review of 2019/20 priorities will begin in November.
BP.2	We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards	Paul Woodrow	G	On track. Currently meeting national performance targets having taken steps to increase the proportion of DCAs in the fleet and ensure appropriate frontline resource is available.
BP.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.	Fenella Wrigley	G	APP numbers are under review and considering potential adoption of rotational roles. Recruited the first and second cohort, and will start third phase following winter. Monitoring through pioneer services steering group.
BP.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	Angela Flaherty	G	Five year strategy complete and published. Enabling strategies in progress across the organisation.
BP.5	We will pilot the new 'Pioneer Services' set out in our new strategy	Trisha Bain	G	Pioneering services piloting and implementation underway. Mental health and falls are key focuses for 2018/19. Mental health pilot has started, with a review to take place in January which will include system wide service development opportunities.
BP.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.	Trisha Bain	G	Frequent caller dataset available across all sectors and CCGs. Additional five frequent caller team members aligned to each Sector. High impact areas being focused on in terms of system support. Key KPIs / scorecard developed to include in monthly reporting cycle.
BP.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.	Benita Mehra	G	Delivery of the secure drug room is ongoing. An Outline Business Case Kit Preparation, Multi-use Drug Bag and Primary Response Bag is due in Q3, with delivery planned to be completed this year.
BP.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.	Fenella Wrigley	G	The roll out of iPads to paramedics has been complete and there is now an ongoing programme to optimise the use of the iPads and explore suitable apps to support paramedics.

G Business Plan deliverable on track
A Business Plan deliverable off track but with plan in place to resolve issues
R Business Plan deliverable significantly off track
C Business Plan deliverable complete
Business Plan deliverable not started

Quarterly Reporting (Latest report as at 10-Sep-18)

SAFE

- 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.
- 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.
- The **secure drug rooms project** is progressing well for those where it was a agreed that new drug rooms will be built.
- Actions to increase the number of **defibrillators** are progressing well

EFFECTIVE

- The implementation plan for **clinical training** is on track and will be finalised this month.
- New **clinical quality indicators** have been agreed and are included in the monthly CEO performance pack for review.
- 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 November 2018.
- Sector **roster reviews** are underway with regularly feedback being received from sectors on implementation.

CARING

- Work continues to address the **frequent callers** and a KPI to reduce the number of calls has been set.
- 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.
- **Two whole time practice development midwives** have been recruited and implementation of a training programme is underway.

RESPONSIVE

- Review of **operational model** - a paper went to Board which included an action plan which was approved.
- To improve our **response to complaints** a process mapping exercise has been undertaken and an action in place, this includes extra resource

WELL LED

- **Statutory and mandatory training** is on course with trajectories established at station level in place.
- **Leadership programme** has been written and the first cohort undertaken the training this month.
- T3: The progress on P&OD strategy is regularly discussed at the people and culture committee.

		Progress Status			
	Total	**Complete**	**G**	**A**	**R**
TOTAL	**88**	13	**65**	10	0
Change in status since last period		*0*	*0*	*0*	*0*
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
Use of Resources	**8**	1	3	**4**	0

KEY: *Most common status by domain*

Delivery of our Quality Plan for 2018/19 is closely monitored, 34 of these actions are covered by other areas of the Business Plan and our Trust-wide strategic programmes of work.

Overall we have 10 of our 88 actions that have an Amber status, 4 of these have been escalated to the relevant sub-committee

BP.3 Advanced Paramedic Practitioner Service (APP)

We have made progress in our recruitment in North West and North East sectors with our recruitment activity in the South due to be started next month.

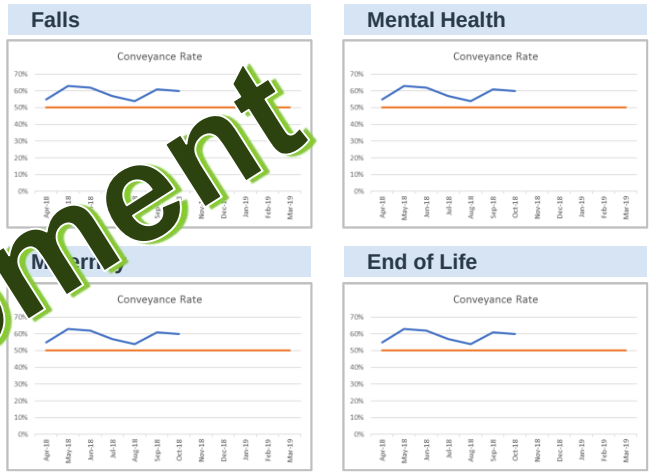
APP headcount by sector

Sector	APP headcount	Target	APP conveyance rate	Target
North West	10	20	42%	40%
North Central	0	20	n/a	40%
North East	10	20	53%	40%
South East	0	0	n/a	40%
South West	0	0	n/a	40%

BP.5 Pioneering Services

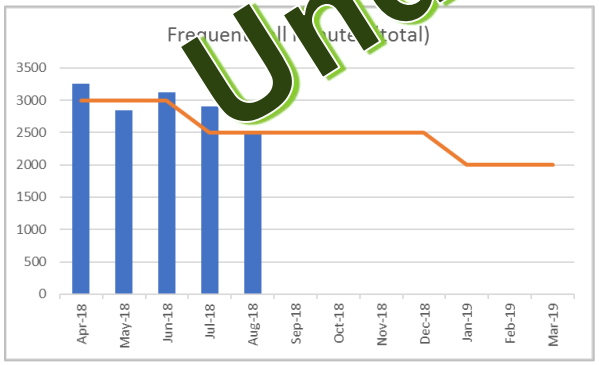
We continue to pilot our Pioneering Services across Falls, Mental Health, Maternity and End of Life.

We are yet to see a meaningful reduction in conveyance rates due to the implementation of these service a… will conduct furth… an…sis und…ta… the … th… we need to … a… changes.



BP.6 Frequent Callers Plan

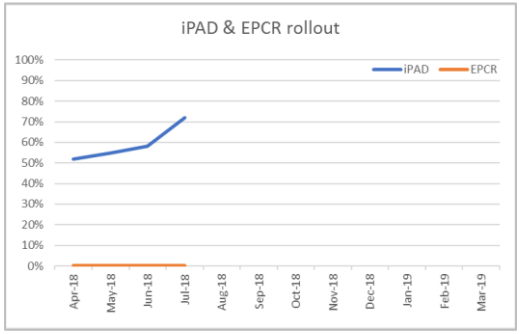
Our frequent callers are now readily identifiable and we have a ra… of plans that we can put in place to help these patients receive the care the… req… hi… also limiting their impact on our finite resources – the number of frequen… ll … ute … total) … ped by 16% in the most recent month .



BP.8 Roll out of iPads to our front-line clinicians

We have accelerated the roll out of iPads to our frontline clinicians during July – over 70% of our frontline clinicians now have access.

We are continuing to collect feedback during the rollout phase and making adjustments to support the necessary business change activities.



People Scorecard

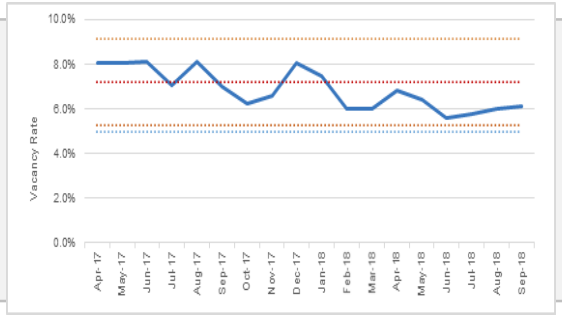
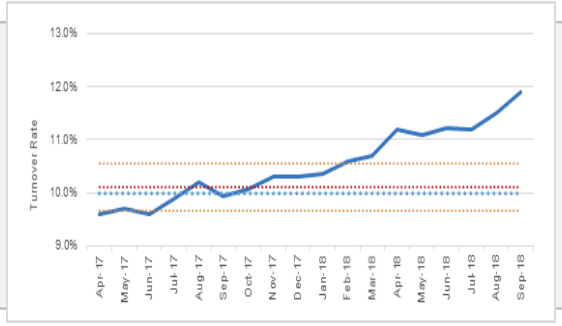
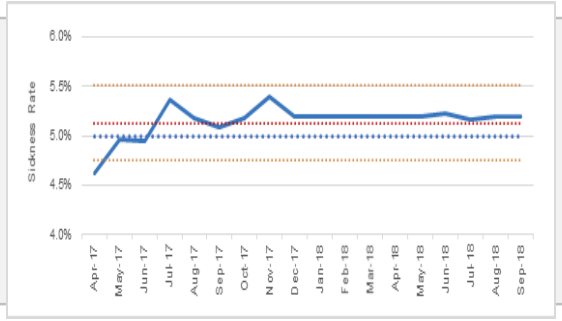
September 2018

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Current Perfomance: Target	Current Perfomance: Latest Month	Current Perfomance: 2018/19 Year To Date Actual	Current Perfomance: Rolling (12 Month Average)	Trajectory: 2018/19 Trajectory	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 11)
Staff Survey engagement score	Y	Score (Range)			3.46							
BME Staff Survey engagement score	Y	Score (Range)			3.46							
Staff survey completion	Y	%			50%							
Staff Sickness levels	M	%	Sep-18		5%	5.2%		5.1%				
MSK related staff injuries (staff survey)	Y	%			50%							
MSK reduction in moderate harm	M	Count			0.25							
Bullying and Harrassment incidents (decreasing)	Y	%			27%							
% of BME Staff	Q	%	Sep-18		15%	14.0%	13.8%	13.3%				
Statutory & Mandatory Training (85% or above)	M	%	Sep-18		85%	88%	88%	82%				
Staff appraisal compliance (85% or above)	M	%	Sep-18		85%	83%	87%	74%				
Flu vaccination rate (increasing - CQUIN)	M	%			65%							

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Vacancy Rates, Staff Turnover and Sickness

The Trust continues to experience higher than average turnover rates at over 11% - vacancy rates continue to remain lower than in FY17/18 as we make progress with our recruitment and are close to our target of 5%

	Trust	Monthly Trend	Frontline	
Vacancy Rate	**Month: 6.1%** Target: 5%		**All Frontline: 9.8%** **Paramedics: 3.2%**	Our overall vacancy rate continues to be below the average from FY17/18, and slightly above target at 6.1%. The focus of recruitment activity is on our non-paramedic frontline staff. Performance against our recruitment target will improve slightly due to lower iPara turnover than forecast. We continue to actively recruit and have a significant programme of domestic recruitment events, a strong pipeline and continue where possible to streamline our recruitment processes for EOC, TEAC and Paramedics.
Staff Turnover	**12 Month Rolling: 11.9%** Target: 10%		**All Frontline: 11.0%** **Paramedics: 12.6%**	Staff turnover rates remain above the average for FY17/18 at above 11%. 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. Other initiatives to improve our intelligence to inform retention activities include the new eForms system now implemented, and more fully utilising the ESR exit questionnaire functionality (planned implementation in Q1 19/20).
Sickness	**12 Month Rolling: 5.2%** Target: 5%			Staff sickness rates remain consistent with the previous 9 months at 5.2%. Work continues to support operational teams to bring sickness levels within target. The Trust is around the national average (last reported in June 2018) of 5.2% for sickness. Our top two reasons for absence continue to be musculoskeletal injury 41% and Mental Health 11%.

Health and Safety

Compliance with Health and safety action plan:

Actions arising from the Health and Safety Review have been progressed in line with the action plan; 60/69 actions have been completed (and continue to be embedded) and 9 actions are in progress and on schedule.

Adverse Staff Events

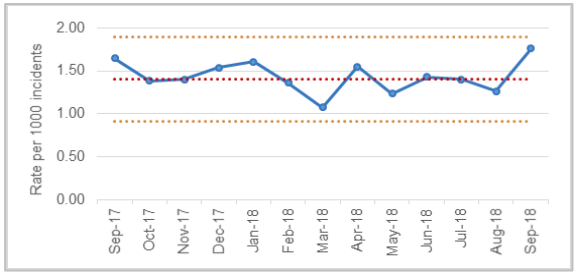
*The total number of H&S incidents was 281 resulting in **3.10 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below.*

157 (55%) of the H&S related incidents reported during September - 2018 resulted in Low Harm.

2 (1.0%) of the H&S related incidents reported during September 2018 resulted in Moderate Harm.

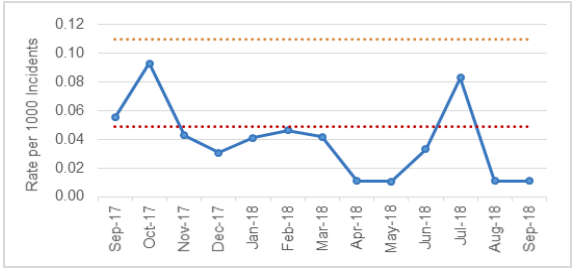
Low Harm

Month:1.74



Moderate

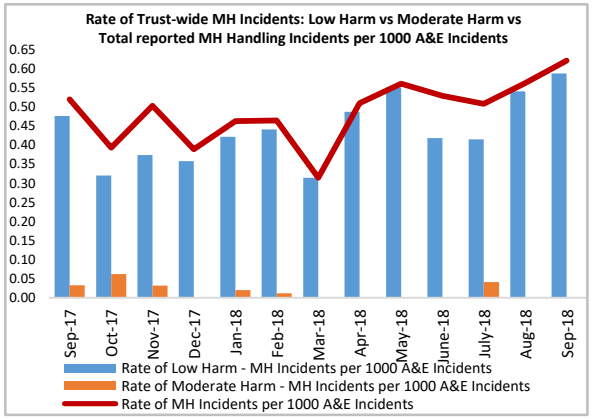
Month: 0.01



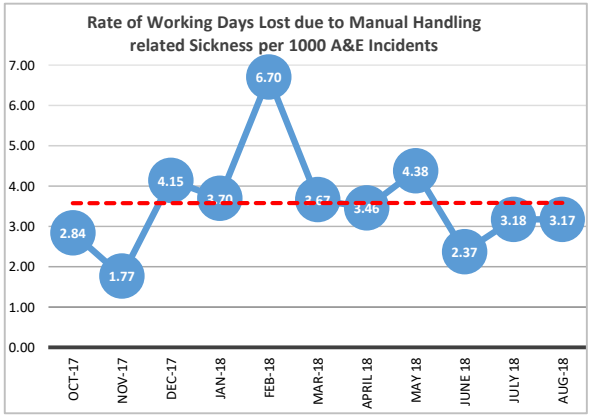
Manual Handling

There has been a increase in reporting of MH incidents since April-2018 when we introduced the programme of practical training, although overall there has been a reduction in the level of harm with an increase of no harm reports being completed.

Manual Handling



Manual Handling Related Sickness



Key Updates:

1.The Practical MH Training was delivered to staff through the CSR 1:2018, a total of 3607 staff attended the training and the Trust's compliance rate is currently at 90.4%. There has been a noticeable increase in the use of manual handling equipment and reference to this equipment from staff which is positive.

2.The Manual Handling Competency Assessment which has been incorporated into the annual Occupational Workplace Review (OWR) went live in September.

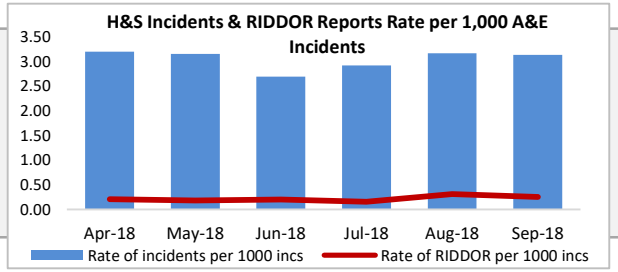
3.A programme of training on how to undertake the manual handling (OWR) assessment and accident investigation for CTL/M's will be delivered during Q3-2018.

4.The tender process for the Trust's fire risk assessment contract is due to close on 18th Oct-2018.

*The total number of H&S incidents was 281 resulting in **3.10 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below:*

Monthly Trend

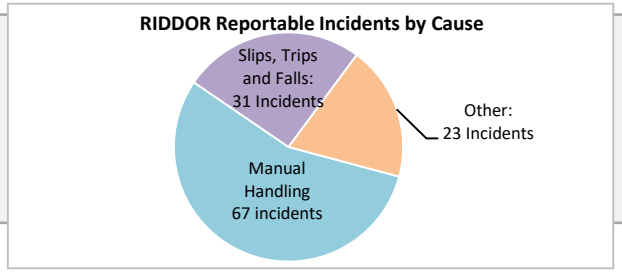
Rate of Incidents



The graph on the left highlights the YTD rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust.

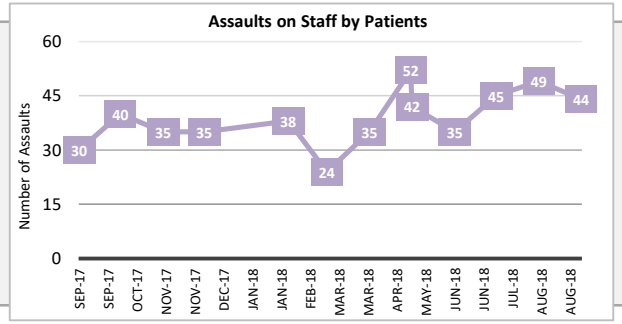
There is no benchmark/comparable data was received from any of the other ambulance Trusts during September 2018.

RIDDOR by Cause



121 RIDDOR incidents were reported to the HSE in 2018/19. 23 RIDDOR incidents were reported in September 2018.
The Trust wide RIDDOR reporting Compliance in September 2018 was **65%.** 8 out of the 23 RIDDOR incidents were reported out of time in Sept-2018**.**

Assaults



There was a slight decrease in the number of assault on staff by patient related incidents in Sep-2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Additional Workforce Analysis

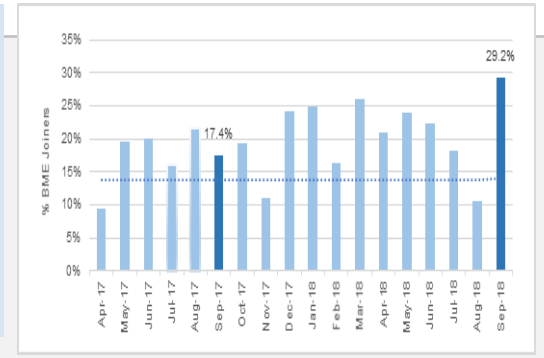
Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

Workforce Race Equality Standards

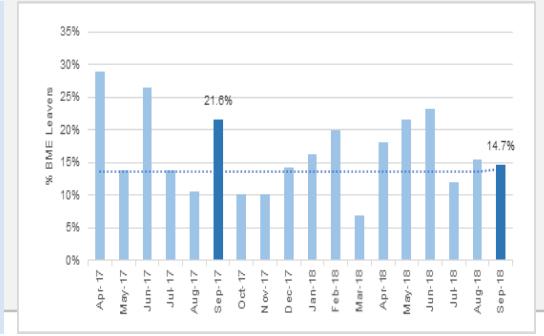
The LAS WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly.

These graphs show the numbers of BME starters and leavers from April 2017 to September 2018 compared to the current Trust BME profile. This year we have recruited 116 BME staff and 56 BME staff have left.

BME Starters



BME Leavers



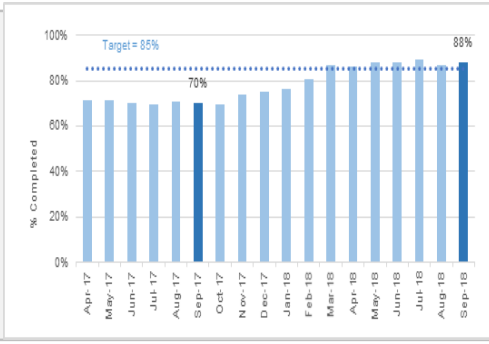
The WRES action plan for 18/19 has been finalised and features new targets and three key themes - Recruitment and Development, Workforce Experience and Senior Trust Leadership.

We have commenced a BME pilot project to ensure diverse interview panels, senior managers workshops to discuss our current BME data and ensuring management teams have visibility and are accountable for their teams through the CEO performance reviews (a new indicator, measuring the % of BME staff by pay band, has been added to each Directorate scorecard with effect from July 2018). This will support targeted interventions where needed.

Statutory and Mandatory Training and Appraisals

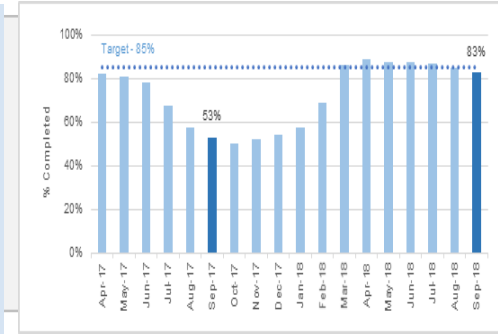
- Trust compliance in Statutory and Mandatory training is **87.6%** with over 67,000 e-learning courses have been completed since go-live. Nearly 4,000 staff have set-up to use from home and these numbers will increase with the newly available auto enrolment functionality.
- Appraisal completions at **82.5%** at the end of September.

Statutory & Mandatory



Trust compliance is 88%, Corporate compliance 89.1% and Operations is at 87.5%. Each Sector now has a compliance lead to ensure that stat and mand and PDR levels meet trajectories. EOC, the subject of the CQC MustDo action, is at 83.7% and a specific trajectory and action plan has been agreed with the EOC management team to bring this in line.

Appraisal Compliance



The appraisal completion rate is 82.6% at the end of September. Compliance has now dropped below the 85% target. This is predominantly linked to a number of Corporate staff who became non-compliant in September and focus is on Business Partners working with their colleagues to see improvement in this area.

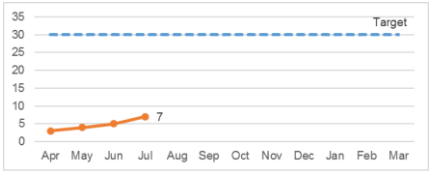
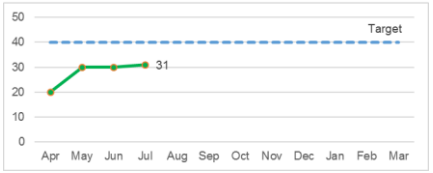
Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.9	We will complete our recruitment plan to fully establish our front-line and newly enlarged Emergency Operations Centre structures.	Patricia Grealish	A	Paramedic recruitment has achieved significant success. There will remain a gap against establishment for non-registered clinicians at year end but work planned for 19/20 should see this addressed. We are planning to be fully established for our Emergency Call Handler roles by the end of the year
BP.10	We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate.	Patricia Grealish	G	In delivery – some directorates are complete, some Directorates ongoing. Remaining directorate (Strategic Assets and Property) will be delivered in 19/20 as agreed during business planning
BP.11	We will embed our new Vision, Purpose, Values and Behaviours across the organisation and fully align our competencies to the employee journey at LAS in: recruitment, promotion, training and development and appraisals.	Patricia Grealish	G	On track. All the new branding is out, appraisals have been updated. It is now within BAU delivery and will continue into next year. Roll out of values is embedded across recruitment and training activities and management actively engaged in culture change
BP.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.	Patricia Grealish	C	Completed. Intend to do the same next year, and will therefore continue to need the dedicated resource
BP.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.	Patricia Grealish	G	On track. There will now also be a Workforce Disability Equality Standard Action Plan which will be developed during 19/20 once the new standards are published (likely now to be in the new year)
BP.14	We will continue to implement our Clinical Education Strategy	Fenella Wrigley	G	On track. Beginning to work on a new sustainable workforce model with a growth in Apprenticeships across the organisation.
BP.15	We will develop and roll-out training and development for all our people across functional and operational teams.	Patricia Grealish	G	On track, leadership development programme in delivery phase. First cohort of visible leaders completed. Roll-out of programme in planning and management essentials now live and with very positive take-up.

G Business Plan deliverable on track
A Business Plan deliverable off track but with plan in place to resolve issues
R Business Plan deliverable significantly off track
C Business Plan deliverable complete
Business Plan deliverable not started

BP.9 EOC and Frontline Recruitment Plans

We have made progress in our recruitment in North West and North East sectors with our recruitment activity in the South due to be started next month.

	Progress against FY18/19 recruitment target	S1	S2	S3
EOC Recruitment		10	5	3
Frontline Recruitment		5	10	15

BP.10 Organisational Restructure

Our Operations restructure is due to start implementation in the next month. We have also worked on the design of the Finance and Performance structure.

Directorate	Designed	CEO approval	Consultation complete	Board approval	Implementation	Status	Due
Operations	✓		✓				Dec-18
Medical & Clinical							Apr-19
Strategy & Communications							Apr-19
Finance & Performance	✓	✓					Apr-19

BP.12 Staff Survey Actions

We have identified a range of actions following analysis of the 2017 Staff Survey. The table below shows where we have taken action to date. The 2018 Staff Survey will be run later this year and will enable us to assess the impact of these actions

Issue	Action	Implemented	2017 Staff Survey Score	2018 Staff Survey Score
Issue 1	Insert narrative here	No	[Q# and score] Tbc	[Q# and score] Tbc
Issue 2	Insert narrative here	No	tbc	tbc
Issue 3	Insert narrative here	No	tbc	tbc
Issue 4	Insert narrative here	No	tbc	tbc
Issue 5	Insert narrative here	No	tbc	tbc

Public Value Scorecard

September 2018

Indicator (KPI Name)	Basis	Data From Month	FY18/19 Target Status	Current Perfomance: FY18/19 Target	Current Perfomance: Latest Month	Current Perfomance: Month Plan	Current Perfomance: 2018/19 Year To Date Actual	Current Perfomance: YTD Plan	Current Perfomance: Rolling (12 Month Average)	Forecast: 2018/19 Forecast	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 11)
Control Total (Deficit)/Surplus	£m	Sep-18	G	(1.6)	(0.5)	(0.5)	(4.4)	(4.4)		0.3			
CIP Savings achieved	£m	Sep-18	G	12.3	1.1	1.1	4.2	4.2		12.3			
CIP Savings achieved - % Recurrent	£m	Sep-18	A	75%	48%		63%			72%			
Use of resources index/indicator	(n)	Sep-18	G	2	3	3	2	2	2	2			
% of Capital Programme delivered	%	Sep-18	A	100%	16%	29%	16%	29%		100%			

G — KPI on or ahead of target

A — KPI off target but within agreed threshold

R — KPI off target and outside agreed threshold

KPI not reported / measurement not started

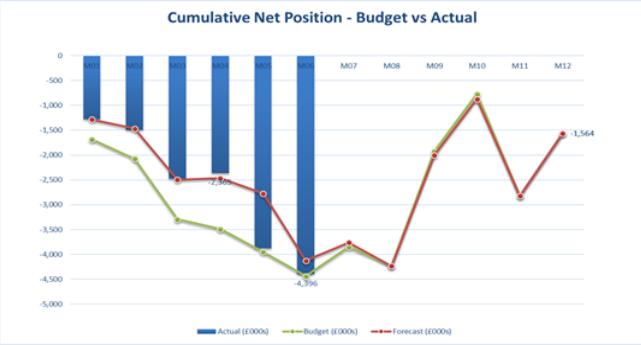
Trust Financial Position

September's financial performance continues to align with our financial plan for FY18/19 with a strong current cash position for the trust, however income continues to be behind contracted levels and our capital plan is not progressing as quickly as anticipated.

YTD outturn vs budget

YTD: -£4.4m

Budget: -£4.4m



- Year to date the position is on plan. The Trust has an improved full year outturn forecast of £0.3m surplus, £1.9m ahead of planned deficit of £1.56m. This will allow the Trust to access additional Provider Sustainability Funding (PSF) of £3.8m.
- Main contract activity for month 6 YTD is 0.17% higher than contract, and the variable income in relation to this (£0.226m) has been recognised in the Trust accounts as over performance. The Trust plan included £4.6m of expected growth full year and the Trust is therefore £2m behind planned income at the end of month 6.

Financial Position Metrics

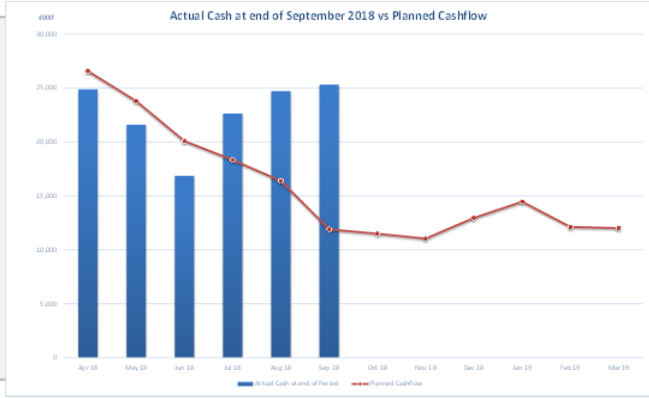
	Month 6 2018-19 £000			YTD Month 6 2018-19 £000			Full Year 2018-19 £000
	Budget	Actual	Variance fav / (adv)	Budget	Actual	Variance fav / (adv)	Budget
Surplus / (Deficits)	(489)	(521)	(32)	(4,436)	(4,396)	41	(1,564)
EFL				18,402	4,983	13,419	18,288
CRL				8,800	5,747	3,053	17,126
Suppliers paid within 30 days - NHS	95%	100%	5.0%	95%	93%	(2.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	87%	(8.0%)	95%	84%	(11.0%)	95%
EBITDA %	3.7%	3.6%	(0.1%)	2.9%	2.6%	(0.3%)	5.0%
EBITDA	1,120	1,071	(48)	5,324	4,709	(614)	18,837
NRAF (net return after financing)				(1.07%)	(1.44%)	-0.4%	(1.9%)
Liquidity Days				(4.90)	(2.59)	2.31	(2.21)
Use of Resources Rating				3.0	3.0	0.0	2.0

- The Trust is £3m behind a capital plan of £8.8m YTD. The Trust was awarded £3.8m capital funding from the sustainability and transformation partnership ambulance schemes to fund the purchase of additional ambulances in addition to the initial £17.1m capital plan.
- Non-NHS 87%, NHS 100% performance (volume) for this month, performance is still below 95% target.

Cash position

YTD: £25.3m

Plan: £11.9m



- Cash is £25.3m, £13.4m above plan. This is made up of a number of offsetting variances.
- An analysis of the cash position shows that receipts from income are £10.9m above planned, there are higher than planned creditor payments of £5.8m 2017/18 PSF 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 £3.5m 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 £4.8m on capital, £0.6m on pay and £0.6m on provisions.

Our Statement of Comprehensive Income reports the Trust's financial performance over a specific accounting period. Financial performance is assessed by giving a summary of how the Trust incurs its income and expenses through both operating and non-operating activities. It also shows the net surplus or deficit incurred over a specific accounting period.

Statement of Comprehensive Income (Month 6 – September 2018)

	Month 6 2018-19 £000			YTD Month 6 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	29,683	29,462	(222)	180,729	177,995	(2,734)	368,781	364,537	(4,244)
Other Operating Income	679	588	(91)	3,510	3,206	(303)	8,915	7,980	(935)
Total Income	**30,362**	**30,050**	**(313)**	**184,239**	**181,201**	**(3,038)**	**377,696**	**372,517**	**(5,179)**
Operating Expense									
Pay	(23,496)	(22,405)	1,091	(139,483)	(135,341)	4,143	(280,937)	(273,241)	7,696
Non Pay	(5,746)	(6,573)	(827)	(39,432)	(41,151)	(1,719)	(77,921)	(79,150)	(1,229)
Total Operating Expenditure	**(29,242)**	**(28,978)**	**264**	**(178,915)**	**(176,492)**	**2,423**	**(358,858)**	**(352,392)**	**6,467**
EBITDA	**1,120**	**1,071**	**(48)**	**5,324**	**4,709**	**(614)**	**18,837**	**20,125**	**1,288**
EBITDA margin	3.7%	3.6%	(0.1%)	2.9%	2.6%	(0.3%)	5.0%	5.4%	0.4%
Depreciation & Financing									
Depreciation & Amortisation	(1,271)	(1,261)	10	(7,686)	(7,102)	584	(16,241)	(15,742)	499
PDC Dividend	(350)	(350)	0	(2,100)	(2,100)	0	(4,200)	(4,200)	0
Finance Income	14	17	2	40	68	29	67	93	26
Finance Costs	(2)	(1)	1	(13)	(5)	8	(27)	(19)	8
Gains & Losses on Disposals	0	3	3	0	34	34	0	34	34
Total Depreciation & Finance Costs	**(1,609)**	**(1,593)**	**16**	**(9,760)**	**(9,105)**	**655**	**(20,401)**	**(19,834)**	**567**
Net Surplus/(Deficit)	**(489)**	**(521)**	**(32)**	**(4,436)**	**(4,396)**	**41**	**(1,564)**	**291**	**1,855**
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	0	19	19	(0)	38	38	0
Remove STP funding 2016/17	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance	**(486)**	**(518)**	**(32)**	**(4,417)**	**(4,377)**	**41**	**(1,526)**	**329**	**1,855**
Net margin	(1.6%)	(1.7%)	(0.1%)	(2.4%)	(2.4%)	(0.0%)	(0.4%)	0.1%	0.8%

Income

- Main contract activity for month 6 YTD is 0.17% higher than contract, and the variable income in relation to this (£0.226m) 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 £2m behind planned income at the end of month 6.

Operating Expenditure (excl. Depreciation and Financing

- Pay expenditure is £4m lower than plan, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure £2.2m and agency spend £1.1m.
- Non-Pay is over by £1.7m YTD and £3.8m FOT due to overspends on consultancy (£0.4m), conflict resolution training (£0.5m), subsistence (£0.2m), uniforms (£0.4m) , new software in EOC (£0.2m), fuel (£0.4m), medical gases and surgical items (£0.2m).
- 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 £4,709k in September which represents EBITDA margin of 2.6%.

Depreciation and Financing

- Overall Financial Charges are £0.7m favourable year to date due to slippage in the Capital programme.

Our Cashflow Statement summarises the amount of cash and cash equivalents entering and leaving the Trust. It measures how well the Trust manages its cash position, meaning how well the Trust generates cash to pay its debt obligations and fund its operating expenses.

Cashflow statement (Month 6 – September 2018)

	Apr-18 Actual	May-18 Actual	Jun-18 Actual	Jul-18 Actual	Aug-18 Actual	Sep-18 Actual	Sep-18 YTD Move	Sep-18 YTD Plan	Sep-18 Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	**30,300**	**24,876**	**21,585**	**16,866**	**22,634**	**24,715**	**30,300**	**30,300**	**0**
Operating Surplus	226	1,280	554	1,613	(35)	1,067	4,705	5,048	(343)
(Increase)/decrease in current assets	716	(5,174)	2,640	3,927	1,249	3,045	6,403	(366)	6,769
Increase/(decrease) in current liabilities	(2,805)	4,667	(5,814)	1,730	1,265	975	18	416	(398)
Increase/(decrease) in provisions	402	(673)	(284)	168	208	(751)	(930)	(3,504)	2,574
Net cash inflow/(outflow) from operating activities	(1,461)	100	(2,904)	7,438	2,687	4,336	10,196	1,594	8,602
Cashflow inflow/(outflow) from operating activities	**(1,461)**	**100**	**(2,904)**	**7,438**	**2,687**	**4,336**	**10,196**	**1,594**	**8,602**
Returns on investments and servicing finance	0	12	10	15	15	17	69	26	43
Capital Expenditure	(3,963)	(3,403)	(1,825)	(1,685)	(621)	(2,071)	(13,568)	(18,342)	4,774
Dividend paid	0	0	0	0	0	(1,680)	(1,680)	(1,680)	0
Financing obtained	0	0	0	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(3,963)**	**(3,391)**	**(1,815)**	**(1,670)**	**(606)**	**(3,734)**	**(15,179)**	**(19,996)**	**4,817**
Movement	(5,424)	(3,291)	(4,719)	5,768	2,081	602	(4,983)	(18,402)	13,419
Closing Cash Balance	**24,876**	**21,585**	**16,866**	**22,634**	**24,715**	**25,317**	**25,317**	**11,898**	**13,419**

Operating Position

- There has been a net outflow of cash to the Trust of £5.0m.
- Cash funds at 30 September stand at £25.3m.
- The **operating surplus at £4.7m** is (£0.3m) below target.

Current Assets

- The movement on current assets is £6.4m, £6.8m higher than planned movement.
- Current assets movement was higher than planned due to receivables £2.1m, accrued income £6.0m and prepayments (£1.4m). Accrued income is below plan as the Trust received its £5.8m PSF income in July.

Current Liabilities

- The movement on current liabilities is £0.02m, a (£0.4m) higher than planned movement.
- Current liabilities movement was higher than planned due to trade and other payables (£3.4m), due to a reduction in the number of outstanding invoices and higher than planned in year non-pay spend, accruals £1.5m and Deferred income £1.5m.

Provisions

- The movement on provisions is (£0.9m), is a £2.6 lower than planned movement.

Capital Expenditure

- Capital cash outflow is £13.6m, is a £4.8m below plan.

Cost Improvement Programmes (CIPS) and Capital Plan

To prepare our Trust for the future we need to ensure we manage our costs effectively and where possible reduce the costs of running the Trust whilst maintaining the absolute best care for our patients. We also need to strategically invest year on year in our estate, fleet and technology capability so that we can continue to offer a world-class ambulance service.

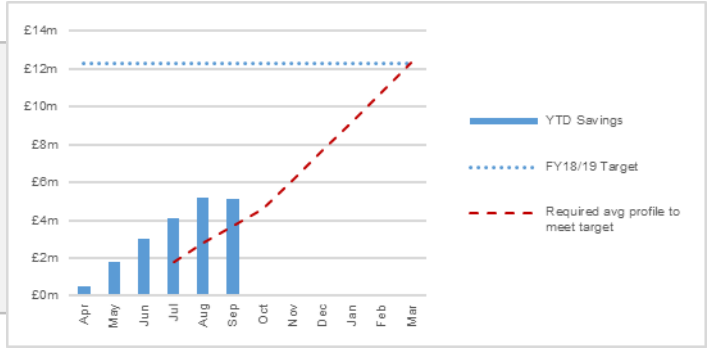
Cost Improvement Programmes (CIPS)

In month CIP was £1.3m and YTD £5.1m both on plan. Delivery of the full year target of £12.3m remains a risk and will continue to be closely monitored for the remainder of the year.

CIP Savings

YTD: £5.3m

FY Target: £12.3m



All plans have been created with documentation complete which has led to a switch from development to delivery. The table below summarises the status of the different initiatives (Red = Not delivering, Amber = Off track with mitigation, Green = Delivering)

RED RAG STATUS	AMBER RAG STATUS
Improving planning of annual leave: The Executive Team continue working with Trades Union colleagues to implement a new policy. The request for further analysis by the Unions has been completed. This scheme will not delivery efficiency savings during 18/19.	**Addressing EOC Incentive Payments**: Decisions were taken to stop paying incentives between September-November 2018 and February-March 2019, with anticipated savings to be generated. The recruitment forecast is much improved with a forecast end of year gap of -2 FTEs.
Driver Training: As reported in Months 4 and 5, this scheme will not deliver any savings during 2018/19	**Vehicle Make Ready**: As reported previously, savings have been limited to negotiation of the current contract.
Maternity Income Generation: The RAG rating for this scheme has been increased to RED as it has been confirmed that this scheme will not deliver any in-year savings. The development of a business case is continuing to be developed to support 19/20 planning.	**Fleet Procurements**: The RAG rating has increased from GREEN to AMBER. This scheme comprises a number of elements related to the purchasing of fleet parts and strengthening contract management arrangements for our fleet breakdown supplier. Anticipated savings of £60k through the clawing back of services charges will not be realised. Fleet Parts Spend Analysis has now been completed, with negotiation meetings commencing with suppliers. Consequently projected savings have been reduced by 50%. Savings to be realised from Medical Gases has also been reduced. A recovery plan has been developed.

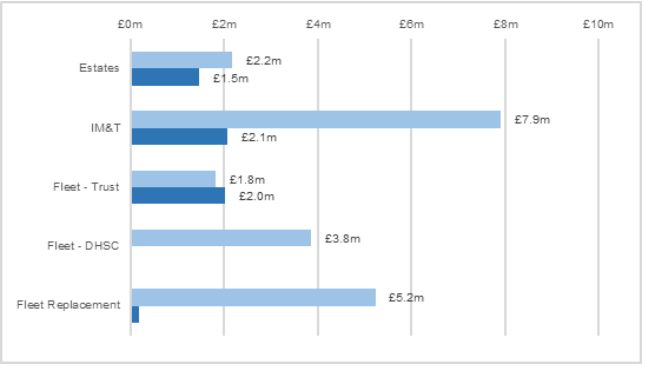
Capital Plan

- Capital spend is £5.8m against a budget of £8.8m, £3m behind plan.

Capital Plan Breakdown

YTD: £5.8m

FY Target: £21m



- 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. In addition the Trust carried forward £1.6m from the last financial year resulting in a total capital plan of £21m
- General Capital £0.2m relates to VAT which will be adjusted in future months as vat is recovered relating to 2017/18.
- Our rate of investment in IM&T is significantly slower than planned with actions in place to ensure this is brought back to plan

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.20	We will deliver our control total and maintain our use of resources rating with NHSI.	Lorraine Bewes		The Trust is forecast to deliver a £1.8m improvement on its initial control total of £1.5m i.e. £0.3m surplus
BP.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.	Lorraine Bewes		The Trust is currently forecasting delivery of the £12.3m CIP programme with 72% delivered recurrently in 2018/19
BP.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.	Paul Woodrow		The recent publication of the Winter Plans is a major part of the ongoing development around business resilience
BP.23	We will manage and deliver our proposed capital programme of £15.5m to support the delivery of our overall strategic objectives.	Lorraine Bewes		At month 6 the Trust has delivered 29% of its capital plan and is £3m behind plan YTD due to slippage on EPCR and Vehicle Replacement Programme but is forecasting to spend its full allocation of £21m
BP.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	Lorraine Bewes		Q1 and Q2 CQUIN delivered, risk included in financial forecast on Conveyance, Flu and Staff Health and Wellbeing results. The STP engagement CQUIN requires close tracking in South West London STP.

G Business Plan deliverable on track
A Business Plan deliverable off track but with plan in place to resolve issues
R Business Plan deliverable significantly off track
C Business Plan deliverable complete
Business Plan deliverable not started

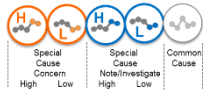
Partners Scorecard

September 2018

Indicator (KPI Name)	Basis	Data From Month	STATUS	Statistical Process Control Icon	Current Perfomance: YTD Target	Current Perfomance: Latest Month	Current Perfomance: Month Target	Current Perfomance: 2018/19 Year To Date Actual	Current Perfomance: Rolling (12 Month Average)	Trajectory: 2018/19 Trajectory	Benchmarking (Month): National Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (out of 11)
Conveyance rate to ED (CQUIN)	%	Sep-18				62.3%		61.5%			58.5%	51.9%	9
STP engagement metric (CQUIN)	£m	Sep-18		N/A	3.2	0.8	0.8	0.8					
Digital (CQUIN)	£m	Sep-18		N/A	3.2	0.6	0.6	0.6					
Call answering - 999 (less than 5 seconds)	%	Sep-18				86%		85%	81%				
Call answering - NHS 111 (less than 60 seconds)	%	Sep-18				86%	95%	90%	89%				

- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Variation Indicators



CQUINs

The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Details of the Trust's CQUINs is shown in the table below with details from the Q1 review to inform forecasted payments for the rest of the FY.

CQUIN	Description	Owner	CQUIN YTD	CQUIN Target	Total Value FY18/19	Value Paid YTD	% of Total Value Realised YTD	% of Total Value Realised Target
National 1a: Staff Health & wellbeing	To achieve a 5% point improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress.	Patricia Grealish	**TBC**	**Q9a = 22.3% Q9b = 57.4% Q9c = 53.3%**	£267k	**£0k**	**0%**	**100%**
National 1b: Healthy Food for NHS staff, visitors and patients	Maintain changes made in 2016/17 including banning price promotions, advertisements for sugar drinks and foods high in fat and introduce 2018/19 changes including signing up to the SSB reduction scheme and ensuring that 80% of confectionary does not exceed 250kcal	Benita Mehra	*Range of targets*		£267k	**£0k**	**0%**	**100%**
National 1c: Flu vaccination rate	To improve the uptake of flu vaccinations amongst frontline healthcare workers with a target of 75% in Year 2 (2018/19).	Fenella Wrigley	39.1% *At 02/11/18*	**>75%**	£267k	**£0k**	**0%**	**100%**
Conveyance rate reduction to ED	A reduction of conveyances to A&E by the introduction and increase in use of PDS matching, SCR and DoS look-up in EOC/Chub. Along with the maintenance of H&T and S&T as well as a workforce support plan and workforce plan, ensuring appropriate numbers of staff and training.	Paul Woodrow	*ED Convey = 61.5% H&T = 3.4% S&T = 26.5%*	**ED Convey = 60.4% H&T – 3.8% S&T – 25.9%**	£801k	**£0k**	**0%**	**100%**
STP engagement	LAS to engage with external stakeholders by supporting STP's including working with partners to support priority plans as well as supply of suitable datasets supporting current work streams being explored by CCG's to reduce overall demand on the LAS.	Angela Flaherty	*Range of targets*		£3,205k	**£801k**	**25%**	**100%**
Digital	To ensure that majority of frontline clinical staff are provided with a personal issue mobile device, with appropriate agreed clinical apps being increasingly utilised to improve patient care.	Ross Fullerton	*Range of targets*		£3,205k	**£640k**	**20%**	**100%**
TOTAL					**£8,012k**	**£1,602k**	**18%**	**100%**

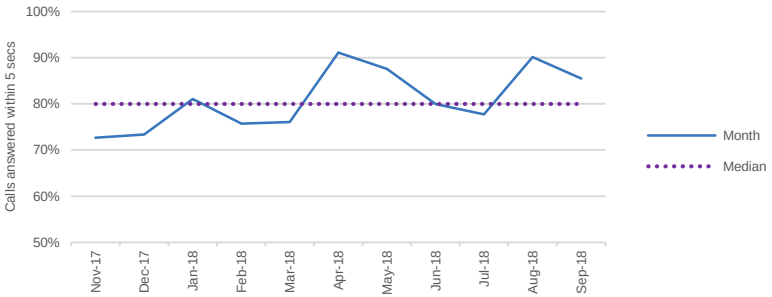
Call Answering Metrics

In July the 999 call answering within 5 secs performance metric was at 78% - this is in line with the median achieved since ARP.

111 call answering within 60 secs was at 91.5%, below target but in line with the average achieved in FY17/18. This improved 111 performance when compared to June was despite higher call volumes and additional pressure being placed on the SEL 111 service due to London Call Balancing during the month

999 Call Answering

Month: 85.5%



In terms of the Emergency Operations Centres (EOC), 85.5% of all calls were answered within 5 seconds in September, this was marginally down on August's call answering performance of 90.1%.

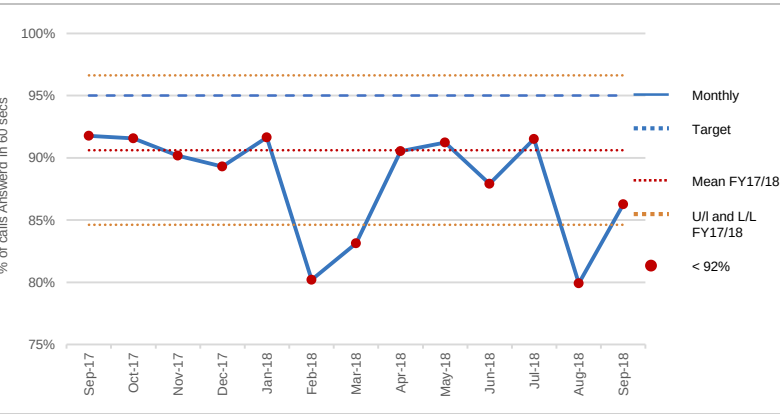
50% of all calls were answered immediately in September, this remains stable and inline with previous months.

The 95th Centile call answering achieved 58 seconds, 14 seconds longer when compared to August 2018. This resonated into the 99th Centile which finished at two minutes 15 seconds.

111 SEL Call Answering

Month: 86.3%

Target: 95%



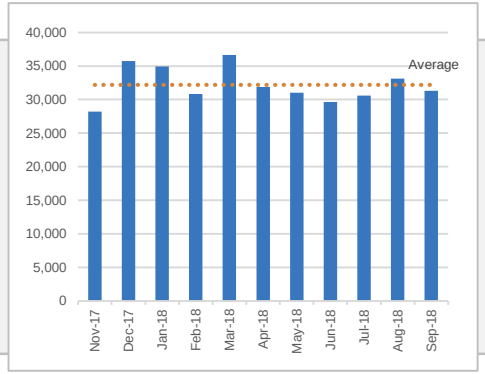
Demand: Call volume in the month of September remained 2.7% below the call answered average.

Capacity: Call balancing from NEL to SEL did decrease in September to 3,615 from 4,811 in August.

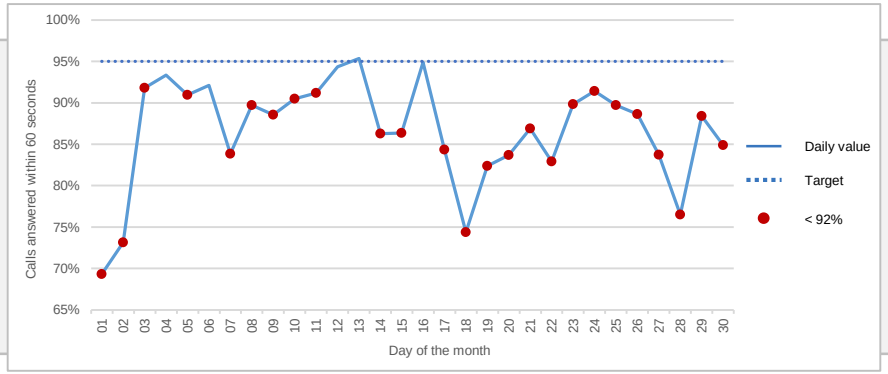
Efficiency: The percentage of calls answered in 60 seconds or less was 86.3% this is a 6.4% improvement in calls answering performance when compared to August 2018. The improvement in performance could be attributed to the dual skilling of clinicians, which place additional capacity into call answering in the event that there is no Health Advisor to answer the call.

111 South East London

Monthly Calls Answered



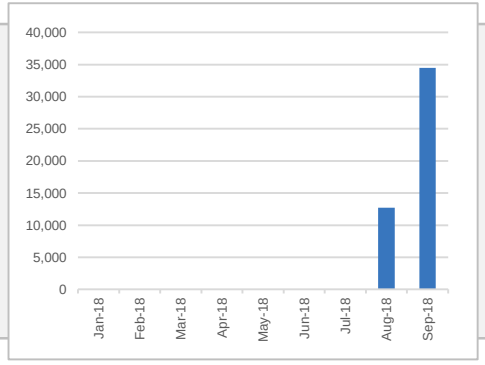
Daily Analysis of Calls Answered within 60 secs

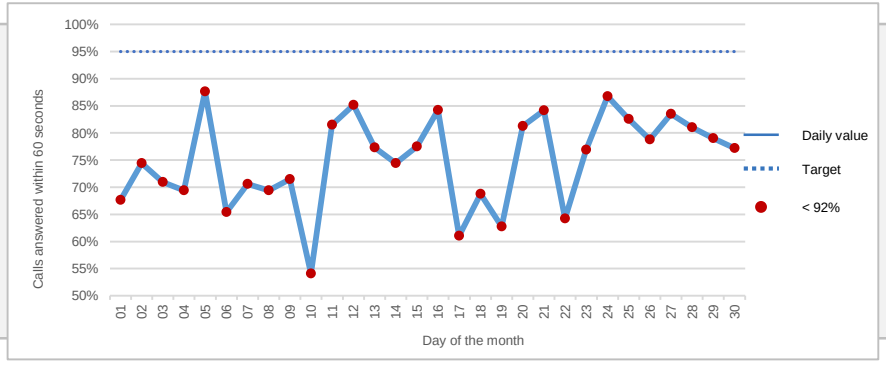


111 South East London experienced lower than average call volume in September. In comparison to last September number of calls answered increased by 25.7%.

25 out of 30 days in October failed to achieve the 92% or more within 60 seconds for call answered against the national target of 95%

111 North East London





111 North East London experienced an increase of 12.1% for calls answered in-comparison to August.

During the month of September no individual day achieved the national target of 95% for calls answered within 60 seconds or less. Call answering performance across each day failed to achieve a call answering performance of 90% or more

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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	Multiple SROs	A	We are closely engaged with commissioners and STP partners led by our 5 Stakeholder Engagement Managers. We chair a system group on ACPs that are working to identify new and improved care pathways. We have not yet delivered a reduction in conveyance to ED but have an action plan to address this in the remaining part of the year.
BP.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.	Fenella Wrigley	G	NEL IUC contract mobilised. Awarded SEL 111 service and on track to go live this year.
BP.18	We will work closely with London acute hospital EDs, 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)	Paul Woodrow	G	On track. Continue to work closely with acute hospital EDs, NHSI and NHSE to reduce delays to patients and our crews at hospitals. Realised a tangible improvement in performance last winter that has been sustained. We are playing an active role in supporting the system to manage winter pressures.
BP.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.	Angela Flaherty	G	We continue to 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. This includes being part of the formal Blue Light Collaboration team that has identified six thematic areas to focus on: Prevention activity; Response activity; Control rooms; Business support and infrastructure; People; Strategy.

G Business Plan deliverable on track
A Business Plan deliverable off track but with plan in place to resolve issues
R Business Plan deliverable significantly off track
C Business Plan deliverable complete
Business Plan deliverable not started

5. Strategic Themes

Delivering our 5 Year Strategy

Our vision is to be a world class ambulance service in a world class city. We want to be London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'. Below is a progress update on the **3 key themes** to our strategy:

	Progress Summary:	Achievements to date:	Next steps:
Theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients	This theme is primarily being delivered through our iCAT strategic Programme, supported by our IM&T, Data and Digital strategy and clinical strategy. The Integrated Clinical Assessment and Triage (ICAT) programme seeks to provide patients a single point of access to clinical assessment and triage. Once fully implemented, patients will be able to access ICAT services via 111 or 999 and be assessed by a single integrated assessment and triage team. As key enablers, following significant development, the IM&T, Data and Digital strategy is being presented to the private part of the November Trust Board Session. The Clinical Strategy was discussed at a board briefing session in October and will be presented to Trust Board for sign off in January 2019.	• Successful mobilisation of our NEL IUC CAS to 'Live' on 1 August 2018 • Mobilisation commencement of the SEL IUC CAS for full service go live in February 2019 • Working to enhance interoperability and resilience between our 111 and 999 services with ability to access each other's queue of calls by the end of the 2018/19 financial year	• Progressing implementation of Adastra™ system within the 999 clinical hub • Clinical Strategy sign off
Theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital	This theme is being taken forward through our Pioneer Services strategic programme, supported primarily by our clinical strategy. Our Pioneer Services programme has seen the establishment of a steering group to drive forward this work and oversee progress. This programme seeks to finalise the design specification, pilot and roll out new services for five patient specific patient groups. We have designed a pilot evaluation framework which will establish a strict set of evaluation criteria for each pilot before they start operating, so we have clarity about what we are measuring and what our baseline is, so that we are able to formally and accurately evaluate the benefits or challenges associated with the pilot.	• Development of pilot evaluation framework • Successful recruitment to posts needed to run mental health pilot • Development of end of life care work programme utilising MacMillan funding	• Launch of Mental Health pilot on 26th November • Launch recruitment for falls service pilot • Present Maternity business case for funding of 6WTE midwives to work in the CHUB • Pan London maternity conference in early 2019
Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners	This theme is being taken forward through our commissioning and contractual form strategic programme as well as changes to the structure of our stakeholder engagement functions. Directed by Trust Board, we are developing an engagement plan and stakeholder impact assessment, to clarify the relative benefits and risks of new commissioning models. The Trust issued its Commissioner intentions on 28th September 2018. These set out the contractual approach and main issues for LAS, including how we start to move our strategy into the commissioning and contractual arena. Our refocused Strategic Partnerships function will also have oversight of all partnership working, particularly focusing on availability and equity of ACPs	• Transferred SEMs into strategy team • Options paper presented to Trust Board on the future of 999/IUC commissioning	• Recruitment of Head of Partnerships • Continue to ensure representation in any development programmes to help influence national contracting decisions

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	12			
Report Author(s):	Frances Field, Risk and Audit Manager			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Consideration by Executive Committee on 14 November 2018 (ExCo/18/214) 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. The risks currently on the BAF are set out below in descending order of severity.

Severity	Risk	Risk Owner	Scrutinising Committee	Comments
1	**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	
2	**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	
3	**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	
Proposed for addition to the BAF				
	BAF Risk 52 There is a risk that the Trust will not deliver the required control total through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards taking account of cost pressures including agency and potential IT server licence cost pressures.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	Proposed addition to the BAF following discussion at Board meeting on 25 September 2018.
Proposed for de-escalation/removal from the BAF				
	BAF Risk 49 The Trust may not have sufficient capacity and	Lorraine Bewes, Director of Finance and	Finance and Investment Committee	Proposed for de-escalation from BAF, as

	capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 2018/19.	Performance		have now hit target risk.
	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	Proposed for removal from the BAF

Risk discussions in September, October and November

Board Assurance Committees

People and Culture Committee

2. 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 Board Assurance Framework (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; however delivery of this action plan has now been delayed and it is now not due to be considered by the People and Culture Committee until its meeting on 10 January 2019.

3. At its meeting on 08 November 2018 the Committee acknowledged that BAF Risk 47 regarding low staffing levels at Bow and Waterloo remained a risk. It was anticipated that this would be reviewed and an updated provided for the January 2019 Committee meeting.

4. There was a discussion regarding the corporate risk register risk relating to musculoskeletal injuries to frontline staff, the Committee was informed that in light of a number of mitigations, musculoskeletal injuries at the Trust had decreased and that the risk could potentially be de-escalated pending a further improvement.

5. The Committee was informed that a risk was being set out regarding PAM, the Trust's occupational health provider. It was noted that there were two elements to the risk, the first addressed the delivery of the service and the second the resilience of the PAM organisation itself. The Committee noted that a significant number of staff had raised concerns over occupational health service delivery at the Trust's roadshows, that the Trust had organised a meeting with PAM in response to these concerns and produced an improvement plan. In addition, a letter of concern had been written to PAM outlining poor performance against key performance indicators. It was noted that alternative options for ambulance occupational health provision were being explored with other ambulance trusts.

Finance and Investment Committee

6. At its meeting on 11 September 2018 the Finance and Investment Committee considered BAF Risk 49, relating to delivery of the 2018/19 CIP of £12.3m, and agreed that it should remain on the BAF, subject to any further discussion at the Board meeting on 25 September 2018 (see paragraphs 14 and 17 below) .

7. Further to these discussions, at its meeting on 13 November 2018 the Committee considered that BAF Risk 52 regarding the Trust's ability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards should be re-drafted. The risk set out in the attached BAF reflects this.

Quality Assurance Committee

8. The Quality Assurance Committee, at its meeting on 18 September 2018, discussed issues relating to staff and fleet capacity and performance. The Committee noted that these would be discussed by the Trust Board at its meeting on 25 September 2018 with regard to the Trust's ability to achieve Ambulance Response Programme (ARP) standards, performance and activity (see paragraphs 16, 17 and 18 below).

9. The Committee also received an oral update on the all the current training-related risks on the Corporate Risk Register and the views of the people and Culture Committee as set out above. The Quality Assurance Committee concurred with the People and Culture Committee, but additionally agreed that the issues outlined in the independent training review should be added as a risk to the Corporate Risk Register.

Logistics and Infrastructure Committee

10. The Logistics and Infrastructure Committee reviewed BAF Risks 50 and 51 at its meeting on 10 October 2018. It was noted that BAF Risk 50 should be updated to reflect the current control and assurances in place around the Uninterruptable Power Supply (UPS) upgrade work required at the Trust's Bow site, as the planned shutdown and work was provisionally scheduled to take place on 11 November 2018. The Committee was informed that third party specialists had been sought to provide input on the scheduled work to provide further assurance of the process and that project teams had developed a plan detailing the cost, dates, resilience and movement of staff. It was anticipated that BAF Risk 50 would be proposed for de-escalation from the BAF at the Trust Board meeting in November 2018 following the scheduled UPS work. This work is no longer planned to take place in November 2018; an update was provided to the Audit Committee and BAF Risk 50 has been updated to reflect this (see paragraph 13 below).

11. It was noted that information on BAF Risk 51, regarding third party suppliers, had been provided to the Committee in correspondence following the last Logistics & Infrastructure Committee meeting in June 2018**.** In light of this it was agreed that the BAF risk 51 should be de-escalated to the corporate risk register, as the Trust had a contingency plan to mitigate this risk.

12. The Committee reviewed BAF Risk 45 in terms of its plan to mitigate cyber-security risks. The Committee suggested that the Trust should implement its cyber mitigations at a faster pace as some targets, such as those in Q4 2019, were too far in the future to provide assurance. The Committee acknowledged the challenge and complexity of ensuring the security of the Trust's systems. It was noted that some of the Trust's software was not covered by current security measures due to their age, and some suppliers had yet to accredit their systems. It was agreed by the Committee that cyber risk was to be escalated to the Board in order to receive additional assistance in achieving its planned mitigations against threats to cyber-security (see paragraph 22). This is reflected in the Committee's Assurance Report to the Trust Board elsewhere on the agenda for this meeting.

Audit Committee

13. At its meeting on 5 November 2018 the Committee noted that BAF Risk 50 had also been discussed at the LIC meeting and that at that time it had been anticipated that the risk would be removed from the BAF as a result of work being undertaken on 11 November 2018. This work had subsequently been delayed and would not take place until January 2019. Benita Mehra, Director of Strategic Assets and Property, provided reassurance to the Committee that a project team was in place consisting of herself, the Chief Information officer and the Director of Operation; however concern was expressed by Committee members that relatively minor appeared to be causing a delay to the overall project of maintaining site back up and resilience. It was considered, to provide a level of reassurance, that more detailed information should be provided to the Committee to confirm that arrangements for cover were in place, and a project team had been organised to progress the site back up plans.

14. At the same meeting the Audit Committee considered the cyber risk (BAF Risk 45) and expressed concern that this risk was not being addressed adequately. The Committee discussed the need for further resource and investment and it was noted that, despite the additional funding recently agreed, this might not be sufficient for the work required to ensure full resilience. The Committee noted that this matter would be escalated to the Trust Board in November.

15. The Committee was also updated on highly rated corporate risks not on the BAF.

16. The Committee was provided with an update on the organisation's progress in relation to the General data Protection Regulation (GDPR). This has not been as swift as anticipated and, whilst not currently considered a risk to the organisation, it is something that the Audit Committee wishes to keep under closer review.

Corporate Risk Register

Highly-rated CRR risks not included on the BAF

17. The following 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 834 - There is a risk of no back up process should the electronic prescribing system at the IUC in North East London and South East London fail to work which may lead to prescribers unable to write prescriptions for patients if not properly managed.

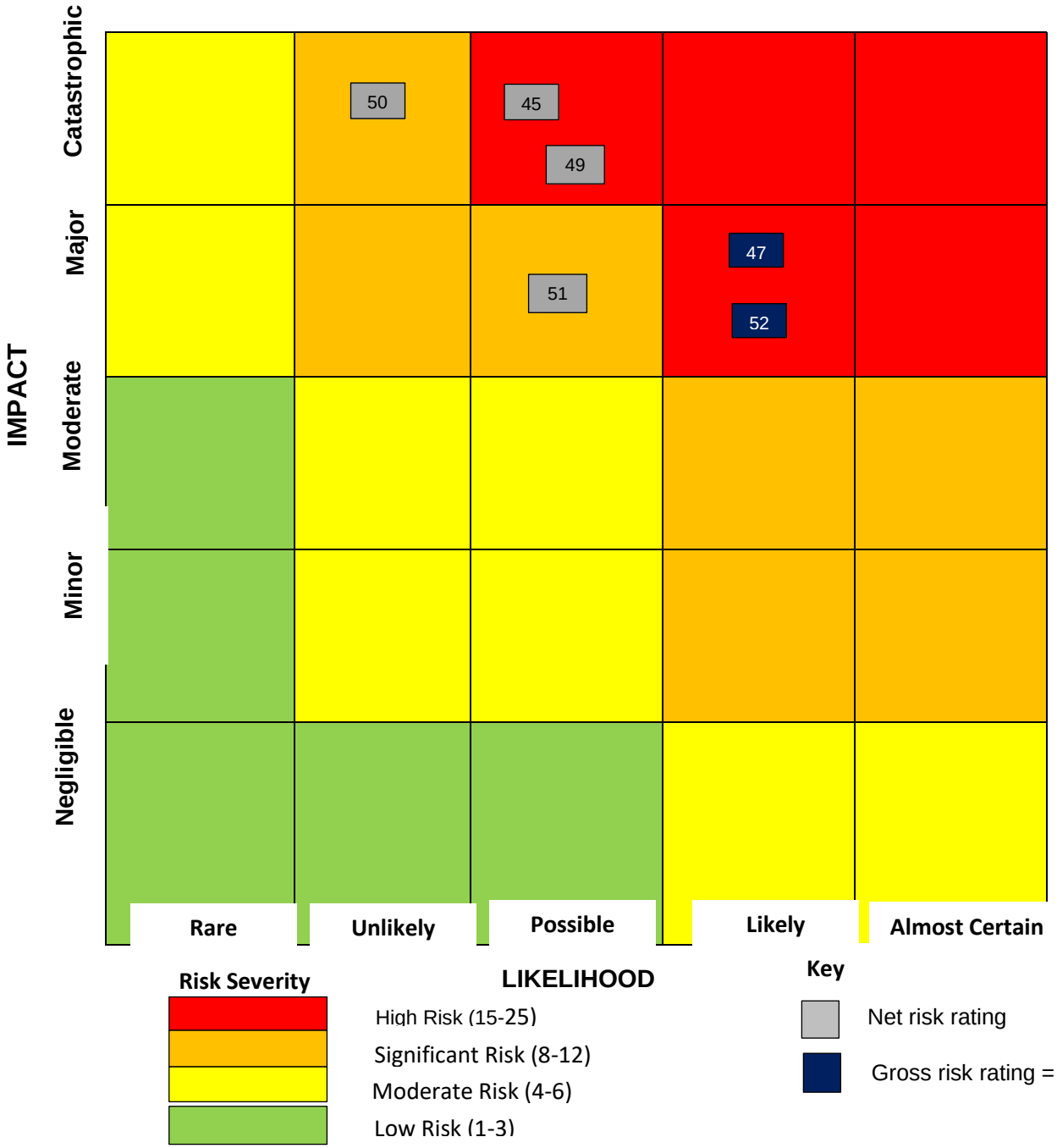
- Datix ID 844 – Risk of time slippage due to wifi issues at Logistics Support unit at Deptford which may let to the KitPrep project timescales not being met if not properly managed.

- Datix ID 841 - There is a risk that the Trust is inadequately licensed for Microsoft products as a result of expanded usage since committing to an Enterprise Agreement which may lead to significant cost increase and budget overspend.

18. These risks are due to be considered by the Risk, Compliance and Assurance Group at its meeting on 22 November 2018 and ratings may change follow this consideration. An oral update will be provided to the Board if this is the case.

Philippa Harding
Director of Corporate Governance

Board Assurance Framework – November 2018



In order of severity:

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 52
There is a risk that the Trust will not deliver the required control total through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards taking account of cost pressures including agency and potential IT server licence cost pressures.

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.

Anticipated proposed removal from the BAF

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 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	52 There is a risk that the Trust will not deliver the required control total through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards taking account of cost pressures including agency and potential IT server licence cost pressures.	1. Prepare and finalise business case for commissioners in collaboration with Operations, BI, Contracting and Finance. • Share business case with Commissioners for discussion at next CPM Meeting.
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.
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

BAF Risk no. 52 There is a risk that the Trust will not deliver the required control total through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards taking account of cost pressures including agency and potential IT server licence cost pressures.

Risk Classification: Finance	**Risk Owner:** Lorraine Bewes	**Scrutinising Committee:** Finance & Investment Committee
Date risk opened: 12/10/2018	**Date risk expected to be removed from the BAF:** 31 December 2018	

Underlying Cause/Source of Risk:
Risk identified following review of the financial position for the Finance and Investment Committee in month 5.

Gross Rating	Current/Net Rating	Target Rating
16	16	8

Existing Controls	Positive Assurance of Controls	Further Actions	Due Date
Commitment from Commissioners during 2018/19 contracting round to consider funding the costs of the impact of new national performance standards once known. Gaps in Controls Business Case required to demonstrate that London Ambulance Service has incurred additional pay and non-pay costs in the delivery of current levels of performance that require additional funding.	1. Working group established between Operations, BI, Finance and Contracting to develop business case for commissioners 2. Issue flagged with commissioners at CPM meetings in July and August 3. Case for commissioners prepared in collaboration with Operations, BI, Contracting and Finance 4. Case shared with commissioners and discussed at SCB	1. Prepare and finalise business case for commissioners in collaboration with Operations, BI, Contracting and Finance. 2. Share business case with Commissioners for discussion at next CPM Meeting. 3. Develop paper for presentation to STP Accountable Officers for approval of funding 4. Chief Executive-led review meetings to assure on agency recovery plan 5. Executive Committee paper on Microsoft licences to be decided upon	Complete – initial case presented to Strategic Commissioning Board on 12/11/18 End Dec 18 End November End November

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 & Culture Committee
Date risk opened: 17/11/2017	**Date risk expected to be removed from the BAF 31/03/2019**	

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. EOC intensive action plan looking at increasing training capacity and collaboration with other Ambulance Trust to cover peak demand. 4. 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. 5. EOC is currently undergoing a restructure which will include looking at levels of pay and resolving long outstanding acting up positions. 6. Ongoing review to the process for candidates - 3 month window of change and review to assess impact. 7. Professional apprenticeship pathways are being considered to improve retention and to be built into the apprenticeship delivery model. 8. Additional capacity has been provided to carry out assessments and EOC have planned and made available training capacity to take increased number of recruits. 9. 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. 10. A range of recruitment activities throughout Q3 will specifically target recruitment to EOC. 11. EMDs have been released to support job fairs to promote the role. 12. 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 and a further review of the impact of this approach will be reported in October. **Gaps in Assurance** None identified	1. The recruitment team continue to plan and attend a wide range of recruitment and engagement activities to attract people to core front line roles, in addition to advertising across other online platforms than NHS jobs. 2. 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. 3. Streamlining of selection process, including re-assessing pass rates and introduction of online assessments. Streamlining and improvement of pre-employment checking. 4. EOC restructure – the consultation process started in August and will improve retention as well as address other management capacity issues. 5. 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. 6. Streamlining of selection process, including re-assessing pass rates and introduction of online assessments. **Gaps in Assurance** None identified	Review online assessment pilot for EOC recruitment and run pilot EOC Recruitment Project Meetings Allocate appropriate resource to interview and assessment activities Super Saturday recruitment events supported by recruitment team and frontline staff	On-going On-going On-going On-going

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. Mitigation of a number of necessary cyber mitigations which were identified by PA Consulting's Independent CAD review 3. The Introduction of a professional cyber team as a managed service from Nov 17 4. Introduction of a process to review all CareCert notifications across all support teams, measured as part of the IM&T's KPIs (reported to IM&T SMT and ExCo monthly) 5. Untertaking of several further audits and tests to identify additional mitigations (added to the Cyber action plan). 6. 18/19 Programme of planned improvements initiated. 7. Internal discovery tool implemented. **Gaps in Controls** Gaps in Controls are documented in the action plans and the Programme. The most significant residual themes relate to • Network share security • Currency of critical security updates, patching and versions (particularly challenging in the CAD environment) • Unser authentication and SQL weaknesses • Weaknesses related to potential DDoS and intrusion/malware attacks	1. Cyber Reports to Information Governance Group of cyber-related incidents each quarter 2. Untertaking of several audits and tests including the NHS Digital led review of LAS cyber security to identify additional mitigations. (added to the Cyber action plan). 6. CareCert notifications performance measured and reported as part of the IM&T's KPIs (reported to IM&T SMT and ExCo monthly) 7. Reporting of action plan progress at LI&C and Board **Gaps in Assurance** • NHSE have asked all Trusts to provide a plan to achieve addional assurance in the form of the HMG's National Cyber Security Centre's more advanced standard of good practice Cyber Essentials Plus by 2021 • The Trust has been audited and the technical controls required to meet Cyber Essentials Plus are mapped into future work.	1. Introduce scenario planning and rehearsals a cyber attack on LAS 2. Deliver Phase 2 (18/19) of the cyber programme (incorporating the following projects) a. Cyber Secure Internet Access b. Cyber DDOS prevention c. Cyber SIEM capability d. Cyber Discovery system Tool e. Cyber Project Sec Arch Resource f. Advanced Patch Management Capability g. Advanced Endpoint Management 3. Actively monitor the action plan of mitigations identified by audits quterly: Next Quarter LIC Feb 19 4. Develop and obtain funding for 19/20 cyber programme 5. Initiate 19/20 cyber programme	30/12/2018 16/05/2019 28/02/2019 30/03/2019 30/07/2019

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:** February 2019	

Underlying Cause/Source of Risk:
Existing UPS is undersized for the demand requirement in the building

Gross Rating	Current/Net Rating	Target Rating
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. Monitoring of UPS and its equipment being undertaken on a monthly basis (this has been increased from quarterly). 4. Design of new provision relating to the UPS switching panel has been ordered due for delivery by November. 5. IMT equipment has been ordered, e.g. Airwaves. 6. Regular engagement with UKPN to Mitigate risks associated with essential work repairs or known service interruptions. 7. Schedule of work has been defined for the UPS replacement. 8. Fall back accommodation in place for all operations currently working out of Bow. 9. Costs for programme agreed with Finance. **Gaps in Controls**	1. Ongoing monitoring of UPS demand is still operating in range. 2. UPS maintenance contract in place. 3. Generator maintenance and test schedule in place 4. Weekly Project Group meetings. 5. Weekly assurance group in place involving stakeholders. **Gaps in Assurance**	1. Project team in place to investigate/manage upgrade project and identify window for upgrade works . 2. Revised project plan start date for upgrade and replacement of UPS (subject to assurance from internal and external stakeholders). 3. Share assurance paperwork with NHSI and NHSE. 4. Share assurance paperwork with Non Executive Directors.	Complete 31/012019 30/11/2018 14/12/2018

Signed: Benita Mehra

Proposed to be removed from the BAF

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:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
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.	**25**	**10**	**10**

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.

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. 51 Due to the vulnerability of sector suppliers following Carillion's demise our incumbent suppliers who provide soft FM and Make Ready could be vulnerable to market volatility leaving the Trust without a service provider at short notice

Risk Classification: Strategic Assets and Property	**Risk Owner:** Benita Mehra	**Scrutinising Committee:** Logistics & Infrastructure Committee
Date risk opened: 20/02/2018	**Date risk expected to be removed from the BAF**: June 2018	

Underlying Cause/Source of Risk:	**Gross Rating**	**Current/Net Rating**	**Target Rating**
1. External influences to the market volatility affective service provider's ability to function.	**16**	**12**	**4**

Existing Controls	**Positive Assurance of Controls**	**Further Actions**	**Due Date**
1. Business continuity plan is in place which includes Legal and People and OD feedback. 2. In the event of a supplier no longer being financially viable, staff will either TUPE across to LAS or a third party supplier for this sector for FM (soft services). 3. Confirmation received from the Cabinet Office of the agreement for full debt refinancing secured until 2021 of our incumbent suppliers who provide soft FM and Make Ready.	1. The business approach is being discussed with NHSI and the Cabinet Office bi weekly.	1. We are aligning our service specification and potentially considering a joint tender with South East Coast Ambulance Service and South Coast Ambulance Service which will be concluded in August 2020. 2. No further actions as this risk is being articulated on a separate risk to be added to the Corporate Risk Register. This will outline the risk of what will happen in the event a 3rd provider fails to be a going concern and be unable to provide the contracted services.	April 2020

Signed: Benita Mehra

Corporate Risk Register - November 2018

ID	Description	Opened	Rating (initial)	Risk level (initial)	Controls in place	Risk Owner	Last review date	Rating (current)	Risk level (current)	Assurance	Rating (Target)	Risk level (Target)	Further Actions
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.	27/10/2017	20	High	Future space requirements are being considered as part of the Estates strategy. The current lease is being extended until December 2019 due to being unable to identify an appropriate alternative location and, also, due to the pressures on IM&T to support the move. IM&T also operate within the site and, again, would have required alternative space provision. A formal specification of EOC training requirements is to be created and alternative locations to be identified. To accommodate lead times for a relocation to new premises, a new location will need to be identified and agreed by August 2019.	Dawson, Steve	22/11/2018	16	High	DDO Control Services is fully aware and briefed on the seriousness of the estate and impact on the training team. John Downard aware and supportive of the urgent review of premises and continued co-located situation.	8	Significant	
834	There is a risk of no back up process should the electronic prescribing system at the IUC in North East London and South East London fail to work which may lead to prescribers unable to write prescriptions for patients if not properly managed.	24/08/2018	16	High	Purchase order signed. Cabinet in place and bolted to wall.	Wrigley, Fenella	01/11/2018	16	High	Inspection of cabinet in situ	1	Low	
841	There is a risk that the Trust is inadequately licensed for Microsoft products as a result of expanded usage since committing to an Enterprise Agreement which may lead to significant cost increase and budget overspend.	18/09/2018	20	High	The Trust has engaged with Microsoft to investigate and determine route to resolve.	Fullerton, Ross	30/10/2018	20	High	N/A	4	Moderate	Review SQLserver utlisation Review client licensing
844	There is a risk of time slippage due to wifi issues at Logistics Support unit Deptford which may lead to the KitPrep project timescales not being met if not properly managed.	01/10/2018	20	High	1. IM&T have attempted to put in a temporary solutions (ADSL) to support access to WIFI at Deptford. 2. Access to guest (LAS) WIFI is also available but this is time limited. 3. One BT and two IM&T engineers are exploring the issue to fix it.	Crichton, Stuart	10/09/2018	20	High	BT and two IM&T engineers provide status reports into the ongoing problem with suggested solutions.	4	Moderate	

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Carter Report – high level overview of the opportunity			
Agenda item:	13			
Report Author(s):	Murray Keith, Business Planning			
Presented by:	Lorraine Bewes, Director of Finance & Performance			
History:	N/A			
Status:	☐	**Assurance**	☐	**Discussion**
	☒	**Decision**	☐	**Information**

Background / Purpose:

The Trust Board is invited to review the Trust response to the publication in September of the Lord Carter of Coles publication entitled the '*Operational productivity and performance in English Ambulance Trusts: Unwarranted variations' on 27 September 2018*. This paper focuses upon the response to both the key findings that highlight variations and also the recommendations made by the review.

Recommendation(s):

The Trust Board is recommended to accept and implement the detailed recommendations. (see Appendix 2 Section 9.0)

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

The attached report contains reference to strategic and improvement programmes and projects. Some of which have efficiency savings. These need to be prioritised to confirm when business cases will be presented. Prioritisation is required to take account not just of financial restraints but also management and operational constraints. This links to the following BAF risks:

BAF Risk 49

- The Trust may not have sufficient capacity and capability to deliver the level of efficiency programme to bridge the gap to deliver the required control total for 18/19

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	☒

Carter Review – High Level Overview of the Opportunity

Introduction

1. Lord Carter of Coles published his review '*Operational productivity and performance in English Ambulance Trusts: Unwarranted variations'* on 27 September 2018. By identifying unwarranted variation in the delivery of ambulance services, the report highlighted the opportunity for around £200m productivity savings if all Trusts were to match the best in each area across the 10 Ambulance Trusts. A further £300m is forecast to be saved across the health system by reducing avoidable conveyancing through a combination of treating patients at home or directing them to more appropriate health services.

2. London Ambulance Service (LAS) has welcomed the report, known as the 'Carter Review' with many of the recommendations aligning with the Trust's 5 Year Strategy.

Required Trust Response to Carter Review

3. This paper focuses upon both a high level summary of the key findings from the Carter Review. It also details the response required to the detailed recommendations. A requirement of the Carter Review is for Finance & Investment (FIC) to recommend to the Trust Board that it accepts and implements the recommendations in the review – see Appendix 2 Section 9.0

Summary of Key Findings

4. The Carter Review highlights the following areas of success and achievements:

- Operationally, we are now one of the stronger ambulance services
- The LAS 5Yr strategy, focused on reducing conveyance, closely aligns with Carter report
- LAS 111 performance is amongst the best in the country, particularly when considering transfers of 111 calls to 999
- We have relatively low staff turnover (compared to others)

5. The report does highlight that we have further work to do, to reduce areas of variation where the Trust is an outlier and make improvements (See appendix 1). These include:

- Our See and Treat rates are c10% lower than the highest performing Trusts at 28%. And yet our numbers of frontline paramedics compare favourably to the highest performing Trusts for See and Treat
- We have significantly more mental health patients than any other ambulance service, but we are conveying 55% of these patients to hospital. This compares to 23% for the highest performing Trust. We also have the longest Job Cycle Time for mental health patients in the country.
- Our proportion of lost hours due to post-hospital handover hours (handover to green) is higher than anyone else in the country.
- Corporate Services costs, as a percentage of our turnover, are 8%. This is 4% higher than the best performing Trust, which is an organisation considerably smaller and therefore unlike LAS has limited opportunity to ammortise costs across their cost base

Next Steps

6. In anticipation of the publication of the Carter Review in September 2018, originally planned for publication in July 2018, we have taken a range of actions as part of our business planning process to address the areas of opportunity – clinical productivity and corporate efficiencies. In addition the Carter Review with recommendations are being tracked and embedded into our plans, so that we can be sure that the themes and priorities will be addressed by the Trust as a whole, and across Directorates (See Appendix 2/3).

7. A key enabler and driver in support of actions is our newly formed collaboration with South Central Ambulance Service NHS Foundation Trust. In parallel the members of the Trust are also visiting other Ambulance Trusts nationally with the following objectives:

- Undertake further benchmarking work to further identify areas where services and data can be compared.
- Identify areas where LAS can collaborate with other Trusts to deliver efficiency savings, whether this is procurement opportunities, or learning from how operational policies can drive productivity improvements in clinical practices for the benefits of our patients

8. Business Planning have also undertaken significant analysis of all benchmark data. This activity is continuing as we have recently received 2017/18 benchmark data for all Trusts. See Appendix 3 which shows size of opportunities at function and sub-function level.

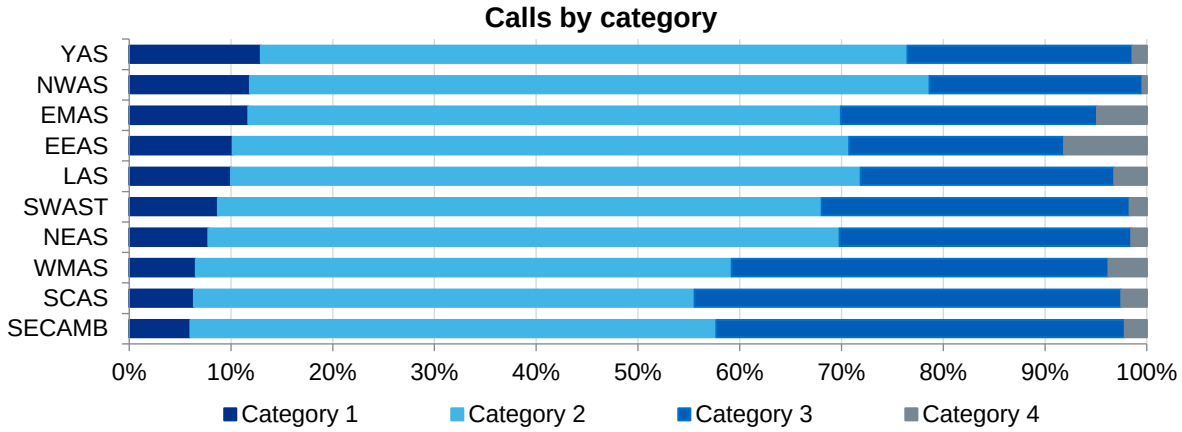
Lorraine Bewes

Director of Finance and Performance

Appendix 1: Carter Data Findings

The following data charts from the Carter Review highlights the areas where improvements is required:

1. Enabling Effective Benchmarking	Findings / Key Trust Actions



ARP Model Vs LAS Acutal by Category	% of Calls per Category	LAS
Category 1	8%	10.0%
Category 2	48%	61.9%
Category 3	34%	24.9%
Category 4	10%	3.2%

Findings

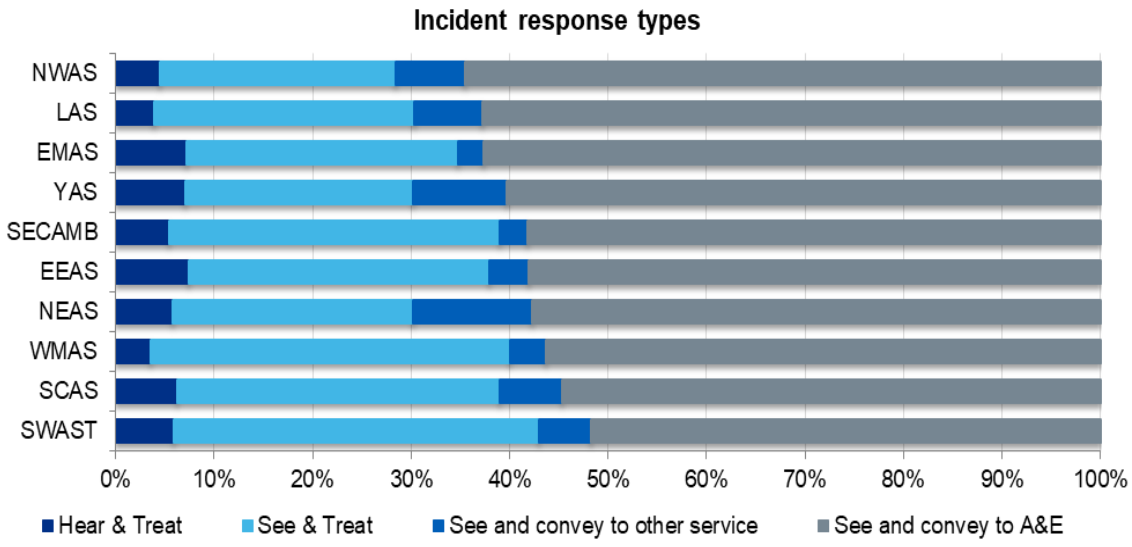
- LAS is higher than the Ambulance Response Model by category for Category 1, 2 and lower for Categories 3 and 4

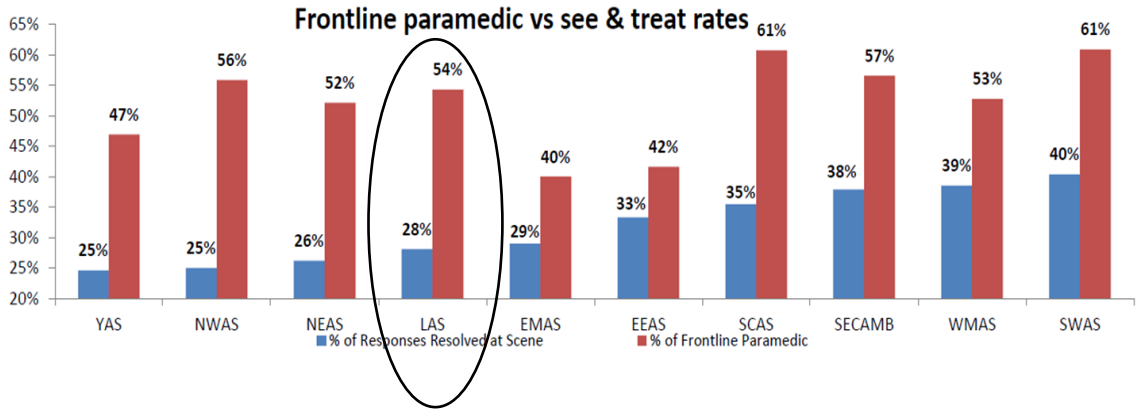
Considerations

- Does the fact we are on AMPDS Vs Pathways affect our % by categorisation?
- Is there an impact upon our see & convey rates?

Key Trust Actions:

- Review key pathways linking with National ARP project regarding EOC scripting
- Review of operational response model by ExCo and Trust Board
- Commissioner negotiations to deliver operational performance to meet ARP requirements
- Development of integrated approach to business planning to underpin / inform model development
- Review of NETS to increase utilisation and effectiveness





Findings:

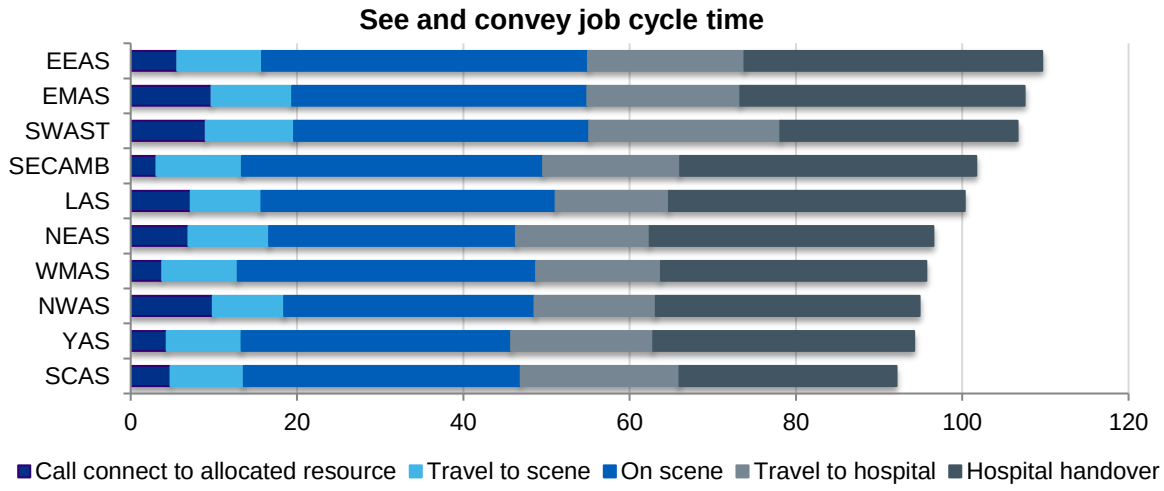
- LAS is has very high See & Convey to A&E, and yet still one of the lowest Hear and Treat / See & Treat incident rates
- And yet LAS has higher than average levels of frontline paramedic

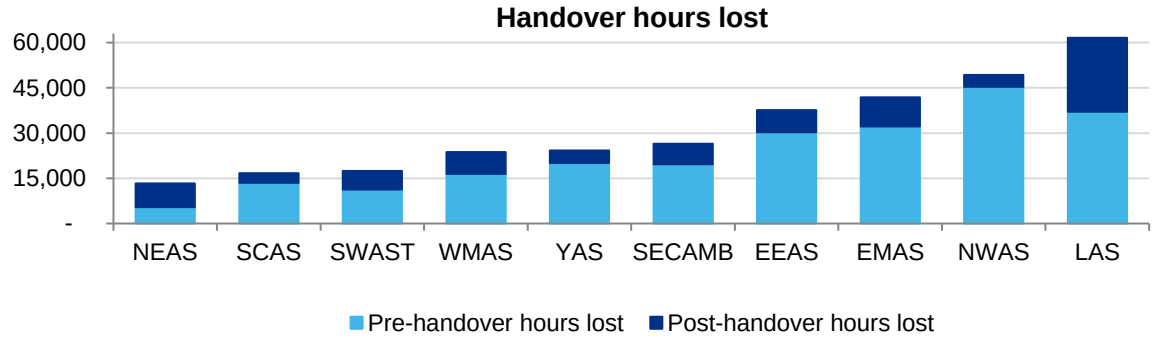
Considerations:

- What are the key considerations that would enable a change in our incident response type?
- What do we need to do within our operational response model and on scene decision-making to change this?

Key Trust Actions:

- Enable correct skill mix via both Pioneer strategy development and upskilling of paramedic incl. Introducing tools (video conferencing) to inform hear and treat decisions.
- Ops ED conveyance action plan includes increased usage of MIDOS for alternative referrals
- Support required from Commissioners and STPs to maximise opportunities for enabling alternative pathways (See & Convey to Other Services)
- Reviewing the clinical composition of the EOC team (ranges from 7-9% nationally). Dual training staff across 999 and NHS 111 as part of ICAT strategy.





Findings:

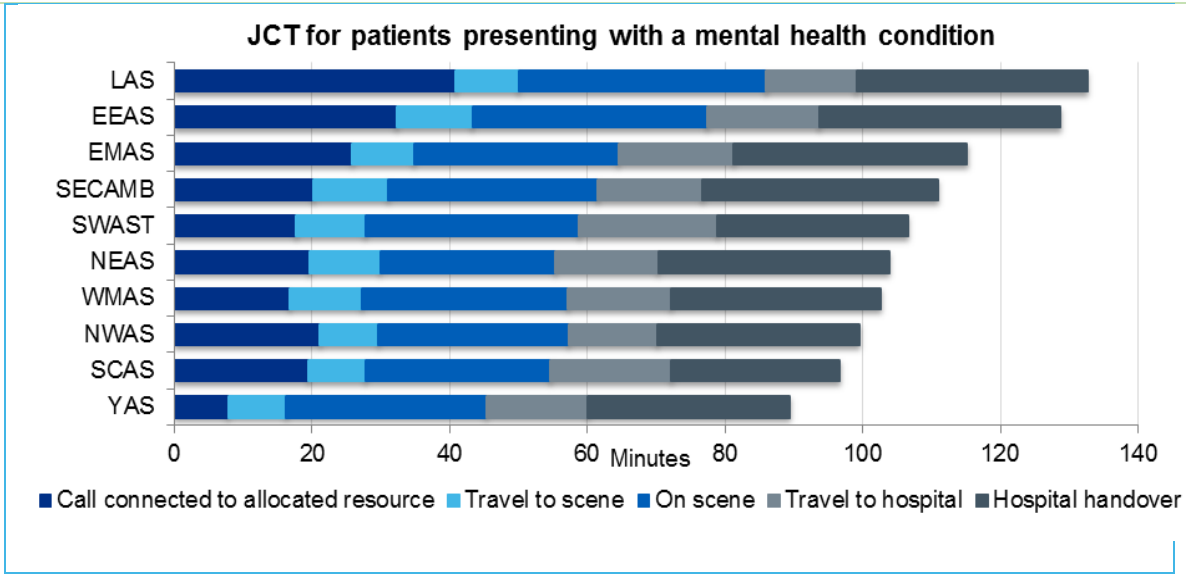
- LAS has one of the longest Call Connect to allocated resource as part of the Job Cycle Time (JCT) and one of highest proportion of Hospital post - handovers

Considerations:

- How can we improve time taken to call connect?
- What are other Trusts doing to influence their Hospital Handover times?

Key Trust Actions:

- Action plans have been refreshed for both Call Handling and Handover to green (post-handovers hours lost) by Operations including Performance Mgt at a Sector level
- Director of Ops and Medical Director engaging with NHSI Emergency Care Improvement Programme for hospital pre-handovers.
- New 24/7 Tactical Operations Centre (TOC) supporting management of increased demand and single point of focus for escalation of issues including Acute delays by health care partners.



Findings:

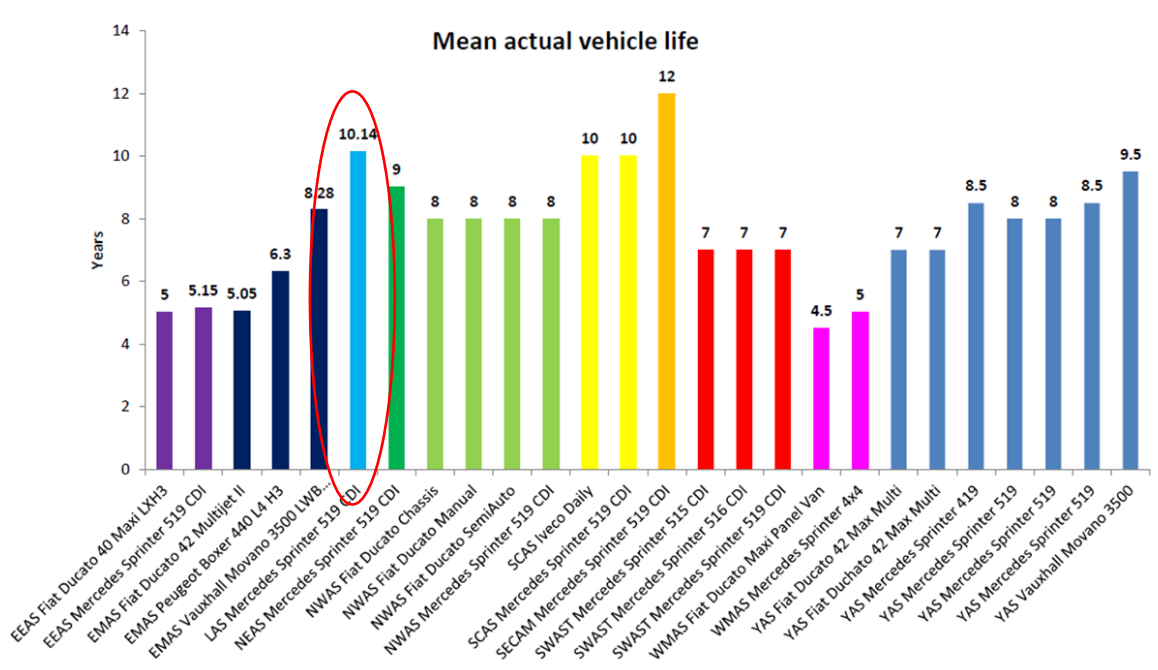
- LAS has the highest JCT for mental health which is created by a combination of factors including call connected to allocated resource and access to alternative mental health services

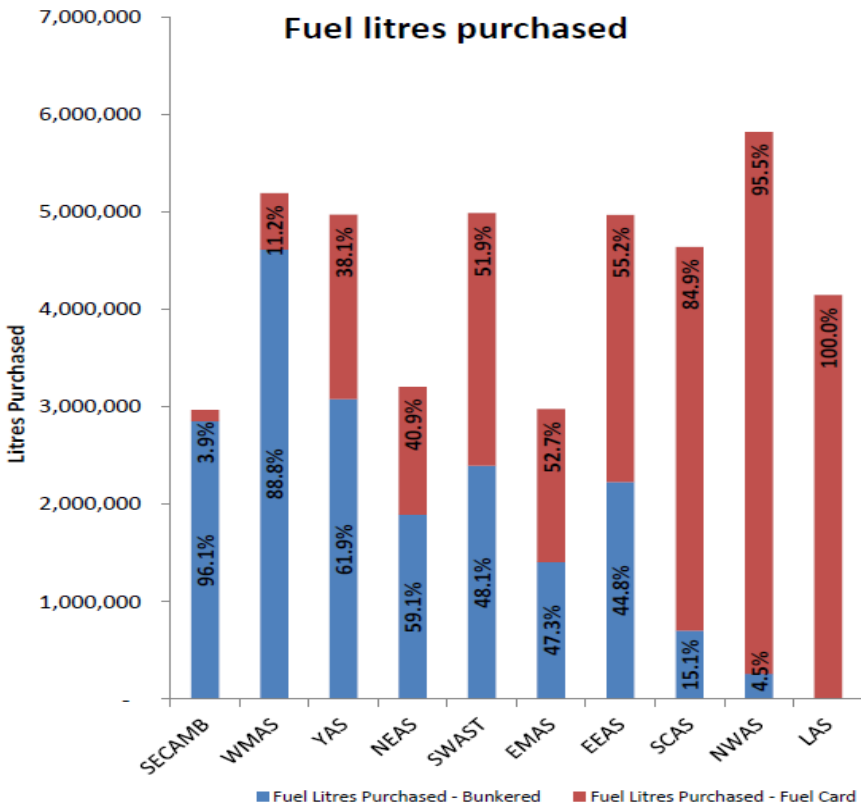
Considerations:

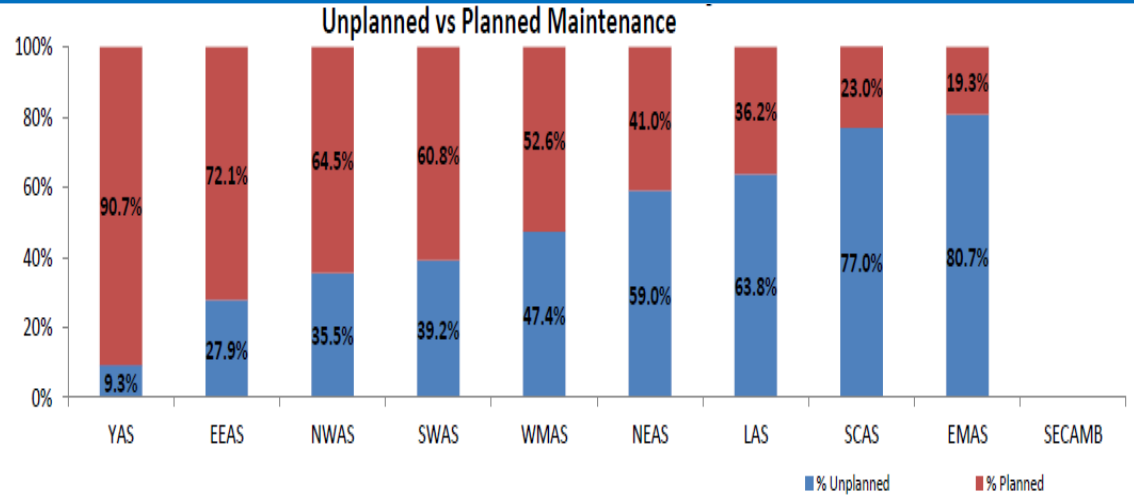
- What evidence is available to support the variation against other Trusts?

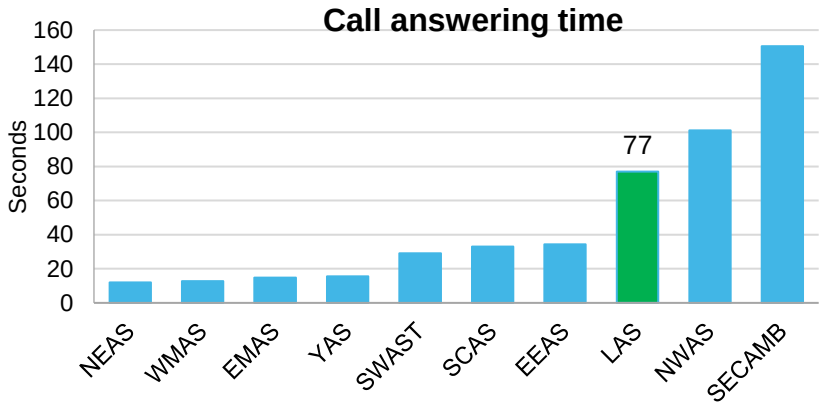
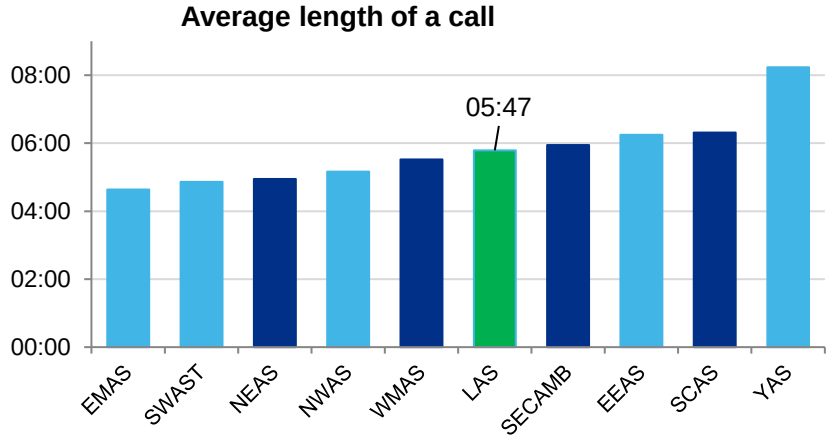
Key Trust Actions:

- Additional mental health resources have been appointed to support call handling and dispatch within the Emergency Operations Centre
- Mental Health is one of the Trust's pioneer strategies and a pilot is being put in place to support rapid access to appropriate place and reduce unnecessary conveyancing to EDs

2. Effective Fleet Management	Findings / Key Trust Actions
	**Findings:** • LAS has one of the oldest mean actual vehicle age **Considerations:** • How will our current fleet replacement plan affect the mean actual vehicle life of our fleet? **Key Trust Actions:** • With the current roll-out of this year's fleet replacement plan, our mean age is anticipated to be lower (data being collated) • Data indicates opportunities to work with other Trusts to achieve even greater economies of scale • LAS will seek to understand whole life cost of both van and box vehicles to ensure that decisions on future standardization are evidence based

2. Effective Fleet Management	Findings / Key Trust Actions
	**Findings:** • LAS is mid-range in terms of fuel spend per litre and the only Trust with 0% bunkered fuel for BAU (with some sites holding bunkered fuel for resilience only) **Considerations:** • Are there any efficiencies that could reduce our fuel consumption e.g. national tender for fuel drive further efficiencies? • Would the cost benefit analysis from an investment in bunkered fuel decrease fuel cost and improve efficiency (future scheme – possible capital plan)? **Key Trust Actions:** • Progressing feasibility of bunkered fuel development plan – either collaboratively or as a capital investment requirement • Anticipated savings minimum of c£0.10 pence per litre. Fuel savings of c£400k could be realised.

2. Effective Fleet Management	Findings / Key Trust Actions
	**Findings:** • LAS Planned Vs Unplanned maintenance shows LAS with higher unplanned maintenance levels at 63.8% **Considerations:** • How will the impact of the fleet replacement plan reduce fleet running costs, and improve productivity? **Key Trust Actions:** • Continuing with fleet replacement plan which will in turn reduce vehicle age, failure rates and costs • New Head of Fleet focused driving improved fleet and workshop technical standards. • Ongoing focus reducing fleet spend, negotiating agreement / new supply arrangements. • Additional procurement support • Increasing technical standards / upskilling of staff and reduce no of agency, full implementation of Tranman to better understand and provide evidence based actions, and would lead to a reduction in operational out of service. • Explore procurement frameworks and other procurement opportunities for fleet maintenance? • Potential opportunities may result from linking in with our partners (in particular SCAS).

3 Improving performance and strengthening resilience and interoperability	Findings / Key Trust Actions
 	**Findings:** • LAS has a higher than average call answering time with a mid-range for average length of calls **Considerations:** • How can we improve call answering time? **Key Trust Actions:** • New and refreshed Cal Handling Action Plan by operations to address and provide focus • Actions include standardising operating procedure for the EOC • Reviewing clinical composition of the EOC team (ranges 7-9% nationally). Dual training staff across 999 and NHS 111 – as part of ICAT strategy development

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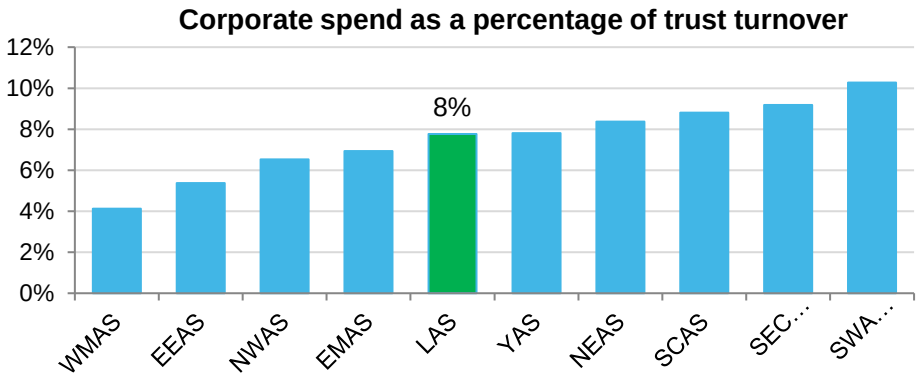
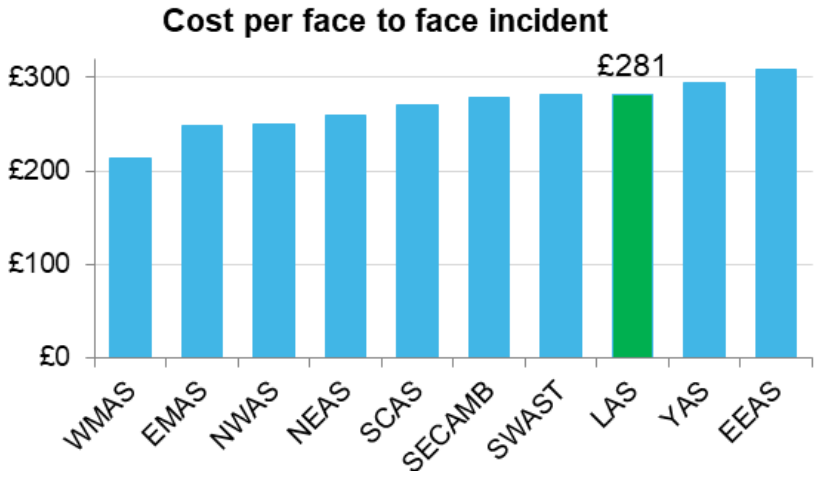
4. Maximising use of non-clinical resources	Findings / Key Trust Actions
 	**Findings:** • LAS is mid-range for share of expenditure on corporate services • LAS has the joint 3rd & 2nd highest cost for face to face incidents **Considerations:** • How can the Trust reduce it's spend on Corporate Services moving towards the lowest benchmark Trust at 4%? **Key Trust Actions:** • Efficiency savings development has commenced targeting three areas: Corporate Services; Support Services; Frontline (non-rostered) budgets over next three years (2019/20 – 2021/22) • 'Bottom up' ledger based analysis focused upon transactional areas being undertaken, to be reviewed by Directorates and Finance Team to agree plans • Improvement and Productivity planning focused upon forming 'top down' transformational approach to generate ideas and formulate plans.

Appendix 2: Carter Recommendations

R1 **Enable effective benchmarking** - NHS Improvement should make operational data routinely available to ambulance trusts to enable them to effectively benchmark services starting in autumn 2018, and trusts should take action to review levels of variation. (p28)

R2 **Delivering the right model of care and reducing avoidable conveyance to hospital** – NHS should accelerate work to support reduction of avoidable conveyance to hospital, working with ambulance Trusts , lead commissioners, STP, NHSI and NHS Digital (p33)

R3 **Efficient use of available resources** – Ambulance trusts should maximise resource availability and reduce lost hours to ensure and ambulance response is available for patients that need it the most (p36)

R4 **Optimising workforce, wellbeing and engagement** - The ambulance service should develop a five-year workforce, recruitment and staff wellbeing plan to: improve wellbeing and reduce sickness absence; encourage leadership at all levels of the organisation; improve staff engagement; and minimise vacancies (p46)

R5 **Effective fleet management** - NHS Improvement should work with trusts boards and the Association of Ambulance Chief Executives, to agree proposals to rapidly move to a standard specification for new fleet across England and deliver significant improvements in the way fleet is managed. (p56)

R6 **Improving performance and strengthening resilience and interoperability** - Ambulance trust boards should take steps to improve performance in their control centres and have plans in place to provide a resilient service in the event of a major incident or system failure by winter 2018 (p64)

R7 **Developing the digital ambulance** - Ambulance trust boards must utilise available resources and invest in future technology within their control centres to enable an interoperable service with maximum resilience and improved operational efficiency. (p67)

R8 **Maximising use of non-clinical resources** - Ambulance trust boards should review their estates to match modern demand and optimise their corporate services functions through improved collaboration. (p73)

R9 **Delivering effective implementation** - NHS Improvement and NHS England must work with ambulance trust boards, the Association of Ambulance Chief Executives and other national bodies to take the required action to implement these recommendations and agree a clear delivery plan for taking this forward. (p78)

ID	Description	Trust/NHSI Actions	Carter Due Date	Owner
1	**Recommendation 1: Effective Benchmarking** NHS Improvement should make operational data routinely available to trusts to enable them to effectively benchmark their services starting in autumn 2018, and ambulance trusts should take action to review levels of variation			
1.1	NHS Improvement routinely providing operational productivity and performance **benchmarking data** to ambulance trusts by **autumn 2018**, building on the data used to support this review	**NHSI Action:** Benchmarking portal to be made available to permit Boards to review and drive review of variation of productivity	Autumn 2018	NHSI
1.2	A&E delivery boards must have comprehensive and agreed plans for **minimising ambulance handover** delays in line with the guidance issued by NHS Improvement and the Royal College of Emergency Medicine prior to **winter 2018**.	Need to understand current engagement plans with A&E delivery boards to influence	Winter 2018	A&E Delivery Boards
1.3	Ambulance trust boards should work with A&E delivery boards to agree local standard operating procedures for any **hospital handover** delays over 30 minutes, by **winter 2018**.	Director of Ops and Medical Director to work with NHSI in support of plans	Winter 2018	Paul Woodrow/Fenella Wrigley
1.4	NHS Improvement and ambulance trust boards working together to identify the most appropriate data source to enable effective benchmarking and opportunities to improve the patient journey for those presenting with **mental health** conditions by spring 2019	Mental Health access and JCT reduction plan - To include review of EOC response times currently c40mins - Also to confirm the mental health conditions - Under ARP Spring Review, requirement to report on S136 patients, as a driver to improve efficiencies. - Dependency on workforce model - mental health / APPs	Spring 2019	tbc

ID	Description	Trust/NHSI Actions	Carter Due Date	Owner
2	**Recommendation 2: Right Model of Care** **Delivering the right model of care and reducing avoidable conveyance to hospital (Chapter 3)** **NHS England should accelerate work to support reduction of avoidable conveyance to hospital, working with ambulance trusts, lead commissioners, Sustainability and Transformation Partnerships, NHS Improvement and NHS Digital.**			
2.1	NHS England working with lead commissioners, ambulance trusts and Sustainability and Transformation Partnerships to develop a long-term plan to **reduce avoidable conveyance** by 2023. This plan should be developed and agreed by spring 2019.	Review of operational response model by ExCo and Trust Board to determine target and actions for increasing S&T, reducing S&C to A&E and increasing S&C to others units.	Spring 2019	NHSE
2.2	NHS England and NHS Digital supporting trusts to enable ambulance staff to **access patient information** and set out the delivery timetable by winter 2018.	Review improvements in productivity created by use of SCR	Winter 2018	NHSE / NHS Digital
		Continue use of *5 line for rapid access to GPs (used as a case study)		
		Continue model of accessing SCR (used as a case study).		
2.3	Lead commissioners working with trusts and Sustainability and Transformation Partnerships to ensure the **directory of services** is an accurate and useful resource provided to frontline ambulance staff. Trusts should undertake a review of the directory of services and provide a report to their Board before April 2019	Review of effectiveness of Directory of Services and provide a report to Trust Board by April 19	April 2019	LAS U&E Lead Commissioner
		Review and confirmation of position and plans for all crews to have access to an electronic DOS. - Dependency with IUCS pan-London Commissioners for engagement and ensuring completeness and appropriateness of the eDOS.		

2.4	NHS England developing a common set of **evidence based clinical protocols** to support reductions in avoidable conveyances and effective patient care by summer 2019	Review of trajectory and impact from Implementation of current operational restructure to introduce LGM providing clincal support. Assessment to include long term sustainability at	Summer 2019	NHSE
		Review current plans for increasing APPs alongside upskilling of paramedic B6 workforce.		
		Work with other Trusts with support from NHS England to identify, codify and share evidence-based best practice in delivering clinical		
		Assess range of analytics (including distributions on efficiency) to increase reporting from Boards to frontline, to include analysing on scene and clinical decisions to individual staff to identify further guidance and support required		
		Assess effectiveness of performance management approach and capacity to ensure that underlying causes of long on scene times and avoidable conveyances are addressed.		
2.5	Ambulance trust boards agreeing a **common clinical supervision model** by April 2019 and then rolling this out across the service, ensuring it is fully embedded by April 2021.	Review of senior clinical leadership model meets requirement to deliver sustained clinical support arrangements.	April 2019 to April 2021	Fenella Wrigley
		Review clinical supervision model by April 19, and embedding within April 21. - Dependency on contract and commissioning - Dependiency and links to current strategic plans in progress		

ID	Description	Trust/NHSI Actions	Date	Owner
3	**Recommendation 3: Efficient use of available resources** **Ambulance trusts should maximise resource availability and reduce lost hours to ensure an ambulance response is available for patients that need it the most.**			
3.1	NHS Improvement working with ambulance trust boards to develop a standard measure of **efficient resource utilisation** by April 2019.	Performance directorate involvement in effective resource utilisation and supporting development of standard measure of efficient resource utilisation.	April 2019	NHSI
3.2	Ambulance trust boards reviewing **rotas and demand modelling** approaches and agreeing a good practice approach by April 2019.	**Development of integrated business planning model by Nov 18**	April 2019	Lorraine Bewes / Paul Woodrow / Patricia Grealish
		Review capacity and capability of demand modelling and rota development approach and provide assurance to Trust Board by April 19		
		Identify and review policies impacting resource availability (e.g. Single Movements Policies impacting on Out of Service lost hours identiifed during 2018/19 CIP Programme)		
3.3	Ambulance trusts reviewing **staff hours worked** to ensure a balance between contracted and actual hours with plans to manage this in a report to their board by April 2019.	Determine current position, analysis and reporting	April 2019	Patricia Grealish
		Provide report to the Trust Board at earliest possible opportunity (before April 19)		
3.4	Ambulance trust boards reviewing their **private ambulance spend** annually to ensure it offers value for money and that adequate controls are in place.	Review the effectivnessof our PAS model against demand/rosters is effective - Dependency with 2018/19 efficiency programme and plans to continue in 2019/20	Annually	Paul Woodrow
3.5	Ambulance trust boards developing plans to implement **make ready systems** with support from NHS Improvement by April 2019.	Current Vehicle Make Ready business case / tender paused, following review of other Trusts' models and reconsidering strategy.	April 2019	Benita Mehra

ID	Description	Trust/NHSI Actions	Date	Owner
4	**Recommendation 4: Optimising workforce, wellbeing and engagement** **The ambulance service should develop a five-year workforce, recruitment and staff wellbeing plan to: improve wellbeing and reduce sickness absence; encourage leadership at all levels of the organisation; improve staff engagement; and minimise vacancies.**			
4.1	Ambulance trust boards ensuring staff have an **annual performance review** and developing a standard appraisal process and reviewing this alongside appraisal quality measures.	Check and review current appraisal actions (number and quality) to identify opportunities for improvement. - Dependency with CQC outstanding programme - Dependency with Ops restructuring to improve support and training to line managers appraising staff - Dependency and links to OOS efficiency programme (2018/19) reviewing arrangements for planned stand-downs of crews for appriasals, statutory and mandatory training and welfare type meetings.		Patricia Grealish
		Promoting leadership and career progression amongst diverse groups		
4.2	NHS Improvement People Strategy Team working with ambulance trusts to apply the **Health and Wellbeing Framework assessmen**t and present a plan to their boards for improvement against the key indicators, including sickness absence, by winter 2018.	**NHSI Action**: Implementation a programme of improved reprorting and collaboration building on the Stevenson Farmer review (supporting mental health of staff due to high risk of trauma and stress).	Winter 18	NHSI
		Review use of AACE Employee Mental Health Strategy Guidance		
		Trust to review approach and policy to support delivery of increased attendance from managing sickness and supporting well-being.		
		Review of Trust's data set and trends, inclusion/exclusions (e.g. review of what is included in the long term sick category)		
		Requirement to engage with NHSE's Health and Wellbeing Framework to identify causes of sickness and production of health and wellbeing plans.		

4.3	Ambulance trusts board encouraging their staff to engage in **#ProjectA** and support the implementation of the ideas they generate.	Confirmation, review and reporting of engagement in #Project A to be clarified.		Patricia Grealish
		Implementation of 4 major change ideas which it is anticipated will start making a difference by Winter 18.		
		Review of staff engagement approach, engagement and approach by ELT - Dependency with CQC Outstanding plan - Dependency on strategic objectives within LAS		
4.4	The Association of Ambulance Chief Executives, NHS Improvement, NHS England, ambulance trust boards and the police working together to ensure that the toughest possible action is taken against every **act of violence, bullying and harassment** towards staff.	Trust Board level reporting review and action plan		AACE/NHSI/NHSE
		Review and confirm current arrangements for ongoing B&H campaigning (2015 B&H programme cited as Carter case study)		
4.5	Health Education England producing a clear **national workforce plan** with ambulance trusts to enable long-term recruitment planning.	Review workforce planning, recruitment and retention capabilities.		HEE
		Results of self-assessment evaluation for paramedic level involvement at a leadership level		
		Involvement in new HEE rotational working model		
		Engagement work to promote equal gender repreentation and use the gender pay gap data set (published in Mar 18)		
4.6	Ambulance trust boards analysing turnover rates for all staff groups to understand the true number of staff who leave the ambulance service and their reasons for leaving, to enable more effective **staff recruitment and retention planning.**	Strong emphasis on workforce planning, recruitment and retention		Patrica Grealish
		Results of self-assessment evaluation for paramedic level involvement at a leadership level		
		Involvement in new HEE rotational working model		
4.7	Ambulance trust boards working with Health Education England to consolidate and streamlining training across the service by developing a **national core training package** with local delivery and adaptation, to provide a consistent level of patient care across the country.	Assess impact of new paramedic Band 6 job description is enabling delivery of new models of care		Patricia Grealish
		Paramedic evidence-based education project engagement addressing significant variation in training		
		Review recommendations are in line with LAS Clinical Education Strategy		

ID	Description	Trust/NHSI Actions	Date	Owner
5	**Recommendation 5: Effective Fleet Management** **NHS Improvement should work with trusts boards and the Association of Ambulance Chief Executives, to agree proposals to rapidly move to a standard specification for new fleet across England and deliver**			
5.1	NHS Improvement working with ambulance trusts to **agree which of the current specifications**, and associated load list, should become the common standard for any new investment across England by February 2019.	**Trust continuing with current fleet replacement plan until new national specification has been agreed.**	February 2019	NHSI
		Participation / engagement in devleoping and agreeing a common set of requirements		
5.2	NHS Improvement developing a **centralised procurement model for flee**t by autumn 2019 and developing a model for testing and then implementing proven innovations at scale.	Fleet and procurement teams to engage with new NHSI capacity (purcahsing power) to address variation in costs. Strengthen focus on standardisation of medicines, consumables and equipment and account management	Autumn 2019	NHSI
5.3	NHS Improvement agreeing clear plan with each trust for moving to a **modernised common specification** and associated load list by April 2019.		April 2019	NHSI
5.4	Ambulance trust boards reviewing their **fuel arrangements** to ensure they are securing value for money and ensuring the governance process for fuel cards is robust where its use is appropriate by April 2019.	**Business case to develop bunkered fuel capacity agreed, to be developed at pace.**	April 2019	Benita Mehra

5.5	NHS Improvement agreeing the requirements for a **new fleet and fuel national data collection** and implementing this by April 2019.	**Implementation of Tranman stock modules being prused at pace.**	April 2019	NHSI
5.6	Ambulance trust boards agreeing plans to install and utilise black box technology and strengthen **management of accidents** by April 2019.	**Capital investment plan for introducing black box technology planned for Dec 18**	April 2019	Benita Mehra
		Continued focus on 2018/19 efficiency programme to improve reporting of RTCs leading to reduced costs.		
		Review and implement recommendations from current evidence-based evaluation of our practices by insurers (QBE).		

ID	Description	Trust/NHSI Actions	Date	Owner
6	**Recommendation 6: Improving performance and strengthening resilience and interoperability** **Ambulance trust boards should take steps to improve performance in their control centres and have plans in place to provide a resilient service in the event of a major incident or system failure by winter 2018**			
6.1	Ambulance trust boards with support from NHS Improvement and NHS England working together to develop **standard operating procedures** (including performance metrics and measures) and models to identify best practice and reduce performance variation by April 2019.	Significant warranted variation - impact on Ops / EOC strategy / people / processes / technology (CAD)	April 2019	TBC
		Variation shows that LAS is the only trust where dispatchers are taking calls also.		
		Engage with NHSI and NHSE to support development of standard operating procedures to reduce variation.		
		Check and challenge performance metrics for call answering and performance.		
		Assess current plans within EOC (restructure and recruitment) to confirm addressing of any underlying variations in the call answering and performance model.		
6.2	Ambulance trust boards undertaking a comprehensive assessment of their **disaster recovery plans** prior to **winter 2018** and escalating concerns where they consider the risk to be outside of tolerable levels.	***Review of disaster recovery plans by Oct/Nov 18, risks to be informed (where not tolerable) to NHSI. Reivew to include check of 50/50 physical size requirements at both sites.***	***Winter 2018***	Paul Woodrow
6.3	Ambulance trusts working with Association of Ambulance Chief Executives and NHS Improvement to develop disaster recovery standards for inclusion in the Emergency Preparedness, Resilience and Response annual assurance guidance published in July 2019. These standards should be fully adopted across all services by **summer 2020.**	Contribute to development of ambulance trust disaster recovery standards by Autumn 2019	Summer 2020	TBC
		Implementation of Disaster Recovery standards by Summer 2020		

6.4	Ambulance trust boards reviewing their current three to five year **control centre capacity** plan to ensure they are adequate to meet projected demand by **summer 2019.**	3-5 year Control Centre capaicty plan to be reviewed and shared with Trust Boar confirming workforce and physical size/growth plans	Summer 2020	Paul Woodrow/Benita Mehra
6.5	Ambulance trust boards reviewing their current **workforce strategies for call handlers** and dispatch staff as part of wider workforce planning by **April 2019.**	Implementation of Integrated business model will build on the work undertaken in 18/19 to increase control room staffing and EOC restructure.	Apr-19	Paul Woodrow/Patricia Grealish
6.6	Ambulance trust boards accelerating delivery of **national CAD interoperability** between all trusts and agreeing a delivery date by **winter 2018**.	***Assessment of impact on LAS CAD for development of national CAD interoperability between all Trusts and agreeing delivery date of Winter 18***	***Winter 18***	Ross Fullerton
		Asess impact on Strategic EOC / CAD plan		
		Enggement with plans to extend designated partner trust arragement - current system not sufficiently resilient (extend to EMD)		
		Consider opportunities for collaboration / shared telephony		

7	**Recommendation 7: Developing the digital ambulance** **Ambulance trust boards must utilise available resources and invest in future technology within their control centres to enable an interoperable service with maximum resilience and improved operational efficiency**			
7.1	NHS England and NHS Digital supporting ambulance trusts with the rapid adoption of technology assessed through the **digital exemplar programme** and identifying digital ready technologies that should be implemented by all trusts by April 2019.		April 2019	NHSE/I
7.2	NHS England, NHS Improvement and NHS Digital working with ambulance trusts to develop the **vision for the digitally enabled ambulance and control centre** and how this can connect the patient with wider services and support reductions in avoidable conveyance by summer 2019.	Engage and support work to develop the vision for digitally enabled ambulance and control centres.	Summer 2019	NHSE/I
		Check plan and timetable for introduction of ePR.		
7.3	NHS England, NHS Improvement and NHS Digital should work with ambulance trust boards and the **National Ambulance Radio Programm**e to develop a costed business case by summer 2019 for delivering an interoperable and resilient call handling infrastructure.	Support engagement with partners to develop costed business case for delivering plans for an interoperable and resiliencce callhandling infrastructure.	Summer 2019	NHSE/I

ID	Description	Trust/NHSI Actions	Date	Owner
8	**Recommendation 8: Maximising use of non-clinical resources** **Ambulance trust boards should review their estates to match modern demand and optimise their corporate services functions through improved collaboration.**			
8.1	The NHS Improvement Estates and Facilities team working with ambulance trust boards to improve the categories and definitions of the **Estates Return Information** Collection by 2019/20.	Engagement with Strategic Assets Team to propose opportunities for making efficiency improvements, liaising with the Procurement Team.	2019/20	NHSI
8.2	Ambulance trust boards reviewing their strategic estates and facilities plans to modernise their configuration and rationalise their estate to match modern demand profiles identified from the **Estates Return Information Collection** data set by	**Draft estates strategy (spatial development) currently under review.**	Summer 2019	Benita Mehra
8.3	NHS Improvement working with ambulance trust boards to ensure the accurate application of the **corporate services data request** definitions to enable more effective benchmarking by **winter 2018**.	Engage with requirements to meet submissions for corporate services data request.	Winter 2018	NHSI

8.4	NHS Improvement Corporate Services team providing **annual benchmarking reports** to ambulance trust boards to enable identification of opportunities for improvement. This will be supported by the bi-annual publication of the opportunity list to enable ambulance trusts to identify potential Cost Improvement Programmes	**2017/18 data received, being analysed and informing shaping of improvement and productivity 3 year plans.**		Lorraine Bewes
8.5	The NHS Improvement Corporate Services team to explore the benefits that could be achieved through the deployment of **robotic process automation** and publish findings by **December 2018**. Trusts should utilise these findings to adopt new ways of working made available through automation	Engage with the NHSI Corporate Team, as appropriate, to consider ideas.	01/12/2018	NHSI
		Utilise findings from opportunities for robotic process automation when these become available		
8.6	Ambulance trust boards identifying opportunities for collaboration in corporate service functions regionally, through **alliances or across the wider NHS** including across sustainability and transformation programmes where appropriate by **April 2019**.	**LAS collaborating with SCAS and considering other collaborations with cross-border Trusts (e.g. SECAMB),**	April 2019	Garrett Emmerson

ID	Description	Trust/NHSI Actions	Date	Owner
9	**Recommendation 8: Delivering Effective Implementation** **NHS Improvement and NHS England must work with ambulance trust boards, the Association of Ambulance Chief Executives and other national bodies to take the required action to implement these recommendations and**			
9.1	Ambulance trust boards, NHS Improvement, NHS England, the Association of Ambulance Chief Executives and other national bodies accepting and **implementing the recommendations** in this review.	**Paper to Finance and Investment Committee incorporating recommendations**		All
9.2	NHS Improvement and NHS England working with the Association of Ambulance Chief Executives to **agree a delivery plan** as part of the Ambulance Improvement Programme which clearly identifies the accountabilities and	Through our membership of AACE, contribute to the shaping of the implementation programme, confirming workstream leads and process for managing the programme.		NHSI/NHSI/AACE
9.3	NHS England ensuring that the recommendation of this review are appropriately **reflected in the NHS business rules, including the NHS Standard Contract, national tariff and CQUIN starting in 2019/20.**	Ambulance Commissioning Framework published October 18. Impact of proposed changes being assessed / reivewed with Commissioners.	2019/20	NHSE
9.4	**NHS Improvement tracking the implementation** of each recommendation, and the Ambulance Improvement Programme Board reviewing progress regularly.			NHSI

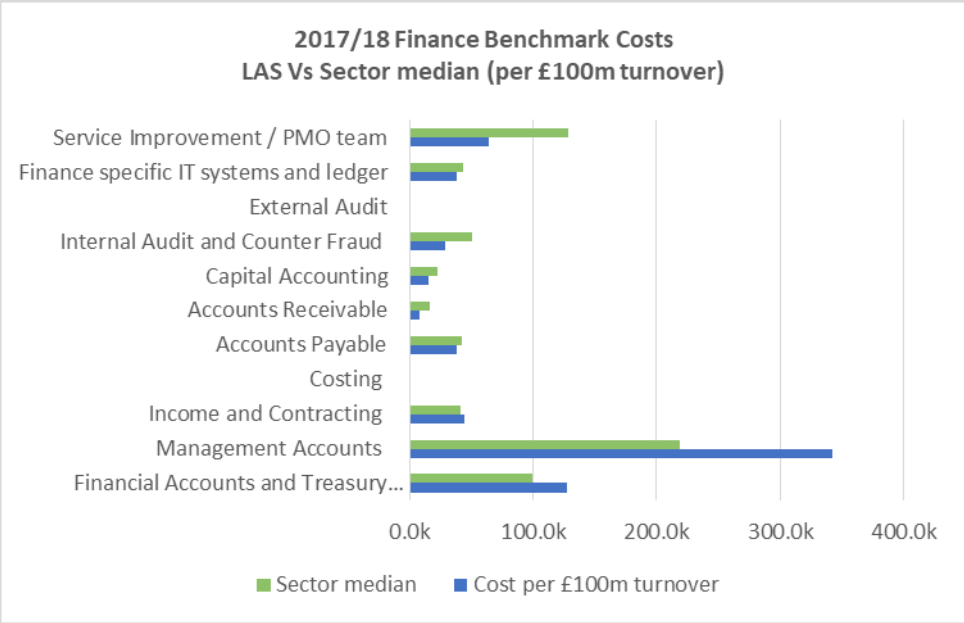
9.5	NHS Improvement developing the **Model Ambulance Service portal** so that there is one source of data, benchmarks and good practice across the ambulance service, with the initial prototype delivered by autumn 2018.		Autumn 2018	
9.6	**NHS Improvement developing the productivity index** and exploring the feasibility of developing a single weighted activity unit or equivalent measure to understand the output of an ambulance trust by autumn 2018.		Autumn 2018	
9.7	NHS England and NHS Improvement developing a **single data warehouse and national data set** for the ambulance service that underpins the Model Ambulance Service portal by autumn 2019. This should include a single service specific data dictionary.		Autumn 2019	

Appendix 3: 2017/18 NHSI Benchmark Data

The benchmark data suggests between **£3.6m** (function level) and **£10m** (sub-function level) efficiency savings could be realised. The findings from the 2017/18 NHS Benchmarking exercise both nationally and across the Ambulance Sector are presented on the following pages. The following is noted:

- The data in the report has been taken from the LAS Trust return for the 2017/18 national corporate services data collection which took place between Jun-Jul 2018.
- NHSI have reported that greater effort has been placed on data validation with 97% of Trusts submitting data
- There are some occasions where activities fall under a function but data has been grouped/collected under a different function. The Communications department is an example of this. Data has been submitted through the LAS return and grouped under a sub-heading of 'Communications' within Governance and Risk.
- Following the Trust's submission, NHSI validated activities to highlight possible inconsistencies and incorrect values.
- Where data was not submitted as part of our return the Trust has not been included in a cohort for a benchmark. An example of this is 'Costing' and 'External Audit' within the Finance section. A further example is Legal Services where costs for internal legal services has been submitted but not submitted for external legal costs. Interpreting the findings of the report should therefore be considered with caution. Rather than be considered incorrect it is recommended that further analysis be undertaken. An example of this is the IM&T Directorate who are undertaking a separate benchmark exercise, collaborating with two Ambulance Trusts (SCAS and NEAS).
- The following definitions are provided:
    - Absolute costs for 2017/18 = total costs of each sub-function and function from Trust data submitted
    - Costs per £100m turnover = adjusted to take account of Trust size
- The Benchmark Data also presented WTEs and Quality and Contextual metrics (e.g. cost per complain, costs per payslip etc). These finding are not presented within this report.

Finance (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
Finance	Cost of function per £100m turnover	640.2k	570.1k	253.0k

Finance (Absolute Opportunity)

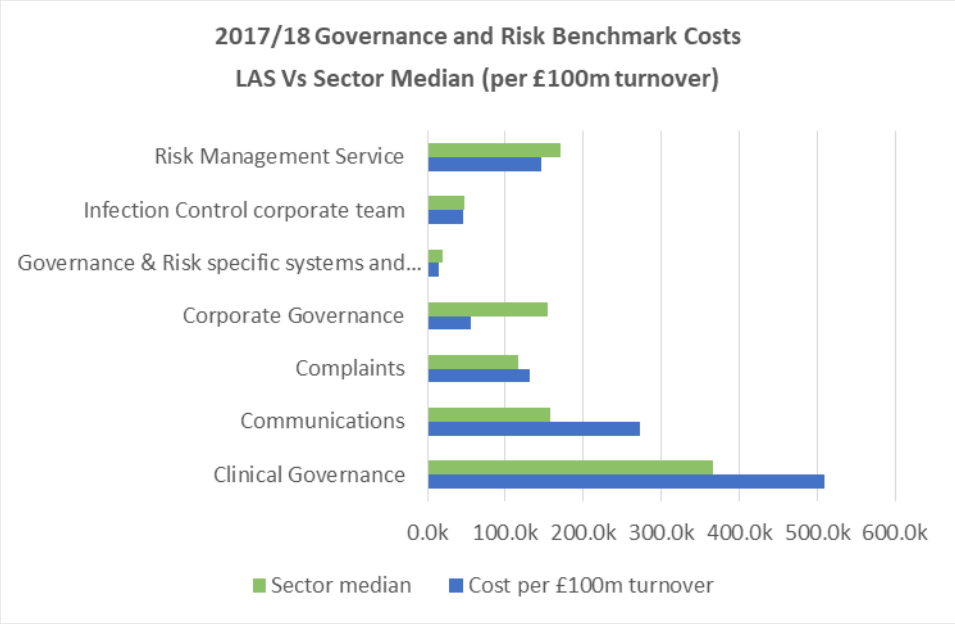
Finance Sub-Function - Absolute Opportunity:

- At a sub function level, the potential opportunity to realise efficiency savings is **£558k (£155k per £100m)**, to the Sector median.
- The benchmark data suggest this could be realised as follows:
  - Financial Accounts and Treasury Management - **£100.6k**
  - Management Accounts - **£446.2k**
  - Income and Contracting - **£11.6k**

Finance Function Level Findings:

- Aggregating the finance sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£253k**

Governance & Risk (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
Gov & Risk	Cost of Governance & Risk function per £100m turnover	1,174.7k	1,201.4k	

Governance & Risk (Absolute Opportunity)

Governance & Risk Sub-Function - Absolute Opportunity:

- At a sub function level, the potential opportunity to realise efficiency savings is **£985.5k (£274k per £100m)**, to the Sector median
- The benchmark data suggest this could be realised as follows:
  - Clinical Governance – **518.6k**
  - Communications - **£415.3k**
  - Complaints - **£51.5k**

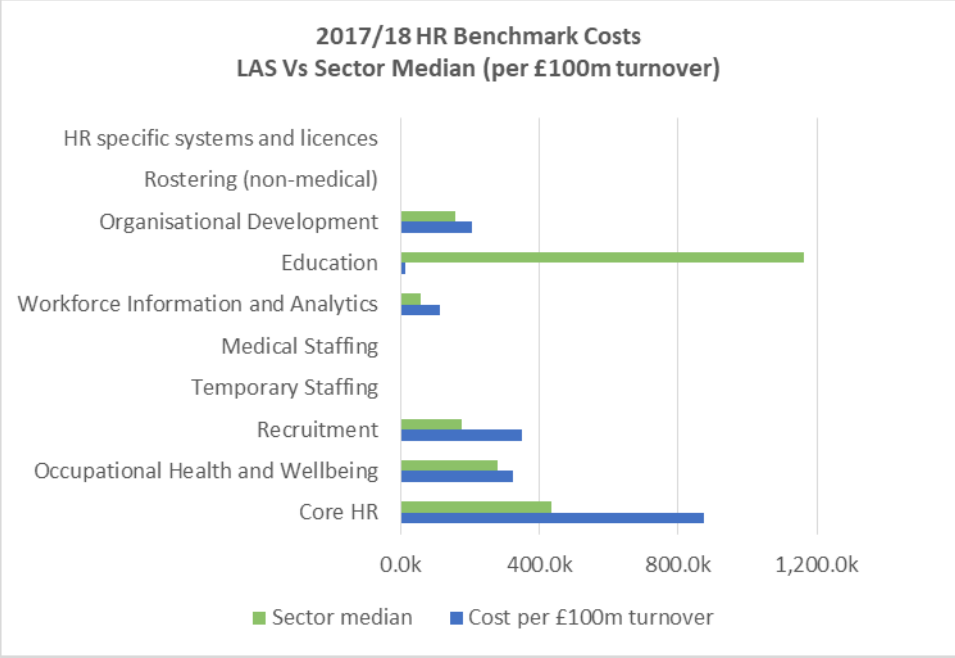
Governance & Risk Function Level Findings:

- Aggregating the sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£0k**

Notes:

- No data was submitted for Clinical Audit and Quality Corporate Team by LAS. Consequently no comparison data is presented.

People & Culture (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
HR	Cost of HR function per £100m turnover	1,876.9k	2,267.9k	

People & Culture (Absolute Opportunity)

People & Culture (HR) Sub-Function - Absolute Opportunity:

- At a sub function level, the potential opportunity to realise efficiency savings is **£2,737.4k (£760k per £100m)**, to the Sector median.
- The benchmark data suggest this could be realised as follows:
  - Core HR – **1,585.4k**
  - Occupational Health & Wellbeing - **£153.7k**
  - Recruitment - **£626.7k**
  - Workforce Information and Analytics - **£200.8k**
  - Organisational Development - **£170.9k**

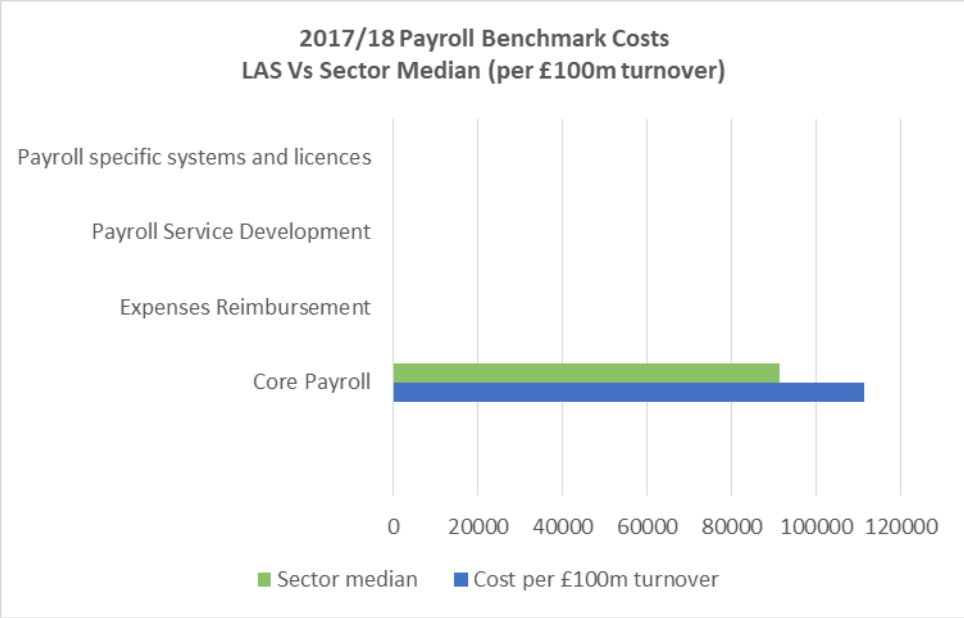
People & Culture (HR) Function Level Opportunity:

- Aggregating the sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£0k**

Notes:

- The data for Education appears skewed, showing only an LAS cost of £11.7k per £100m turnover. It is suggested that other benchmark trusts have included full costs of education, including clinical education, within their returns.
- No data submitted for Temporary/medical staffing or HR specific systems and licenses. Consequently no sector benchmark shown.

Payroll (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
Payroll	Cost of Payroll function per £100m turnover	111.1k	104.7k	23.3k

Payroll (Absolute Opportunity)

Payroll Sub-Function Level findings:

- At a sub function level, the potential opportunity to realise efficiency savings is **£72k**, **(£20k per £100m)**, to the Sector median
- The benchmark data suggest this could be realised as follows:
  - Core Payroll - **£72k**

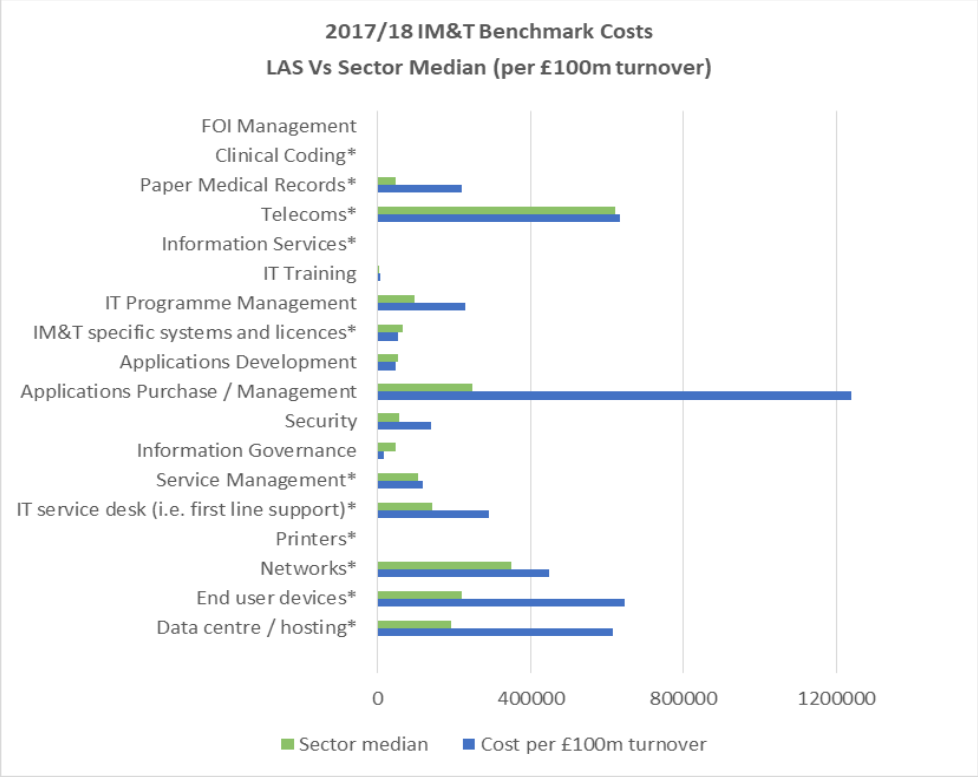
Finance Function Level Findings:

- Aggregating the finance sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£23.3k**

Notes

- No data for costs related to Expenses reimbursement, Payroll service development and payroll specific systems and licenses was submitted – may explain absolute opportunity Function Vs Sub-Function
- Consequently no comparison data has been presented in the benchmark data for these areas
- Further analysis suggested to determine greater detail / granularity.

IM&T (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
IM&T	Cost of Transactional IM&T sub-functions per £100m turnover*	3,029.4k	2,214.9k	2,939.3k

IM&T (Absolute Opportunity)

IM&T Sub-Function Level findings:

- At a sub function level, the potential opportunity to realise efficiency savings is **£4,677.4k**, **(£1,300k per £100m)**, to the Sector median
- The benchmark data suggest this could be realised as follows:
  - Data centre / hosting – **1,533.7k**
  - End user devices - **£1,534.8k**
  - Networks - **£360.3k**
  - IT Service Desk - **£536.1k**
  - Service Management - **£46.0k**
  - Telecomms - **£42.7k**
  - Paper Medical Records - **£623.8k**

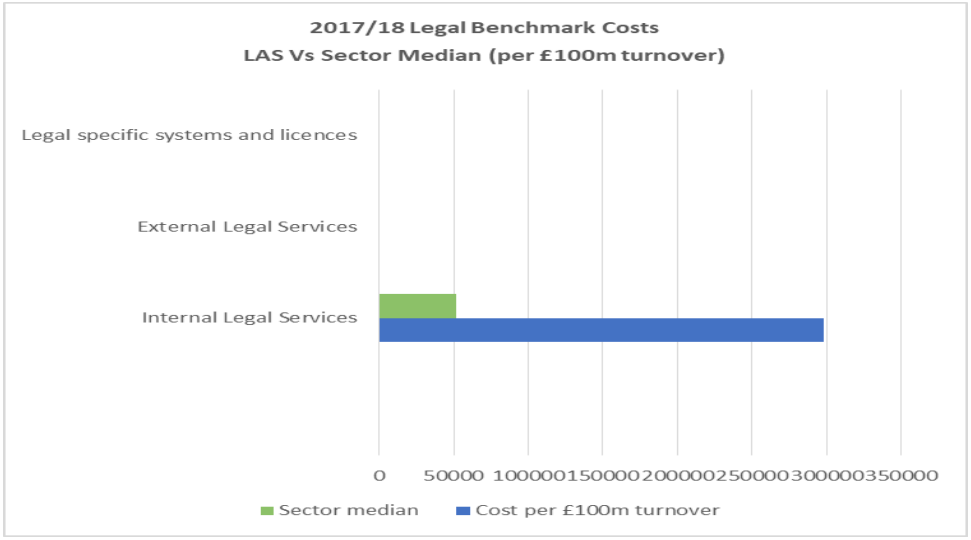
IM&T Function Level Findings:

- Aggregating the sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£2,939.3k**

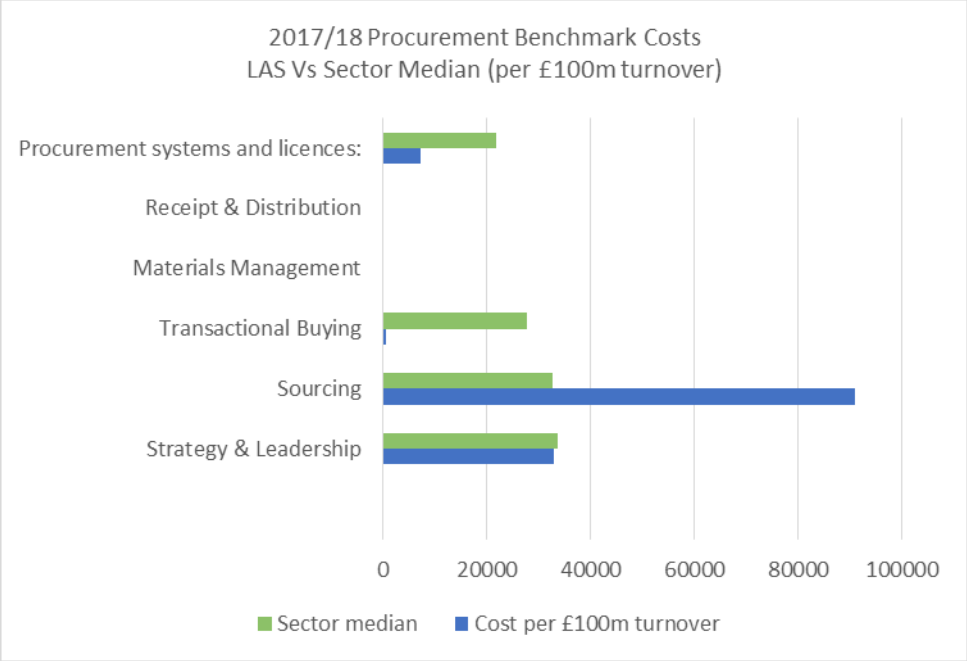
Notes

- No data submitted for FOI management, Clinical Coding, Information Services and Printers.
- NHSI have only calculated opportunities for 'transactional' IM&T sub-functions. Transactional, activity or volume based (see asterisk in charts)
- The ***EPR*** business case is intended to address potential opportunities for Paper Medical Records

IM&T (Opportunity per £100m)	IM&T (Absolute Opportunity)
	• ***CAD Refresh*** identified as a service development / business case • ***Trust Helpdesk Review*** identified through I&P planning • ***Actions to deliver a balanced budget*** for 2018/19 being monitored and scrutinized through CEO Check and Challenge process. • ***IM&T undertaking further benchmarking*** with SCAS/NEAS • The Digital Maturity Assessment indicating investment required in the Trust was undertaken between Sep-Dec 17.

Legal (Opportunity per £100m)	Legal (Absolute Opportunity)
	**Legal Sub-Function Level findings:** • At a sub function level, the potential opportunity to realise efficiency savings is **£887.4k (£246k per £100m)** to the Sector median • The benchmark data suggest this could be realised as follows: o Internal Legal Services - **£887.4k** **Legal Function Level Findings**: • Data was only submitted for Internal Legal Services. The level of potential savings at a function level is therefore the same as sub-function **Notes** • LAS provided details of external legal service contracting but no costs data was submitted. • As this function is skewed it suggests ***further review*** should be undertaken to draw further benchmark information, prior to making efficiency saving recommendations. • No data was submitted for legal specific systems and licenses

Procurement (Opportunity per £100m)



Type	Finance function metric	Cost per £100m turnover	Sector median	Absolute opportunity to sector median
Procurement	Cost of Procurement function per £100m turnover	131.5k	202.9k	

Procurement (Absolute Opportunity)

Procurement Sub-Function Level findings:

- At a sub function level, the potential opportunity to realise efficiency savings is **£211k**, **(£59k per £100m)** to the Sector median
- The benchmark data suggest this could be realised as follows:
  - Sourcing - **£211k**

Procurement Function Level Findings:

- Aggregating the Procurement sub-functions reduces the potential efficiency opportunity, when compared to the sector median, to **£0k**

Notes

- No data was submitted for materials management / receipt and distribution
- Consequently no comparison data has been presented in the benchmark data for these areas
- ***Further analysis suggested*** to determine greater detail / granularity.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Preparedness for departure from the European Union			
Agenda item:	14			
Report Author(s):	Lorraine Bewes, Director of Finance and Performance			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	A national framework for assessing the impact of the UK's departure from the European Union was published very recently by the Department of Health and Social Care w/b 12 October. Papers updating on the preparedness have been considered by the Audit Committee on 5 November, the Finance and Investment Committee on 13 November and a further review by the Executive Committee on 14 November 2018.			
Status:	☐	**Assurance**	☒	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

This paper outlines the Trust's position on preparedness for departure from the European Union on 29 March 2019.

It provides assurance that the Trust has conducted its assessment in line with the framework mandated by the Department of Health and Social Care and updates the Board on the outcome of the Trust's internal risk assessment. Whilst the likelihood of a departure with no deal is unlikely, the guidance is based on taking a responsible approach that covers all eventualities, including a worst case exit until there is certainty on the outcomes of negotiations and the template therefore focuses on a worst case position.

The Board should note that this is a dynamic situation and the risk assessments included in the paper will be kept under on-going review.

Recommendation(s):

The Trust Board is asked to note the activities undertaken to assess the potential worst case impact of departure from the European Union and the outcome of the Trust's risk assessment and confirm whether further assurances are required.

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

The potential for supply chain interruption and possible cost pressures arising from departure from the European Union have implications for the delivery of the Trust's clinical, quality and financial plan deliverables in the Business Plan. The Trust's preparedness is also a matter for its reputation as a well led organisation.

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	☒

EU Exit Preparedness Position

Introduction

1. This paper outlines the Trust's position on preparedness for departure from the European Union on 29 March 2019. It provides assurance that the Trust has conducted its assessment in line with the framework mandated by the Department of Health and Social Care and updates the Board on the outcome of the Trust's internal risk assessment.

Activities undertaken

2. The Trust has carried out a comprehensive review of its preparedness for a departure from the European Union on a worst case basis. With respect to supply chain risk, the procurement team has led an evaluation in compliance with the self-assessment methodology mandated by the Department of Health and Social Care (DHSC). Whilst the likelihood of a departure with no deal is unlikely, the guidance is based on taking a responsible approach that covers all eventualities until there is certainty on the outcomes of negotiations and the template therefore focuses on a worst case position.

3. Directors have been asked to consider and score the risks with their teams, using the Trust risk management framework. Five primary key risk areas have been identified for consideration in terms of the risks posed by different EU Exit outcomes:

    - Supply chain
    - Business continuity/Emergency Preparedness, Resilience and Response (EPRR)
    - Workforce
    - Drugs (but note the national work below)
    - Other – regulatory changes, political upheaval

4. The Department of Health and Social Care (DHSC) has initiated a cross-government approach to identify supply chain contracts that may be impacted by the EU exit, which included the development of a self-assessment methodology for NHS organisations to review contracts that may be affected in a worst case scenario.

5. DHSC is coordinating the risks and mitigation strategies for all vaccines, medicines, medical devices and anything that can be bought from NHS Supply Chain. DHSC and NHSI have advised they will ensure 6 weeks' stock held on UK soil by 29 March 2019. LAS has been instructed not to have local stockpiles. The toolkit is for all remaining contracts that need to be managed at Trust level.

6. Procurement has liaised with internal stakeholders and suppliers, where appropriate, to complete the responses. Details of the DHSC template questions are set out in Appendix A. Contracts identified for further review have been assessed using a set of deep dive questions listed in Appendix B.

7. A task and finish group chaired by the Director of Finance and Performance reviewed the outputs from these activities on the 7 November 2018. Membership consisted of:

    - Director of Finance and Performance – Chair
    - Director of Corporate Governance
    - Director of Operations
    - Trust Pharmacist
    - Director of People and Culture

- Deputy Head of Procurement
- Head of Business Continuity
- Director of Strategic Assets and Property
- Chief Information Officer
- Risk Internal Audit Manager

8. The risk assessment assumes departure from the European Union on a 'maximum change' basis. We have reviewed 820 supplier relationships, covering around £78m of expenditure and carried out a detailed analysis of 250 with whom we spend more than £25k. Out of a review of the 820 suppliers, only 17 suppliers have been given a risk rating and no suppliers have been assessed as above medium risk according to the DHSC methodology. Mitigation plans are being developed and will be shared with the DHSC.

9. These risks, clustered into 6 categories, will be added to Datix when approved by the relevant director and to be considered for addition to the appropriate risk register. The risks will be reviewed by the risk owner on a regular basis. Following the LAS risk methodology the risks are currently assessed as:

Supply Chain category	**Current risk rating**
Vehicle conversions	4
Vehicle parts	9
Body armour	9
Cleaning services contract – office	12
Cleaning & preparation services contract - vehicles	16
Patient facing contracts	6

Note these are subject to change as more information is received from the suppliers and assumes a worst case EU Exit.

10. The LAS currently sources body armour from an EU based supplier. The risk of supply delays is assessed as a low risk and alternative UK based suppliers are under consideration.

11. Drugs are being managed centrally by the government but the Trust will keep stock levels under review to ensure these are optimal.

12. Workforce risk is low, with only 167 EU nationals directly employed by the LAS. The impact on front line is considered minimal and the Trust has put in place arrangements to allow staff special leave to make any relevant visa applications as well as reimburse the cost of the visa (which is currently set at £65.00), which is in line with other NHS Trusts. We employ a number of agency personnel across the Trust and have had discussions with suppliers about the impact to supplying staff. No concerns have been raised. We have also had discussions with our Occupational Health provider and they have confirmed that there is minimal impact on their services due to EU Exit.

13. Business continuity risk is low.

Conclusions and Next Steps

14. The risk assessment has been carried out to cover all eventualities for departure from the European Union and has been conducted on a worst case and 'maximum change' basis. No suppliers have been assessed as above medium risk according to the DHSC methodology. The Board will consider the potential for any contracts to be monitored as a BAF level risk, subject to further clarification of the potential impacts and likelihood of occurrence, in private session due to the commercial in confidence nature of the subject matter.

15. The Trust Board is asked to note the activities undertaken to assess the Trust's preparedness for departure from the European Union and the outcome of the Trust's risk assessment and confirm whether further assurances are required.

Lorraine Bewes
Director of Finance and Performance

Appendix A: EU Exit Triage Contract Data Templates Questions

1. **Contract Expiry:** If this contract is due to expire before the 29th March 2019, is there a requirement to continue the delivery of goods/services post this date? (e.g. via a contract extension or another procurement exercise) (Yes /No)
2. **UK Borders:** How impacted would the contract be by a change in the customs arrangements for supply routes via UK border crossings? (e.g. does it rely on 'just-in-time' deliveries via a UK port – and is the supplier liable for paying service credits in the case of delayed deliveries?) (Inoperable Change/ notice required/ No/ minimal change)
3. **Customs Tariffs:** How impacted would the contract be by a change in customs tariffs between the UK and EU? (e.g. are products manufactured in the EU or the UK – and, if in the EU, who is currently contractually responsible for the higher cost should tariff barriers be raised?) (Inoperable Change/ notice required/ No/ minimal change)
4. **Economic:** How impacted would the contract be by changes in the value of sterling (e.g. who owns the currency risk – and are any exchange rates referenced in the contract tied to the date of the contract's signature)? (Inoperable Change/ notice required/ No/ minimal change)
5. **Finance:** How impacted would the contract be by disruptions to the flow of funding between the UK and EU (e.g. transactions to and from EU bank accounts)? (Inoperable Change/ notice required/ No/ minimal change)
6. **Data:** How impacted would the contract be if data could no longer be stored/processed in the EU? (e.g. back office contract based in a EU country, or data stored in a data centre in the EU) (Inoperable Change/ notice required/ No/ minimal change)
7. **Human Resources:** How impacted would the contract be by a more restrictive immigration regime?(e.g. in the case where delivery of the contract is dependent to some degree on EU nationals working in the UK) (Inoperable Change/ notice required/ No/ minimal change)
8. **Regulation:** Excluding the EU procurement directives, does the contract rely on specific regulations from the EU in order to specify the services/goods being delivered? (Yes/No) – *If yes, please outline which regulations in the comments box*
9. **Supply Market:** Is there a competitive market for the goods/services being provided under this contract and are there substitute products/services that could be procured? (Yes/No) – *if yes, please outline an estimate of the time needed to switch between suppliers in the comments box*
10. **Public Facing:** Do the general public directly interact with the provider of the goods/services in this contract? (e.g. call centre services) (Yes/No)
11. **Volume changes:** Will an EU Exit significantly increase the demand volume on the services being provided (e.g. increase in call volumes)? (Yes/No)
12. **Supplier:** Would the supplier be able to meet its contractual commitments in the event of a 'No Deal' EU Exit? (Yes/No)
13. **Contract Changes:** Will you need to make substantial changes or variations to the contract terms or specification as a direct result of EU Exit? (A "substantial change" is one that materially changes the nature or character of the contract. It does not include minor changes in volume or scope e.g. the development of new IT functionality outside of the initial scope of the procurement) (Yes/No)

Appendix B: Deep Dive Questions

0. **Contract background:** *This section is used to provide background and context for the contract*
    a. Please provide a description of the contract and its purpose.
    b. Please describe the relationship with the contract supplier (e.g. responsiveness, previous issues etc.).
    c. How long have you personally managed the contract for?
    d. What date did this contract commence?
    e. Are there any other similar contracts that you are aware of across government? Is so, please describe.
    f. Have you had any discussions with the supplier regarding EU Exit and how it may impact this contract? If so, please provide a summary of key points raised by the supplier (if any).
1. **Contract Expiry**
    a. Does this contract (and options to extend) expire before/after 29 March 2019?
    b. How critical is this contract to patient care and carer services?
2. **UK Borders**
    a. How dependent is the contract on imports and exports between the UK to the EU?
    b. Does the contract require supplier or customer staff to be aware of and trained in the necessary paperwork and processes to allow the physical (or other) movement of goods (or services) across EU/UK borders?
    c. Does the contract rely on 'just in time' supply chain provisions involving the movement of goods (or services) across UK/EU borders?
    d. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
3. **Tariffs**
    a. Does this contract involve the import of products to the UK from the EU? If so, please describe all products being imported.
4. **Economic**
    a. Are there provisions for exchange rate fluctuations in the contract and how would/could they impact pricing or other risk/reward mechanisms?
    b. What proportion of contract spend is incurred in a non-Sterling currency in the specific contract under review?
    c. What proportion of the supply chain in respect of the specific contract under review is overseas? [NB this should focus on operations rather than ownership, financing etc.]
    d. When the UK EU Exit referendum result was announced two years ago and the value of sterling initially dropped, how did this affect the contract? i.e. did the supplier seek to increase their prices
    e. Is there a threshold for FX movements (the market in which foreign currencies are traded and exchanged in) in the contract? Please specify what this is if so.
    f. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
5. **Finance**
    a. Is the parent company of the contract supplier headquartered in the EU?
    b. Is the supplier a small or medium sized company who would be less able to withstand shocks to its working capital? Please provide the basis for this answer.
    c. Does the contract relate to the payment of pensions? If so, please specify.
    d. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?

6. **Data**
    a. Is personal data transferred outside of the UK in this contract? If so, please specify which countries personal data is held in.
    b. Does this contract involve the flow of ICO special category personal data outside (Personal data which GDPR says is more sensitive so needs more protection) of the UK, including any of; race, ethnic origin, politics, religion, trade union membership, genetics, biometrics (where used for ID purposes), health, sexual orientation?
    c. Does this contract involve the flow of personal data outside of the UK that contains information relating to an individual's financial, medical or criminal history?
    d. How are non-UK based data services used in the contract to deliver services in the UK?
    e. Is personal data used across borders to deliver the services in the contract?
    f. Is personal data transferred from the EU to the UK a feature of this contract?
    g. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
7. **Human Resources**
    a. What proportion of non UK staff are involved in delivering the contract in the UK? Of that, what proportion of those are EU nationals compared to 'rest of world'?
    b. What proportion of non-UK staff would fall below the salary thresholds for individuals to apply for UK visas (£30,000 per year for a tier 2 visa)?
    c. Would the contract be impacted by a more restrictive labour market?
    d. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
8. **Regulation**
    a. If you have identified specific EU regulations that this contract is reliant upon, please explain why each regulation is important to the contract?
    THE FOLLOWING QUESTIONS CAN BE USED TO IDENTIFY OTHER REGULATIONS THAT MAY BE RELEVANT
    b. Is this contract reliant on any EU regulations? If so, please specify.
    c. Does the contract rely on authorisation by any EU body?
    d. Does the contract involve importing any products to the UK? If so, please specify the products.
        i. Multiple regulations depending on type of product imported, e.g. chemical regulations, regulation on electronic products such as batteries, labelling regulation, EU safety regulations, etc.
    e. Does the contract involve the employment or use EU employees?
        i. Relevant regulations include employment law, GDPR , employer insolvency law, pensions law
    f. Does the contract involve the supply of medicines or medical devices?
        i. Relevant regulations include EU Regulations for medical devices (MDR) and in vitro diagnostic medical devices (IVDR) and Human Medicines Regulations 2012
    g. Does the contract involve the authority's ownership of intellectual property with the exception of patents and trademarks? Are you aware of who owns any intellectual property in this contract?
    h. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
9. **Supply Market**
    a. How competitive is the market for the goods/services being provided under contract? i.e. What is the size and scale and maturity of the market for alternative goods or services?
    b. How scarce/bespoke are the goods or services delivered through the contract? i.e. Does the supplier have any exclusivity over the goods/services provided? What are the constraints to switching to an alternative supplier? Are

there options to substitute and/or replace the goods or services with UK options if the contract became inoperable after EU exit?

c. Are alternative goods or services available to enable continuity in delivering of those health and care services impacted by the contract during an interim period if needed? i.e. for period of 3-6months?
d. Could the contract be readily supplemented or replaced by other goods or services contracts on a pre-existing public sector framework agreement?
e. Does the value of the service prohibit a direct award to an alternative contract/service provider if needed to be enacted urgently?
f. Does the value of the service fall below financial thresholds allowing alternative suppliers to be appointed without breaching regulatory or governance procedures process?
g. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?

10. **Public Facing**
    a. Does the service being provided under the contract involve direct interface with the public and if so, does the supplier have any contingency plans in the event of service failure?
    b. Which contracting party bears the risk and liability for poor/non-performance of the contract?
    c. Does the contract contain public facing information centres (e.g. websites, call centres, chat bots etc.)
    d. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
11. **Volume changes**
    a. Do the contracted goods or services include any materials which are 'EU' branded e.g. signs, literature, etc.?
    b. What are the volume parameters in the contract for goods or services? I.e are there volume limits that incur an additional charge if breeched? Is this volume limit likely to be breached? Would the supplier be able to deliver required increase in volume?
    c. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
12. **Supplier**
    a. What resilience does the supplier have in delivering their contractual commitments in the event of EU exit impacts on its operating model?
    b. If the supplier is unable to deliver their contractual commitments, is there a viable market for the replacement of services?
    c. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
11. **Contract Changes**
    a. Is there a contractual contract change process set out in the contract?
    b. Have the contract parties used the contract change process before to assess whether it is effective?
    c. What is the quality of engagement between the contracting parties? I.e. would a supplier be open to agreeing a contract change (subject to agreement) if necessary to make the contract operable beyond 29 March 2019?
    d. In your view, what would need to be done to resolve issues raised in this section and make the contract operable?
12. **Mitigation steps**
    a. What commercial activity (including timelines) would be required to make this contract operable (i.e. change notice, re-procurement, etc.)? Are there any additional points to note regarding commercial activity? Please indicate whether this High, Medium or Low (High = re-procurement, Medium = change notice, Low = within scope of current contract)

b. Is there likely to be any spend or cost implications associated with this commercial activity? Would any element require Cabinet Office or HMT approval? Please provide details.

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Serious Incident Quarterly Thematic Report			
Agenda item:	15			
Report Author(s):	Quality, Governance and Assurance Team			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

This report provides an overview of the incidents reported and declared to the CCG, and a thematic analysis of serious incidents (SIs) submitted to the Clinical Commissioning Group (CCG) and closed in Q2 2018/19.

The SI thematic review provides an analysis of category and key contributory factors for incident activity across the trust and each STP / sector. The findings are compared with those from the previous quarters, with the aim of identifying key themes for action.

Recommendation(s):

The Board is asked to note the report which summarises the findings from the quarter one thematic review of serious incidents (SIs).

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

Operational Risk 21 - 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.

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	☐

Serious Incident Update

Completed investigations

1. During October 2018, five completed Serious Incident (SI) Root Cause Analysis reports were submitted to the CCG. The details of these incidents will be provided in future SI Update Reports when they have been approved and closed by the CCG.

2. The Trust's current position on meeting the 60 working day deadline for submitting SI reports remains at 100%. This position has now been sustained for 12 months.

Serious Incident closures

3. There were five SI investigations approved and closed by the Clinical Commissioning Group (CCG) during October 2018.

4. These 5 investigations generated 21 actions which are detailed in the table below. Of these:-

    - 9 have been completed and closed.
    - 7 are ongoing and are within the assigned target completion date.
    - 5 actions have breached the assigned deadline. These are being followed up through relevant managers to prioritise completion.

StEIS Number	Incident type	Sector	Date Declared	Number of actions and completion	Date for completion	Date submitted to CCG
2018/7400	Dispatch & Call	North East	21/03/2018	Review CHUB /DDS communication - ring backs	31.08.2018	20/06/2018
				Bulletin Reminder and Electronic Board	31.08.2018	
				Adherence to EOC Dispatch and Resources Policy	30.09.2018	
2018/14117	Lost or stolen paperwork (including PRFs)	South West	06/06/2018	Paramedic A and EAC A to meet with CTL	Completed	30/08/2018
				Identification and labelling of a storage place	31/10/2018	
				Procurement of fit for purpose LA1	30/11/2018	
				Tasks of checking presence of PRFs and printouts	30/11/2018	
				Complete implementation of the end of shift	31/12/2018	
2018/17755	Dispatch & Call	South East	18/07/2018	Assigned SIG Action	Completed	11/10/2018
				Update SOP on Careline ring back	Completed	
				Reflective session of the calls	30/11/2018	
				Individual to complete reflective session of the QA of the calls	30/11/2018	
				Continue with ongoing recruitment and retention programme	Completed	
				Operational resources	Completed	
2018/16075	Treatment/ Procedure – inappropriate / Wrong	North East	27/06/2018	Identify training for differing levels of severity and treatment for asthma	06/11/2018	24/09/2018
				Individual training for the Paramedic and EMT 4 in relation to Asthma presentation, differing levels of severity and treatment Feedback should be given on the incident	Completed	
				Re-issue the 'Improving Patient Care' on asthma	30/09/2018	
				Include the lessons learned in Core Skills Refresher for clinical staff	01/04/2019	
2018/16100	Communication failure – outside of immediate team	Emergency Bed Service	27/06/2018	Formulate and Disseminate SOP	Completed	22/10/2018
				Staff must read policy and sign document to acknowledge compliance	Completed	
				Undertake an audit to monitor the use of read/delivery receipts	11/01/2019	

SI Activity by Month

5. During October 2018, 10 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 below shows the monthly distribution of declared SIs across the Trust compared to the previous year. The overall total for the same period in 2017 and 2018 is 78 and 79 respectively so there has been no significant increase in the number of SIs in 2018.

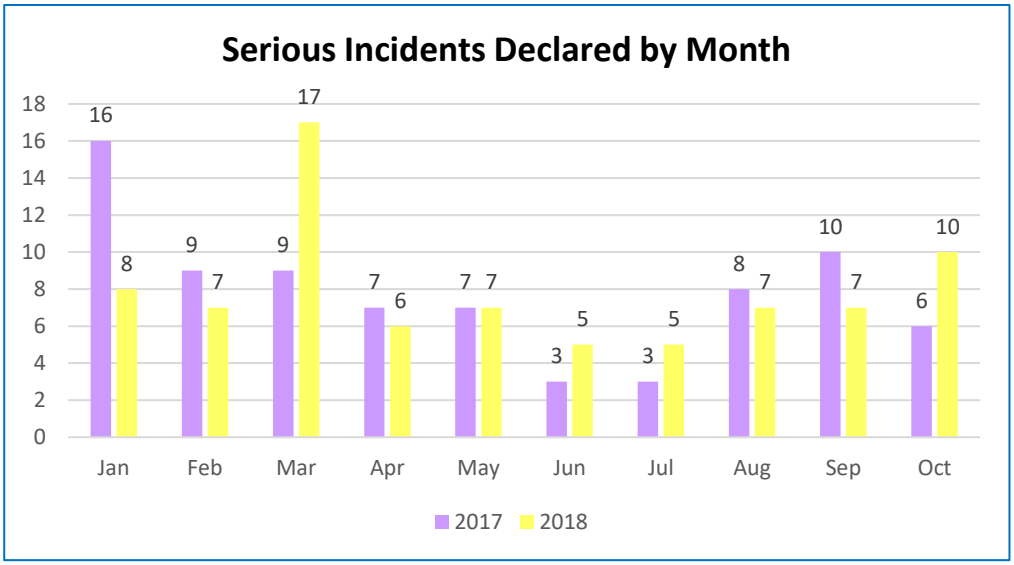


Fig. 1: Serious Incidents Declared/Month

CCG Feedback – October 2018

6. The CCG provide feedback on their review of all SI reports and the Quality Governance Team analyse the themes in order to continually improve the quality of investigations, reports and actions. This in turn decreases the number of queries raised by the CCG which require responses.

7. One issue that the CCG has raised are that some action plans are directed at an individual and not the organisation. LAS were able to respond to these as Trust wide learning is always considered in recommendations and actions, but the contributory factors in these particular incidents were specifically individual issues.

8. There are no overdue responses to CCG queries.

SI Category Themes – October 2018

9. A thematic review of SIs is published quarterly, which provides meaningful information for Trust wide prioritisation, learning and risk management in the last quarter. The last thematic report was produced in early October.

10. This monthly report addresses any specific issues for the SIs closed in October 2018 and the details of the actions taken are in Section 2 of this report.

11. Out of the five SIs, two related to delayed responses due to insufficient resources to meet demand. There were also missed opportunities to upgrade the priority of these

calls as a result of failure to react to “no response to call back”, a second call and failure to contact Careline for further information.

12. One of the SIs related to an Information Governance incident which was the loss of six Patient Report Forms (PRF). The investigation identified issues with the management of PRFs by the crew during the shift and also provision of safe and secure facilities for storage.

13. One SI related to incorrect categorisation of a call to a patient with asthma. The call was coded as a Cat 2 instead of Cat 1. There were also issues with the clinical treatment delivered on site.

14. The final SI related to failure of delivery of 192 safeguarding referrals as they were emailed to a defunct Local Authority email address due to non-compliance with Acceptable Use of Email policy.

Overall SI Action Compliance

15. There are currently 29 SI actions which are overdue, which is significantly higher than the target of <10. There has been an increase in overdue actions over the last 3 months (see Fig 2 below). The Quality, Governance and Assurance team continue to follow up weekly with the responsible managers and provide support where required, and also escalate to senior management as appropriate.

16. The operational restructure has contributed to the number of overdue actions as a result of the changes in responsible managers.

17. It is envisaged that this increase in overdue actions will be addressed effectively and an ongoing trend of increasing overdue actions will not develop.

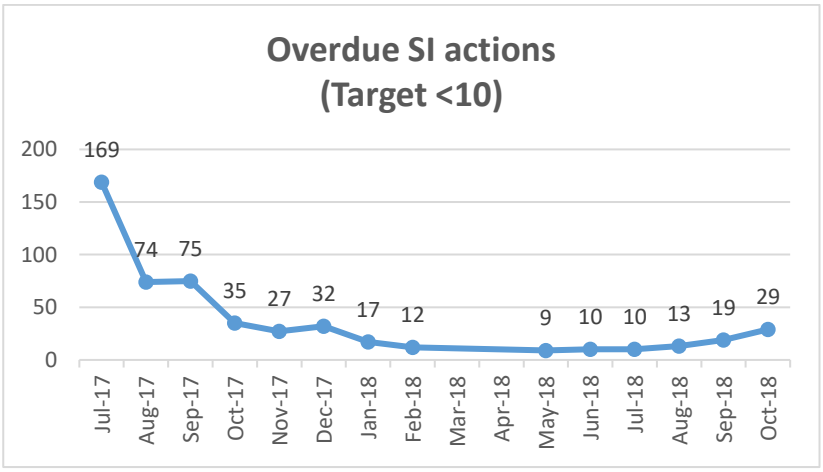


Fig. 2: Outstanding SI Actions by Month

Duty of Candour Compliance – October 2018

18. Duty of Candour (DoC) is a statutory requirement applicable to all SIs within the Trust.

19. In October 2018, six of the ten SIs declared did not receive an initial apology as the Quality, Governance and Assurance Managers were unable to make contact with the patient or their next of kin where appropriate, despite all reasonable efforts being made. These attempts were followed up in writing offering apologies, advising that the incident

had been declared a SI and that an investigation was being undertaken. Contact details were provided for participation in the investigation if desired or to receive updates and outcome of the investigation.

Actions & Assurance

20. The LAS continues to comply fully with the 60 working day deadline for SI report submissions to the CCG.

21. There is a focus on the follow up of SI action completion as there has been an increase in the number which are overdue. The Quality Governance and Assurance Team will continue to monitor and escalate to the relevant senior managers to address the increase and achieve the set KPI of <10.

22. High level reports are presented to individual meetings on a monthly and bi-monthly basis to ensure learning from incidents is considered in proposed changes across the Trust. Examples include the Patient Safety Group, Clinical Standards Working Group, Infection Prevention and Control Committee, Control Services Quality & Business Group, Learning from Experience and Clinical Education and Standards Group.

Dr Patricia Bain
Chief Quality Officer

Serious Incident (SI) Thematic Report
Q2 – 2018/19

Introduction and Background

1. This paper provides an overview of the incidents reported and declared to the CCG and a thematic review of SI's closed by the CCG in Q2. The thematic review is specifically focussed on SI's by category and key contributory factors.

Context

2. During Q2, from a total 887 reported incidents affecting patients, 19 incidents (2%) were declared as SIs. Of these, 3 SI investigations have been submitted to the CCG and are awaiting closure and 1 has been de-escalated. The remaining 15 cases are currently under investigation.

3. 26 SIs in total were closed by the CCG in Q2.

4. The Trust continues to submit SI reports to the CCG within the 60 working day deadline 100% of the time.

5. Significant progress has been made by the Quality, Governance & Assurance team to ensure SI investigations are aligned to key internal milestones. As of September 2018 the Trust has exceeded the Key Performance Indicator (KPI) for the number of SI reports submitted to the CCG <60 working days by 93% (28 against a target of 15).

6. The average time for commissioners to sign off and close a report is currently 51 days (ranging from 17 to 92). The CCG have a target of 20 calendar days to provide comments back to the Trust for clarification or amendment. Any comments referred to the Trust must be answered within 10 working days prior to the CCG agreeing closure of the investigation. During the month of August both the Trust and the CCG experienced difficulty meeting the respective response timeframes. For the Trust it was felt this was affected by annual leave. This position has now been recovered.

7. A number of significant actions have been agreed in response to learning from SI's in Q2 that require oversight to ensure their timely delivery. In response to this the Trust will be introducing an oversight group that will provide assurance to the Quality Assurance Committee on a monthly basis.

Thematic Review
SI's Declared by Sector/STP (comparison Q1 2018/19 – Q2 2018/19)

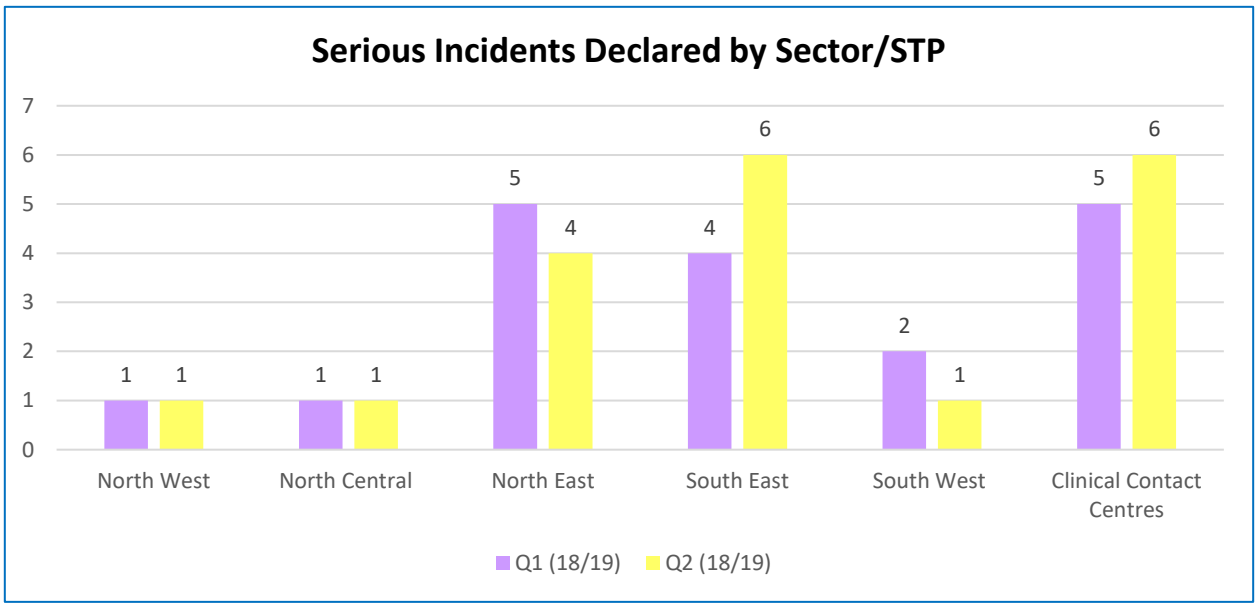


Figure 1

8. Fig 1 illustrates a decrease in serious incidents in the North West and South West sectors, whilst in the South East and Clinical Contact Centres an increase has been observed. There was no change in North Central and North East sectors.

Serious Incidents by CCG – Declared (comparison Q1 2018/19 - Q2 2018/19)

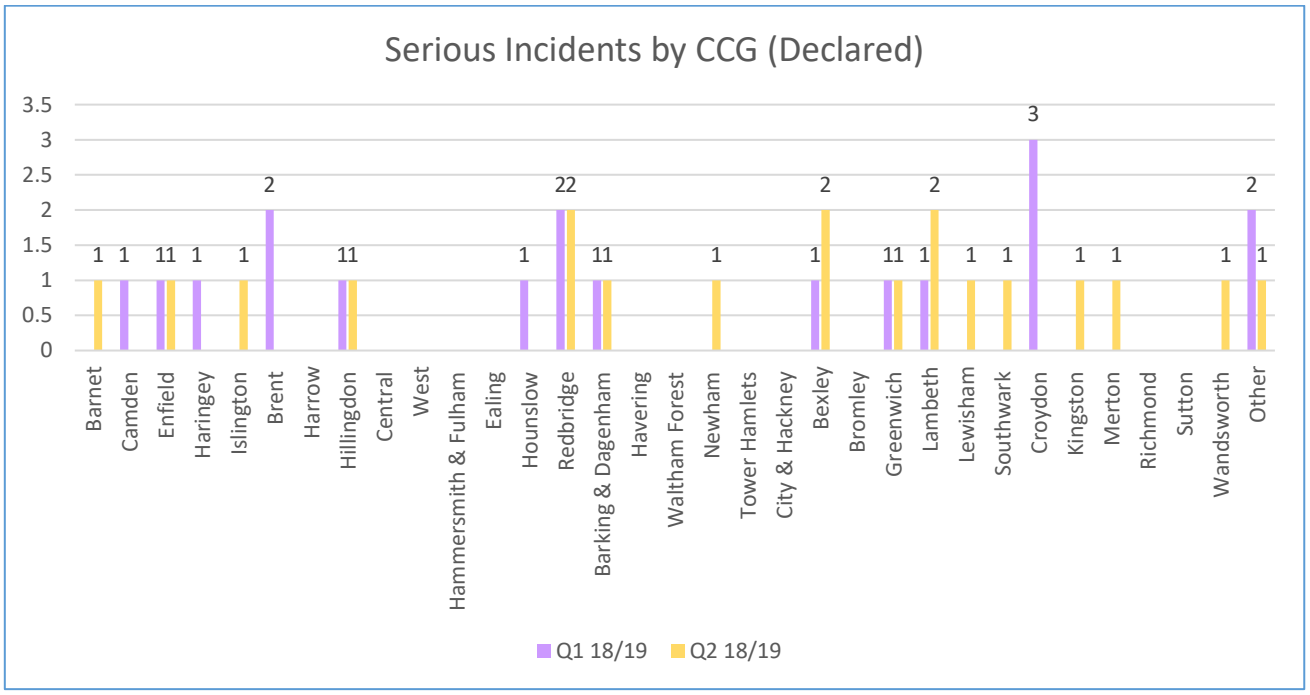


Figure 2

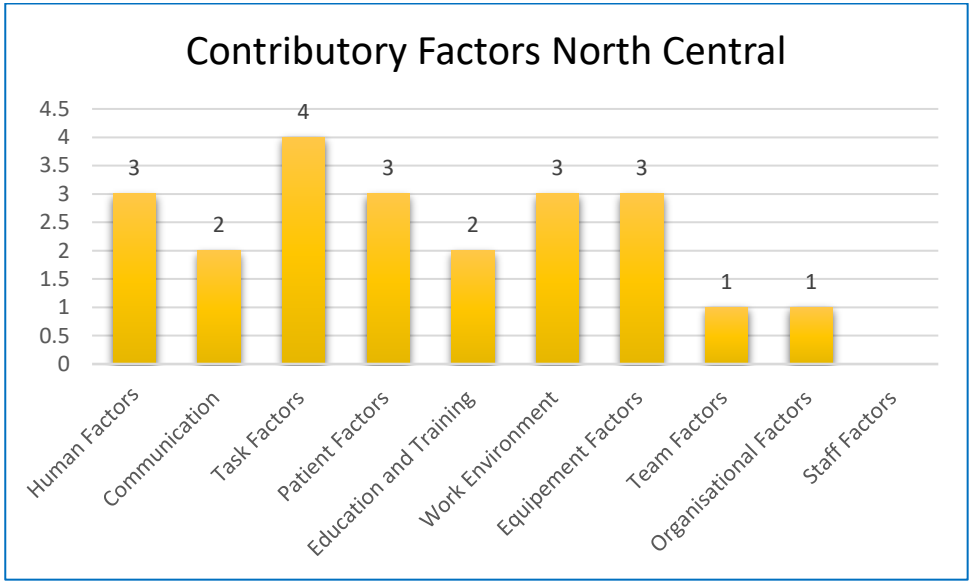
9. Fig. 2 demonstrates the distribution of serious incidents by CCG.

Contributory factors and Declared SI's by Sector/STP

10. The following pages describe the contributory factors in SI's submitted to and closed by the CCG along with a summary of the SI's incident categories that were declared in Q2 (2018/19).

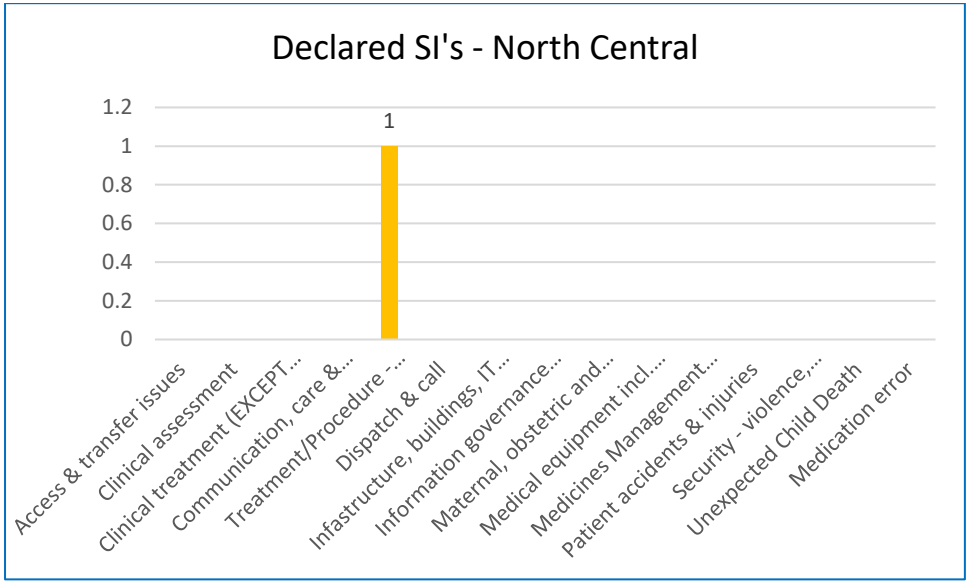
11. It should be noted that the vast majority of SI's declared in Q2 are currently under investigation by the Trust. The summary provided has been obtained from the initial incident report therefore the root cause is yet to be ascertained.

North Central



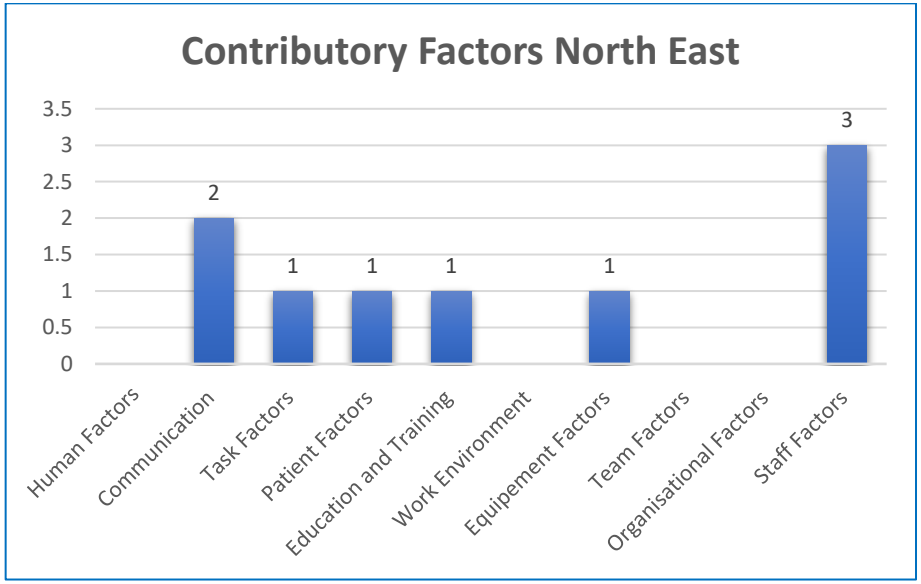
6 SI's were closed by the CCG in Q2. Of these, Task factors were the prevailing contributory factor however Work Environment, Equipment, Task and Human Factors all featured repeatedly in SI reports.

Of the SI reports where Task Factors were a feature, all cited the challenging scenes faced by our staff. This includes the management of critically unwell children whilst attempting to support family members in situations that in other healthcare settings would usually have the support of a significantly higher number of staff with specialist training. In one case the crew omitted to cross check the dosage of adrenaline to treat a paediatric patient in cardiac arrest and inadvertently administered an adult dose. The investigation was clear the error did not cause harm to the patient who was reaching the adult dose age.



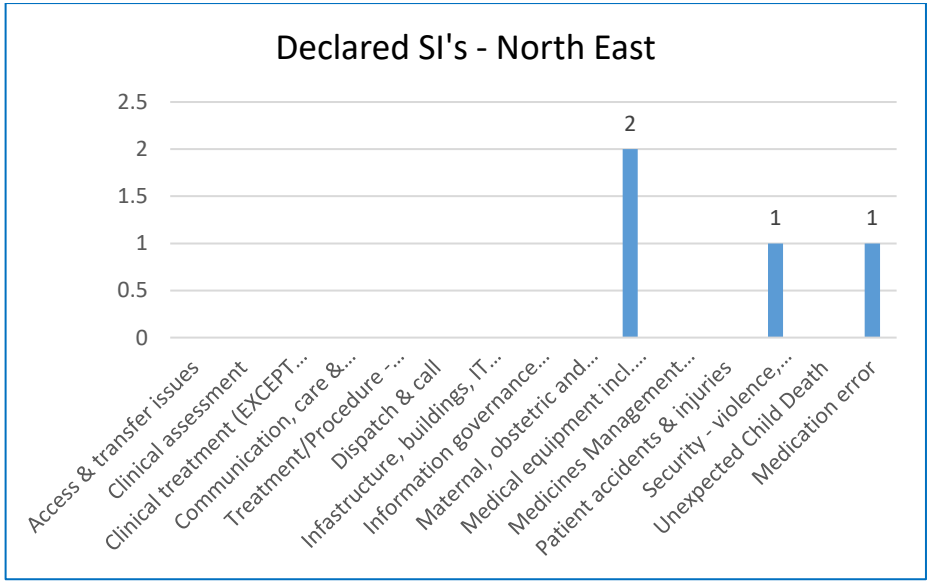
There was 1 SIs declared in the North Central sector in Q2. This case relates to the sudden unexpected deterioration of a patient whilst on board an ambulance. An immediate MDT was undertaken following the declaration of this SI where it was identified the patient was sat in a seat when they suffered a cardiac arrest , unfortunately the crew experienced difficulty lifting and handling the patient and this resulted in a delay to defibrillation. This investigation is still in progress and the contributory factors will be reported in the Q3 thematic report.

North East



Three SIs were completed and submitted to the CCG from the North East sector during Q1.

Of the three staff factors reported; a lack of familiarity and cognitive bandwidth in the clinical scenario faced by the crew was the common theme. In one case a crew attended a patient who had collapsed. On arrival the patient was found in cardiac arrest. The patient's relatives did not speak English and were understandably distressed. Whilst attempt to secure the patient's airway, the paramedic did not observe and remove a foreign body airway obstruction (FBAO). Upon reflection, the paramedic explained they felt inexperienced however it was ascertained by the attending Advanced Paramedic Practitioner (APP) that the FBAO was not visible without specialist equipment. There was no suggestion by the caller or those on scene that the patient may have choked.



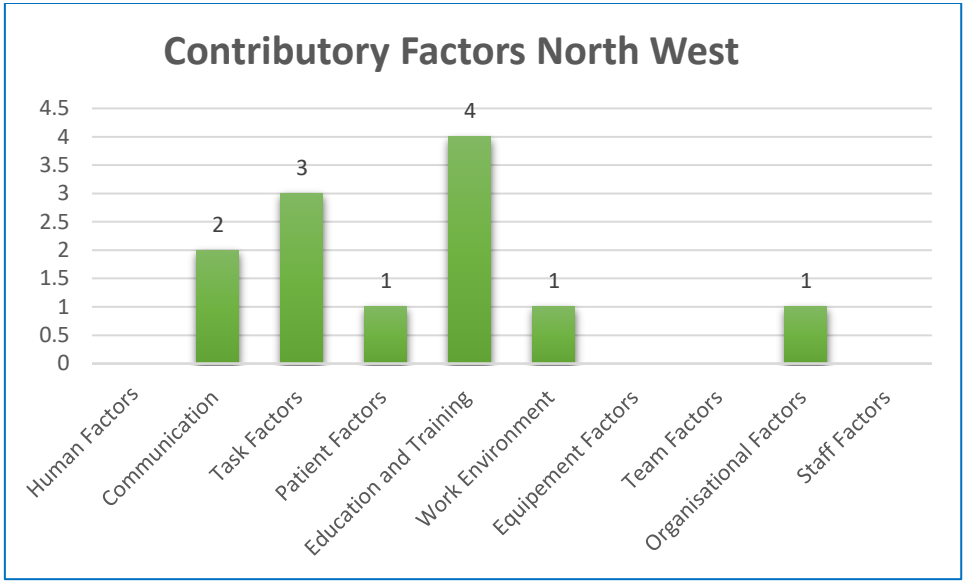
Four SIs were declared within the North East Sector.

One relates to the unauthorised actions of a member of staff. This case was reported to the CQC, CCG, NHSE, NHSI and the police. The final report has been submitted to all interested parties for review and the Trust has responded to a number of clarification questions from the CCG.

Two cases relate to equipment issues during the management of patients in cardiac arrest, one of which was a device used by a third party provider that is not in circulation within the Trust.

The remaining declared SI relates to an epileptic patient who had been fitting for a significant period of time before the LAS were called and who deteriorated whilst in the care of our staff and following the administration of medication to help terminate the seizure activity.

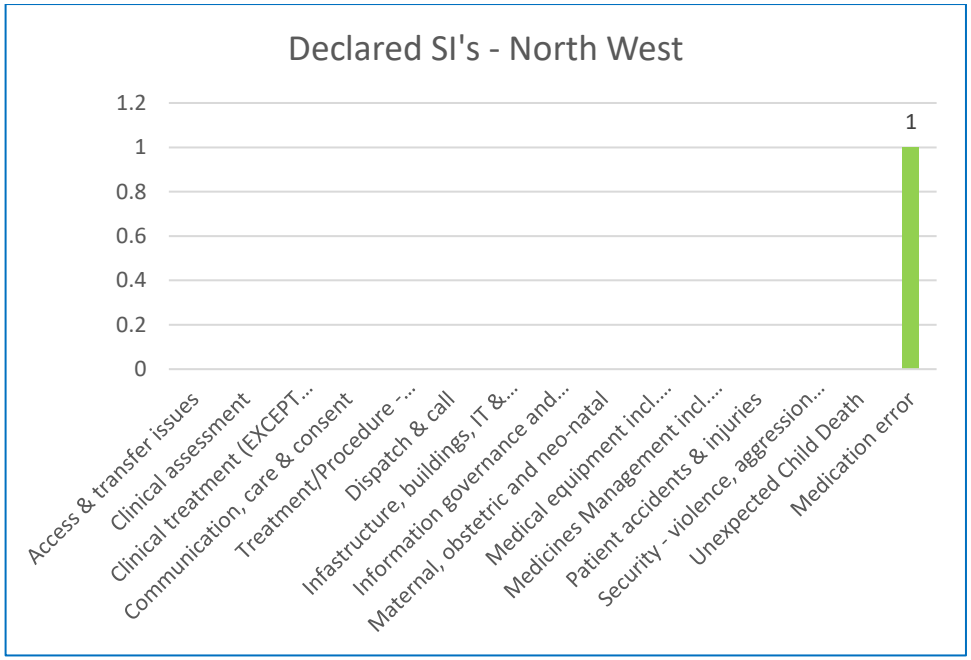
North West



Four SIs in North West were closed by the CCG in Q2.

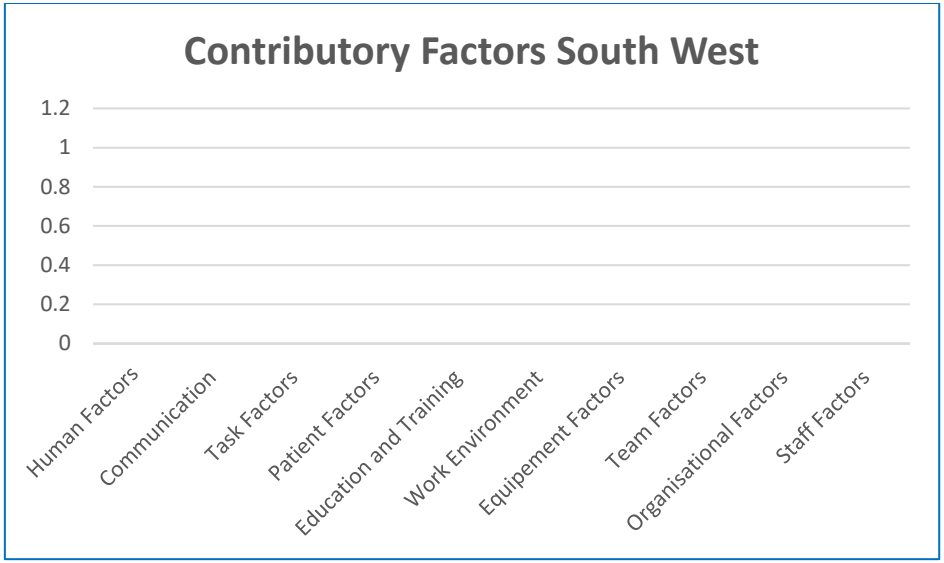
Education and Training and Task Factors were the main contributory factors in SI's closed by the CCG for the North West. Of note was the failure to follow policy and procedure. For example in one case a patient did not fasten their seatbelt before travelling in the ambulance. Following an emergency stop, the patient was injured. The investigation identified that none of the 3 staff on board (2 qualified and 1 trainee) made a concerted effort to ensure the patient was seated securely. Trust policy reflects the Highway Code in that it is the driver's responsibility to ensure that seatbelts are worn when necessary.

Another relates to the failure to immobilise a patient who had fallen and sustained a neck injury.

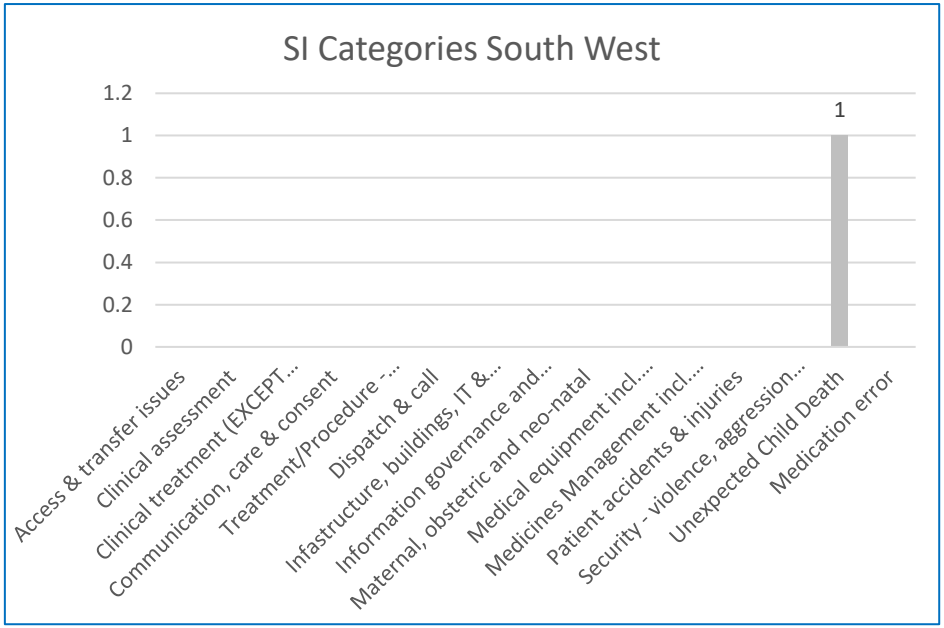


There was one SI declared in the North West which relates to a medication error. In this incident it was reported by the caller the patient was not responding, had a rash and was breathing rapidly. On arrival the crew discovered the patient was actively dying and administered an incorrect dose of medication for the patient's age. An independent clinical opinion was obtained which confirmed that whilst the medication error was outside of ambulance guidelines, it is commonplace in the End of Life Care setting and therefore the crew did not cause harm to the patient. The SI report has been submitted to the CCG for review and we are awaiting their feedback.

South West



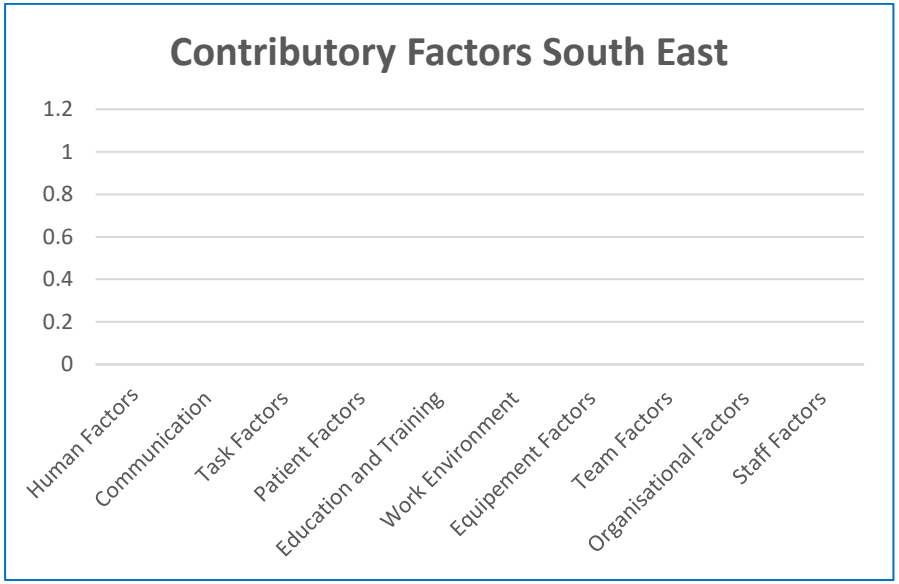
No SI reports in the South West were closed by the CCG in Q2.



One SI was declared in the South West sector for Q2.

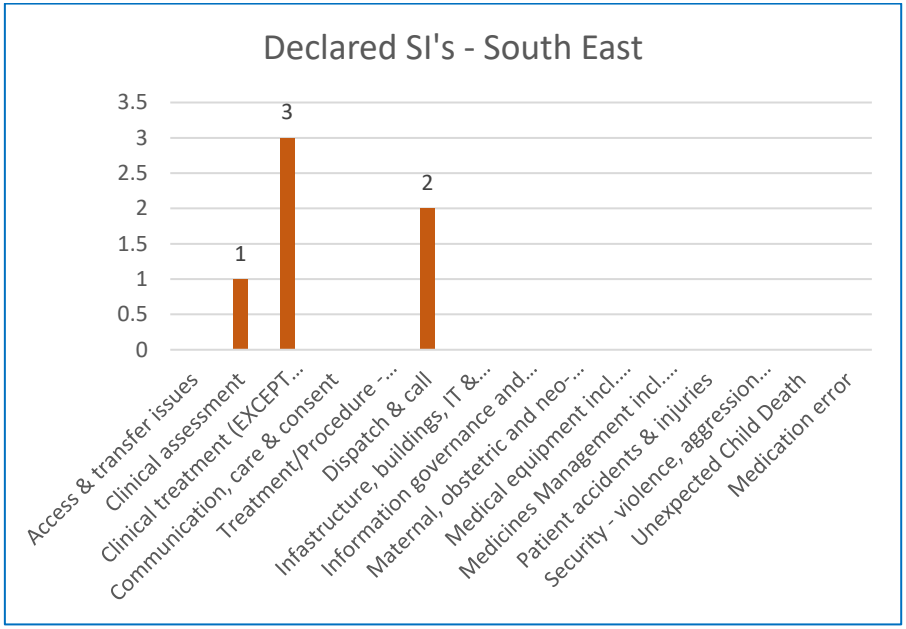
This case relates to a medication error when treating a paediatric patient in similar circumstances to the case closed in North Central. This investigation is currently in progress and will be reported on in the coming months.

South East



One SI relating to activity within the South East was de-escalated by the CCG in Q2. This was in relation to an SI declared on the understanding that there was a missed opportunity to defibrillate Ventricular Fibrillation (VF). Upon interrogation of the device used it was ascertained that the patient was in fact in Pulseless Electrical Activity (PEA) and a shock was not indicated.

There were no other cases closed by the CCG in Q2.



Six SI's were declared in the South East in Q2 and these relate to tow dispatch and call, clinical assessment and clinical; treatment (EXCEPT medication related of patients.

In one case, the crew failed to recognise the extent of the patient's injuries and conveyed them to a general hospital rather than a major trauma centre.

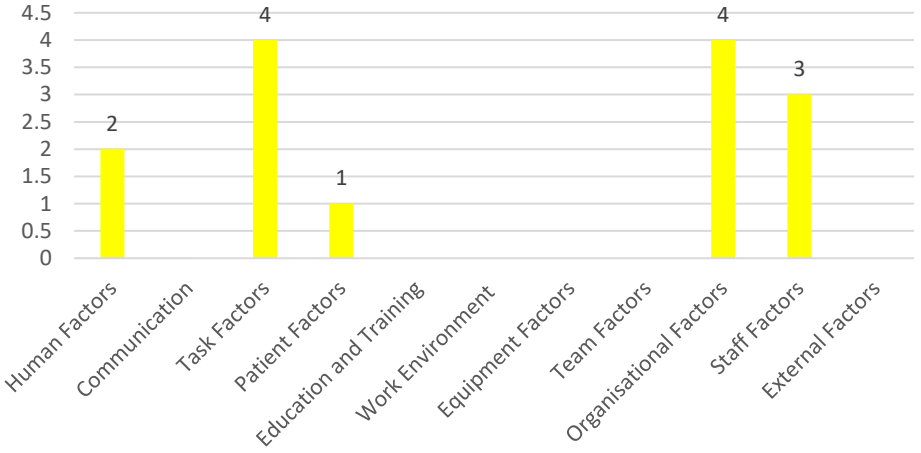
Two relate to a delayed response. One of which was raised by the hospital as a Health Partner Alert.

A further Health Partner Alert from Acute Trust was received querying why the patient was not collared or boarded despite suffering C-spine fractures. This theme is being monitored by the Quality, Governance & Assurance team.

Two relate to the management of patients in cardiac arrest.

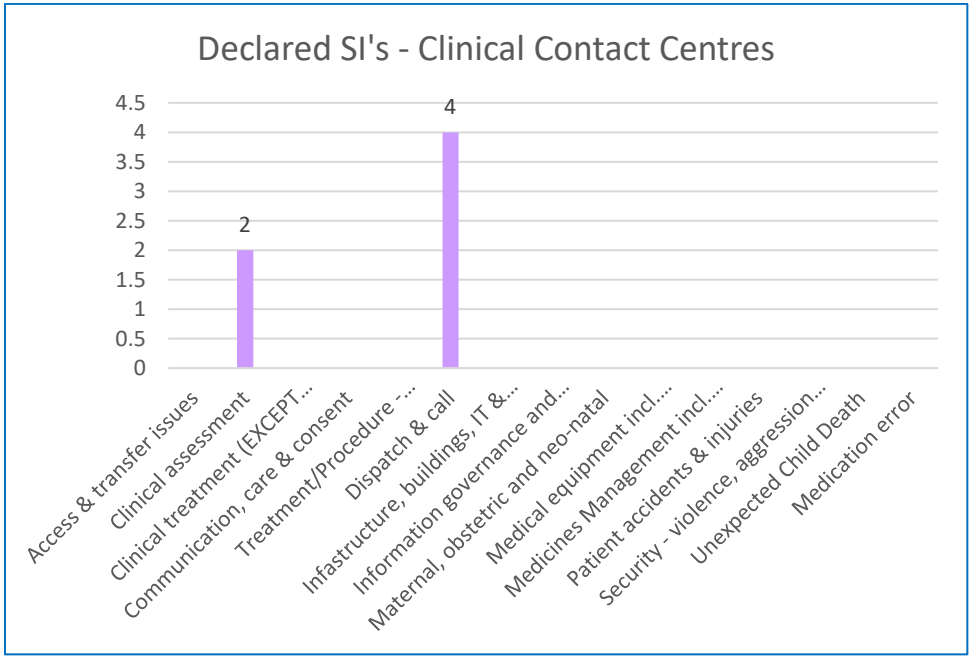
Two of these investigations have been submitted to the CCG for review.

Control Services



13 SI's relating to incidents within our clinical contact centres were closed by the CCG in Q2.

The incidents where Education and Training were highlighted identified a pattern of non-compliance with Trust Policies and had close links with Task factors. For example, the non-compliance with OP/060 (Call Taking Procedure) which instructs Emergency Medical Dispatchers (EMD's) to attempt to convert 3rd & 4th party calls to 1st or 2nd party in order to obtain more accurate information on the patient's condition. This is because callers who are not with the patient are often unable to answer questions fully resulting in a lower priority outcome of the 999 call. Non- compliance with OP/023 (Procedure for dispatch of resources) is also a common theme where guidance on what actions to take when EOC staff receive no reply on ring back is often not followed.



6 SI's were declared in Control Services for Q2. Of these call management, delayed dispatch and failure to follow correct process were common themes.

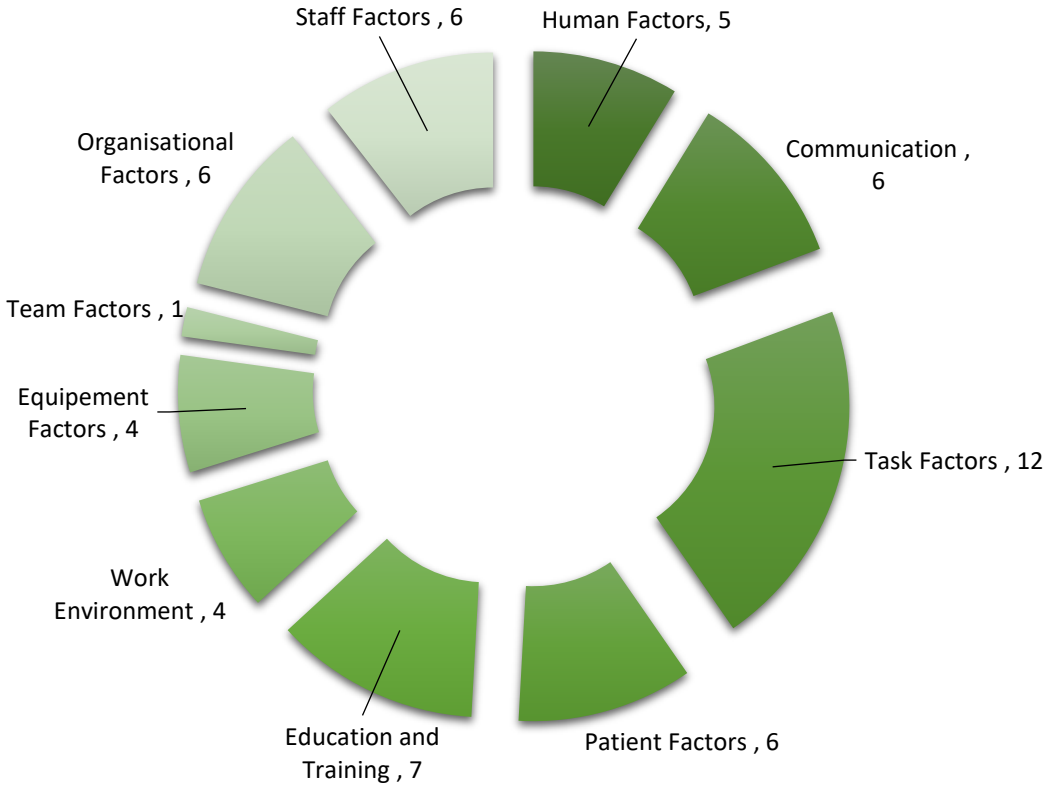
Compliance with pre-triage breathing assessment continues to be a common theme in incidents and serious incidents. A number of actions have already been agreed and implemented in order to reduce the number of incorrectly triaged calls. The latest of which was implemented w/c 8th October and therefore we are yet to understand if this has mitigated future occurrence.

Other cases related to a failure to follow policy.

There were 2 SI's relating to an inadequate/inaccurate clinical assessment by the Clinical Hub. These incidents are currently under investigation.

Overarching Serious Incident Themes

12. The incident theme(s) for the quarter:

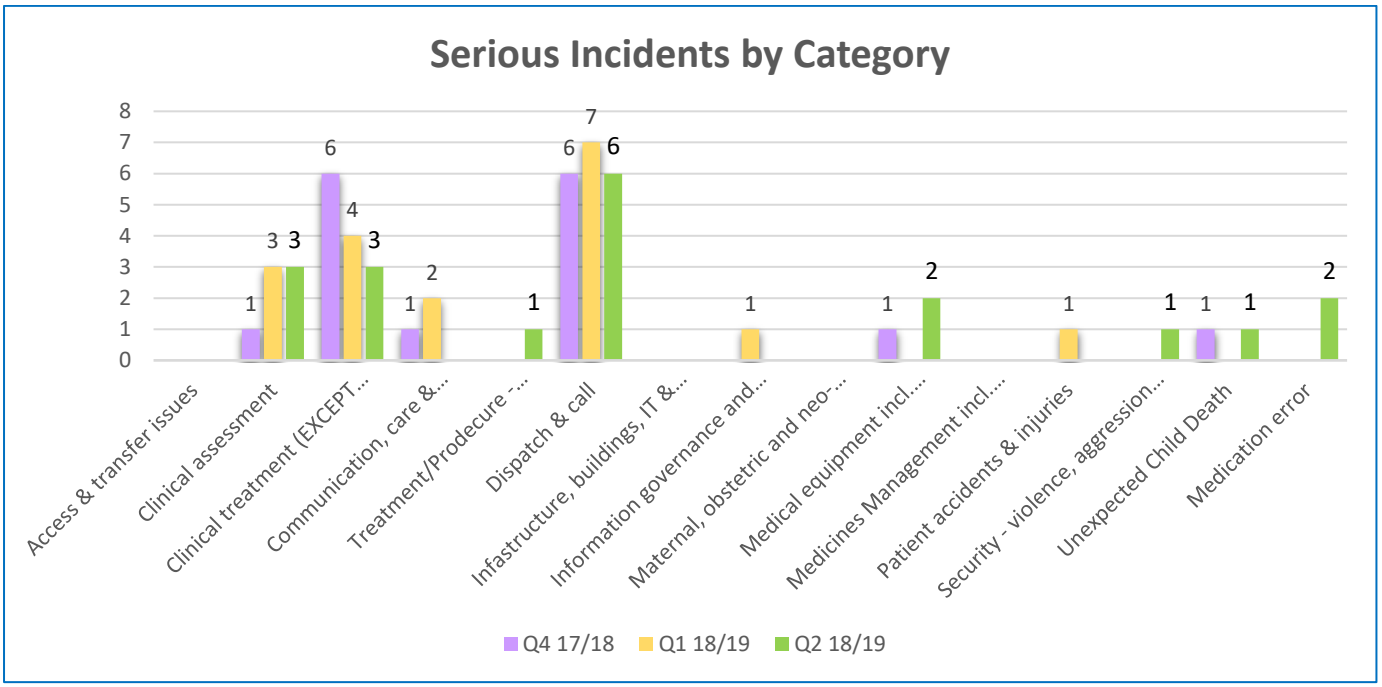


Noted improvements / reductions in incident theme for the quarter

13. Following on from the previous thematic review there has been a further reduction in clinical treatment errors from Q1 (n=4) to Q2 (n=3) and Dispatch & Call errors have also returned to levels previously seen in Q4. However, an increase in the number of incidents related to the pre-triage breathing assessment not being entered correctly by EMD's has been observed and for this reason we are likely to see an increase in this metric in the Q3 report.

Category	Q4	Q1	Q2
Dispatch and Call	6	7	6
Clinical Treatment	6	4	3

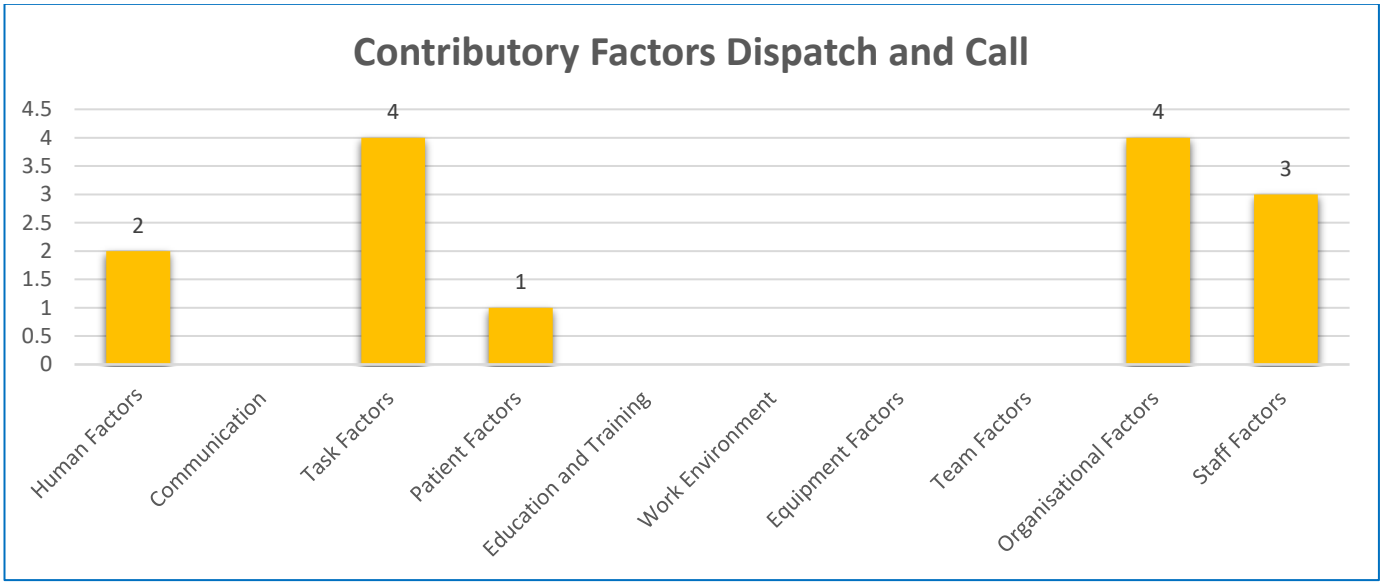
14. The main incident categories identified during Q1 18/19 remain consistent the thematic reviews for Q2, Q3 and Q4 (17/18):



Review of key incident themes

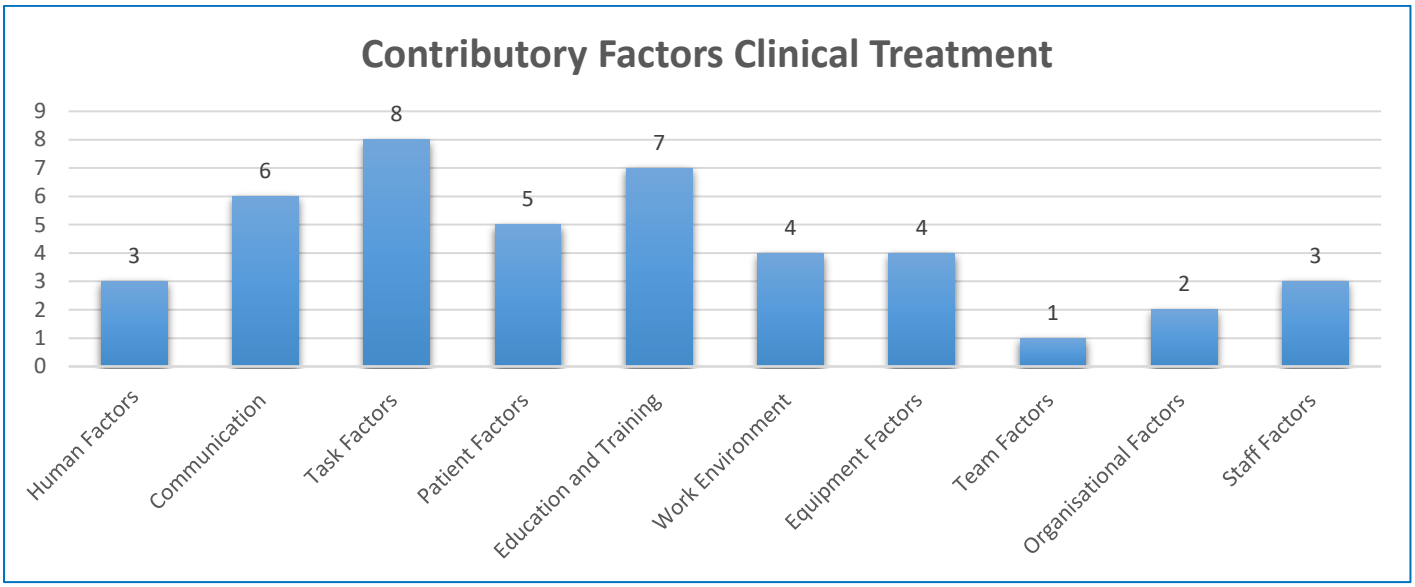
Dispatch and Call

15. A review of the contributory factors that have influenced the root cause of incidents relating to dispatching resources and managing 999 calls highlighted mainly education and training along with staff factors. Failure to follow Trust issued policy and guidance is a recurring theme. There continues to be evidence of non-compliance with the non-reply on ring back section of OP/023 (Procedure for the dispatch of resources by the emergency operations centre) and non-compliance with control services bulletin; Dispatch of Solo Clinicians to Patients With Chest Pain (23rd March 2018).



Clinical Treatment Issues

16. A review of the SI investigations undertaken relating to clinical treatment errors showed that communication, task and education and training factors were the predominant contributory factors that led to the root cause of the incidents.



Staff Factors

17. Issues relating to staff factors typically included:

- Lack of experience in the clinical scenario
- Failure to refer to Trust issued guidance / clinical aide memoires
- Patients condition on arrival found to be different to the expectation of the crew

18. Example: A crew attended a patient with a tracheostomy who deteriorated rapidly. The crew lacked experience both of tracheostomy management and pre-hospital cardiac arrest. This led to errors in care such as not confirming adequate ventilation through chest rise and not referring to national and trust issued guidelines when faced with a challenging and unfamiliar presentation. This case also included a communication factor whereby the crew and the patient's carer did not clearly communicate their roles, experience and concerns at the time. Both staff had recently attended the Core Skill Refresher course that addressed patients with surgical airways.

Education and Training

19. Issues relating to education and training typically included:

- Lack of experience in the clinical condition

20. Example: A nine year old child collapsed with a severe asthma attack and in triaging the call, the call-taker failed to appreciate how dangerous this condition is. Training will look at increasing familiarity with asthma and breathe sounds.

Work Environment

21. The work environment factor now encompasses issues such as lack of staff and poor skill mix, as well as work load/hours of work in line with the NPSA framework.

22. Example: Ring backs by EMD's and clinicians in the CHUB are either delayed or do not occur because

there are not enough staff on duty or staff are re-deployed to other roles in order to provide additional resource to meet changes in demand i.e. staff who would normally undertake ring backs of held calls moving to a call taking function when incoming call demand increases.

Horizon Scanning

23. This quarter saw the publication of a number of reports of interest to the Service:

- Lord Carter review
- The Ambulance Response Programme Review

24. Copies of these are available from the QGA Team.

Delayed Response to Patients

25. Following the introduction of the new national ambulance standards (Ambulance Response Programme or ARP) on 1st November 2017 the Trust observed a number of incident reports relating to a perceived delayed response to patients with chest pain from two specific Medical Priority Dispatch System (MPDS) determinants (10D2 and 10D4), where upon patient assessment by our crews, were either found in cardiac arrest or having suspected heart attacks. In addition, the London Heart Attack Centres also raised their concerns that the time it was taking for heart attack patients to reach specialist care had also increased.

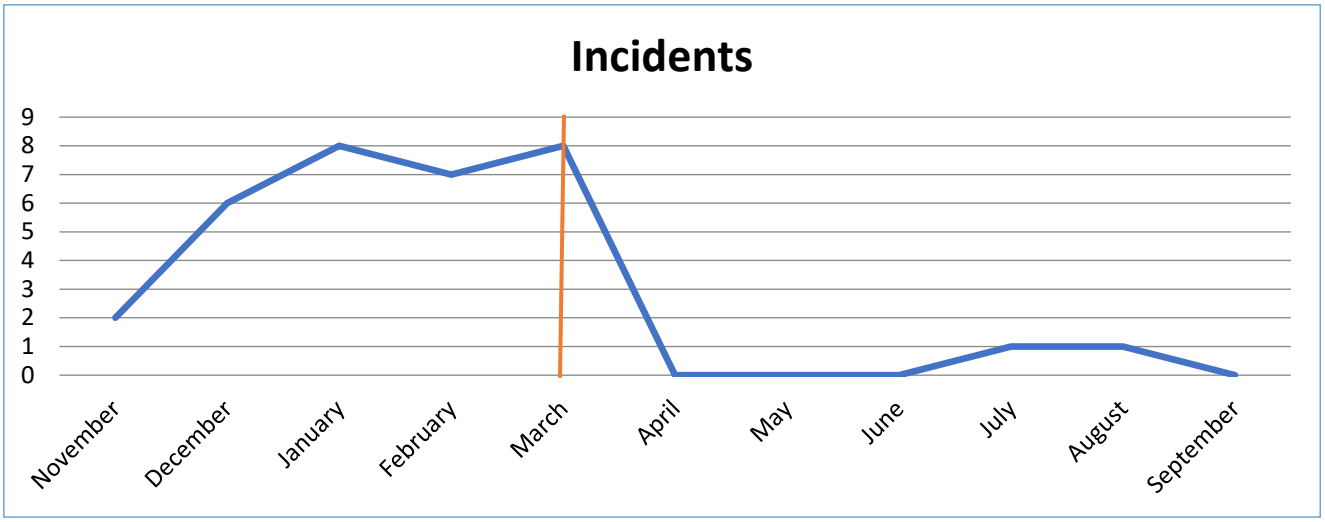
26. Prior to the introduction of ARP, these determinants would have attracted an 8 minute response (Category A). These would be first attended by a Fast Response Unit (FRU) who would undertake an initial assessment and be followed up by a Double Crewed Ambulance (DCA). If the FRU found the patient was in a time critical condition, they would have been able to contact the control room to ask for a DCA to be dispatched as a priority.

27. Following the introduction of ARP, these two determinants were moved to an 18 minute mean response timeframe with calls to be attended within 40 minutes, 90% of the time (Category 2). Category 2 calls require the attendance of a conveyable resource only and therefore are not first attended by an FRU. As the Trust fleet ratio at the time was not aligned to the demand profile of ARP, it was felt that some Category 2 calls received a response that did not meet the patient's clinical needs.

28. This issue was presented to the Serious Incident Group on 21 March 2018 and an immediate mitigating action was agreed whereby if a DCA has not been dispatched within 8 minutes that an FRU will be dispatched to assess the patient and update the control room.

29. This change was introduced to the Trust Computer Aided Dispatch System, CommandPoint™ on 27 March 2018. Since its introduction, incident reports have been monitored by the Quality, Governance & Assurance team for its effectiveness in protecting the safety of our patients.

30. The below graph demonstrates incident reporting levels from the introduction of the new ambulance standards (November 2017) to today. The data (whilst small in comparison to the number of calls received) clearly demonstrates the effectiveness of the action in protecting the safety of our patients.



Conclusion

31. The key contributory factors identified across the Trust in Q2 are;

32. We continue to maintain our target of 60 working days to submit completed SI investigations. SI action plan compliance is monitored weekly by the Quality Governance and Assurance Team. Any concerns are escalated to the Chief Quality Officer where required. We will shortly be introducing a Serious Incident Action Assurance Group for improved oversight.

33. We have evidenced that interventions identified from themes from pervious investigations have been used to influence change within the organisation, namely the dispatch profile for particular MPDS determinants.

34. The Quality Governance and Assurance Team will continue to analyse and monitor themes via the Serious Incident Group and assurance processes, and are now actively working on disseminating learning from incidents by a number of methods across the organisation.

Dr Trisha Bain
Chief Quality Officer

London Ambulance Service NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	CARU Annual Reports			
Agenda item:	16			
Report Author(s):	Clinical Audit and Research Unit			
Presented by:	Fenella Wrigley, Medical Director Rachael Fothergill, Head of Clinical Audit & Research Gurkamal Francis, Assistant Head of Clinical Audit & Research			
History:	Presentation to the Quality Assurance Committee on 20/11/18			
Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

Stroke Annual Report 2017-18

The summary presents information regarding the care provided to suspected stroke patients during 2017/18. The report shows that the LAS has continued to provide excellent care to stroke patients in London. We provided a comprehensive on-scene clinical assessment of patients, and ensured that nearly all patients were transported to an appropriate destination.

Cardiac Arrest Annual Report 2017-18

The summary presents information regarding the clinical care and outcomes of cardiac arrest patients attended by the LAS during 2017-18. The report shows that there has been an increase in the ROSC sustained to hospital rates for patients where resuscitation was attempted and the Utstein comparator group (32.5% and 56.6% respectively). The overall survival rate has had a marginal decrease of 0.1% to 9.4% but the Utstein survival rate has increased to 31.9%.

STEMI Annual Report 2017-18

The summary document presents information regarding the clinical care and outcomes of ST Elevation Myocardial Infarction (STEMI) patients attended by the LAS during 2017-18. The report shows that the LAS continues to maintain a high standard of care for STEMI patients, with a good level of pain assessment, and treatment using aspirin and GTN. The LAS recognises that, for the care bundle provision to improve, a greater focus on delivering appropriate analgesia to patients is needed. We have continued to demonstrate excellent compliance to specialist conveyance pathways. Our outcomes show that patients continue to receive pPCI treatment well within the national time targets

Recommendation(s):

The Board is asked to note the reports.

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	☐

Stroke Annual Report 2017-18 - Key findings

1. From 1st April 2017 to 31st March 2018, the LAS treated 12,165 patients, aged 16 years or over, presenting with symptoms of stroke as identified by the Face, Arm and Speech Test (FAST). This summary provides key findings of the care delivered to this patient group.

Response Times

2. On 01 November 2017, the Ambulance Response Programme (ARP) introduced new standards for ambulance categorisation and response. Prior to ARP, the majority of calls (76%) were allocated a Red 2 response. Following the implementation of ARP, Category 2 was allocated to 80% of calls.

3. During the pre-ARP period, the mean response time for any vehicle to arrive was 14 minutes, with a median time of 8 minutes.

4. Post-ARP, the mean response time from clock start to arrival of an appropriate response was 27 minutes, with a median time of 16 minutes.

5. Comparing the time taken for a vehicle capable of transporting a patient to arrive on scene, the pre-ARP mean response was 23 minutes and the post-ARP mean response was 26 minutes.

On-scene Times

6. The mean on-scene time (first attending vehicle arriving - transporting ambulance leaving) was 34 minutes, and the median time was 30 minutes. This is an improvement of 2 minutes from the previous year (36 minutes and 32 minutes respectively).

7. When measured from arrival of the first conveying vehicle, the average on-scene time was 29 minutes and the median time was 26 minutes. This is consistent with last years' findings.

Journey times

8. The average journey time to hospital for all patients was 18 minutes.

9. The average length of time from the 999 call to arriving at a HASU time was 72 minutes.

10. For patients with a symptom onset within 4.5 hours, the average time from call to HASU arrival was 10 minutes faster, at 62 minutes. This is consistent with last year's findings.

Care Bundle Compliance

11. The care bundle consists of a complete FAST assessment, plus blood glucose and blood pressure monitoring.

12. Overall compliance to the full care bundle was very high at 96.8%.

13. A complete FAST was recorded for 97.9% of patients. Blood glucose was measured for 99.1% and blood pressure for 99.4%.

Conveyance

14. The majority of stroke patients (99.6%) were conveyed to the most appropriate destination, which is consistent with last year.

15. 51 patients (0.4%) were conveyed to an ED when they should have been transported to a HASU. Details of these cases have been shared with local teams for further investigation and feedback.

Summary

16. The LAS has continued to provide excellent care to stroke patients in London. The LAS provided a comprehensive assessment as demonstrated by the excellent care bundle compliance and ensured that nearly all patients were transported to an appropriate destination. Improvements need to be made to reduce on-scene times and further increase the completeness of the FAST.

17. For detailed information, including improvement initiatives, please see the full annual report.

Cardiac Arrest Annual Report 2017-18 - Key findings

1. From 1st April 2017 to 31st March 2018, the LAS attended 10,654 out-of-hospital cardiac arrests and attempted to resuscitate 4,389 (41%) patients. This summary provides key findings of the care delivered to patients for whom resuscitation was attempted.

Response times

2. On 01 November 2017, the Ambulance Response Programme (ARP) introduced new standards for ambulance categorisation and response. During the pre-ARP period, 67% of calls were allocated the highest priority Red 1 response (with 26% Red 2). Following the implementation of ARP, 73% of calls were allocated to the highest life threatening response of Category 1.

3. During the pre-ARP period, the mean response was 7 minutes for patients allocated a Red call.

4. Post-ARP, the mean response time was 7 minutes for patients allocated to Category 1.

5. For all cardiac arrest patients the mean time taken for a response to arrive was 7 minutes overall.

Bystander information

6. Both bystander witnessed and bystander CPR rates were the highest observed over the last ten years.

7. 50% of cardiac arrests where resuscitation was attempted were bystander witnessed.

8. 65% received bystander CPR.

Public Access Defibrillation (PAD)

9. In 107 cases, a member of the public deployed a PAD, and one or more shocks were delivered to 79 patients.

10. When a PAD shock was delivered, the ROSC sustained to hospital rate was 65% (a 3% decrease from last year).

11. The survival to hospital discharge rate for patients where a shock was delivered was 51%, which is a slight decrease of 0.5% from last year.

LAS interventions

12. The average time from 999 call to LAS CPR was 9 minutes; and to LAS defibrillation was 11 minutes.

13. Resuscitation was terminated on-scene for 44% of patients, a decrease of 3% from last year.

14. 56% of patients were conveyed to hospital with either a return of spontaneous circulation (ROSC) or ongoing CPR. Of these, 78% were conveyed to an Emergency Department and 22% were conveyed to a Heart Attack Centre.

Outcomes

15. This year we report the highest ROSC sustained to hospital rate for patients where resuscitation was attempted. ROSC was sustained to hospital was 32.5% (n=1,428/4,389). This represents a 3.1% increase from last year (29.4%).

16. For the Utstein comparator group, ROSC sustained to hospital arrival rose to 56.6% (n=335/592) from 54.5% in 2016/17.

17. 9.4% (n=402/4,292) of patients where resuscitation was attempted survived to be discharged from hospital; a marginal decrease of 0.1% from the previous year.

18. The Utstein survival rate was 31.9% (n=182/571) representing an increase of 2.4% from 2016/17.

Defibrillator downloads

19. Downloads of the electronic clinical files from defibrillators increased to 14% (from 9% last year). This remains an area requiring improvement.

Summary

20. Our improved ROSC sustained to hospital and Utstein survival rates reflect the ongoing efforts of a wider system. The increased bystander witnessed and CPR rates is a commendable achievement by members the public. We have continued to provide a rapid response allowing for early interventions to successfully resuscitate patients' on-scene prior to conveyance to hospital for ongoing treatment.

21. For further information, including improvement initiatives undertaken during the year, please see the full annual report.

ST Elevation Myocardial Infarction (STEMI)
Annual Report 2017-18 Key findings

1. From 01 April 2017 to 31 March 2018, the LAS treated 3,536 patients who were experiencing a suspected STEMI. This summary provides key findings of the care delivered to this patient group.

Response Times

2. On 01 November 2017, the Ambulance Response Programme (ARP) introduced new standards for ambulance categorisation and response. Prior to ARP, the majority of calls (84%) were allocated a Red 2 response. Following the implementation of ARP, Category 2 was allocated to most calls (80%).

3. During the pre-ARP period, the average response time (any vehicle) was 10 minutes, with a median time of 7 minutes.

4. Post-ARP, the average response time was 22 minutes from clock start to arrival of an appropriate response. The median time was 14 minutes.

5. Comparing the time taken for a vehicle capable of transporting a patient to arrive on scene, the pre-ARP mean response was 20 minutes and the post-ARP mean response was 25 minutes.

On-scene Times

6. The average on-scene time from the first attending vehicle arriving to the transporting ambulance leaving scene, has decreased by 2 minutes to 41 minutes.

7. The average time from the first conveying vehicle arriving on-scene to the transporting ambulance leaving scene was 35 minutes (1 minute longer than last year).

Care Bundle Compliance

8. The care bundle consists of the appropriate administration of aspirin, GTN and analgesia, plus two pain assessments (before and after treatment).

9. 74% of patients received all elements of the care bundle or had a valid exception (an increase of 1%).

10. The administration of aspirin and GTN saw high levels of compliance at 97%, as did pain assessment (96%).

11. However, analgesia administration (morphine and/or Entonox) decreased to 75% (from 81% last year).

12. 25% of patients in pain did not receive analgesia (or had an exception), and over a third of these reported they were in severe pain.

Conveyance and Outcomes

13. Over 99% of patients were conveyed to the appropriate destination.

14. A diagnosis of STEMI was confirmed at hospital for two-thirds (67%) of patients.

15. The majority of hospital-confirmed STEMI patients (89%) received pPCI treatment

16. The average call-to-balloon time was 127 minutes, within the national target of 150 minutes.

Summary

17. The LAS continues to maintain a high standard of care for STEMI patients, with a good level of pain assessment, and treatment using aspirin and GTN. The LAS recognises that, for the care bundle provision to improve, a greater focus on delivering appropriate analgesia to patients is needed. We have continued to demonstrate excellent compliance to specialist conveyance pathways. Our outcomes show that patients continue to receive pPCI treatment well within the national time targets.

18. For detailed information, including improvement initiatives, please see the full annual report.

Fenella Wrigley
Medical Director

London Ambulance Service
NHS Trust

Stroke Annual Report 2017/18

November 2018

Produced by:

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Contents

London Ambulance Service
NHS Trust

Stroke Overview | 2017-18

Patients

12,165

Total number of suspected stroke

47% 69 years

53% 72 years

Care Bundle

F A S t

98%

99%

99%

=

97%

Conveyance

99%

Appropriately triaged to a HASU

Timings

999 call to arrive scene

22 mins

Overall on-scene

34 mins

Journey to HASU

18 mins

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1 Introduction

From 1st April 2017 to 31st March 2018, the London Ambulance Service NHS Trust (LAS) attended 12,165 patients over the age of 16 who presented with symptoms of stroke as identified by our clinicians using the Face, Arm and Speech Test (FAST).

As part of the on-scene assessment, our clinicians complete the pre-hospital care bundle for suspected stroke patients: FAST, and measuring the blood pressure and blood glucose. In addition, staff will attempt to establish the time at which the patient's symptoms started as this will help determine the continuing care delivered at hospital.

Suspected stroke patients are conveyed to one of eight specialist hyper-acute stroke units (HASUs) in London for a Computerised Tomography (CT) scan and treatment as needed. Thrombolysis is one of the treatments available to patients where the stroke has been caused by a blood clot obstructing blood flow to the brain. Thrombolysis is most effective when administered early and the optimum timeframe is within 4.5 hours. As such, a pre-alert call is placed for patients who are conveyed within 4.5 hours of symptom onset to expedite their care by the specialist stroke team on arrival at the HASU. These patients are considered as potentially eligible for thrombolysis reperfusion treatment.

Data for this report was sourced from the LAS Suspected Stroke Registry, which holds clinical information collected from the LAS Patient Report Forms (PRFs), and operational details from the emergency call logs and vehicle Mobile Data Terminals (MDTs).

2 Findings

2.1 Patient demographics

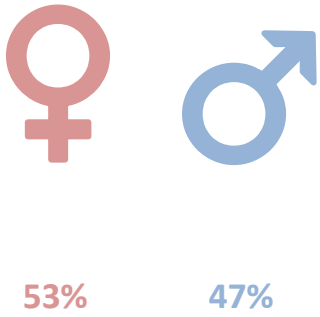

Figure 1: Gender

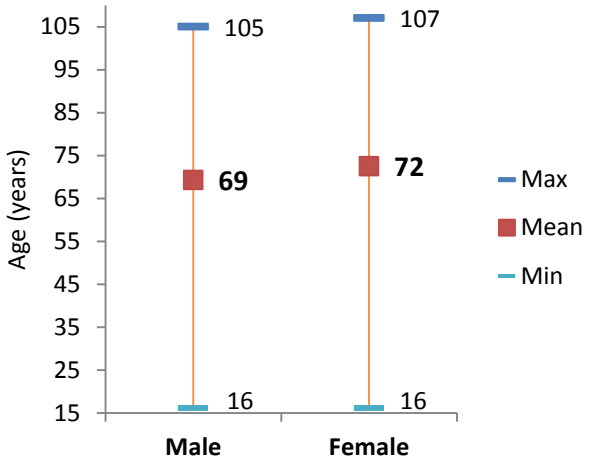

Figure 2: Age by gender

- Just over **half** (n=6,382, 53%) of patients were **female**.
- The mean age was **71 years**, with males being on average 3 years younger than females.

2.2 Call information

Emergency Medical Dispatchers (EMDs) will triage emergency calls based on the information provided by the caller. To help identify stroke patients as early as possible, EMDs will undertake a FAST assessment over the phone.

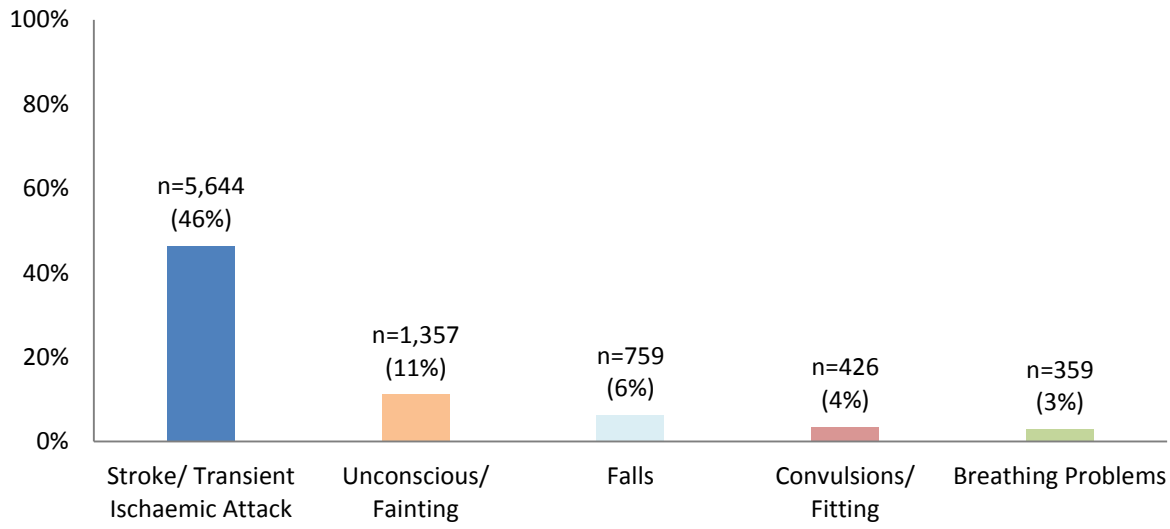

Figure 3: Top 5 chief complaints from emergency calls from members of the public

- **80%** (n=9,732) of calls were from members of the **public**. Just under **half** of patients (46%) were identified as suffering a **stroke** at the point of the 999 call.
- **Healthcare professional** admissions (n=1,121) and **111** transfers (n=1,312) accounted for **20%** (n=2,433) of calls.

2.3 Response information

On 1st November 2017 the LAS implemented the new national standard for call categorisation and associated response times as defined by NHS England's Ambulance Response Programme (ARP). As the new standards redefined response categories and the way response times are measured, this section is divided into two parts representing performance against the previous definitions (pre-ARP) and the new standards (post-ARP).

2.4.1. Pre-ARP (1st April 2017 – 31st October 2018)

During this period, calls were categorised as Red or Green calls. The highest priority (Red) response category was sub-divided into Red 1 and Red 2 (with Red 1 indicating those incidents which were immediately life-threatening). Red 1 responses were measured from the time the call was connected by the operator. The remaining categories allowed a period of time for information gathering by the EMD in order to assign the most appropriate response to each patient. For all categories, the clock stopped when the first resource arrived on scene. Red calls had a national target of 75% of patients receiving a response within 8 minutes.

Category ^	n (%)	Response time, minutes		
		Mean	Median	90th Centile
Red 1	81 (1%)	8	7	14
Red 2	4,855 (76%)	8	7	14
Green	1,427 (22%)	33	20	74
Overall◊	**6,363**	**14**	**8**	**26**

^ Healthcare Professional Admissions are excluded from response time figures.

◊ Total does not add up to 100% due to rounding.

Table 1: Category by response time (Pre-ARP)

2.4.2. Post-ARP (1st November 2018 – 31st March 2018)

From 1st November 2017, calls were categorised into four groups from Category 1 for 'life-threatening illnesses or injuries' such as cardiac arrest through to 'less urgent conditions' in Category 4. For each category, the response time is measured using a set of rules that define the point at which the clock starts and the type of resource that is required to arrive on scene for the clock to stop (see below).

Category	Response standard (mins)		Definitions
	Mean	90th centile	
Category 1 (Life threatening)	7	15	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 30 seconds from the call connecting. Clock stop The arrival of the first LAS resource (whether a solo responder or an ambulance).
Category 2 (Emergency)	18	40	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 240 seconds from call connect Clock stop The arrival of the first LAS vehicle able to transport the patient to hospital.
Category 3 (Urgent)	120 (maximum time)		
Category 4 (Less urgent)	180 (maximum time)		

Category ^	n (%)	Response time, minutes		
		Mean	Median	90th Centile
Category 1	244 (5%)	9	7	14
Category 2	3,739 (80%)	21	15	41
Category 3	563 (12%)	65	36	157
Category 4	134 (3%)	63	52	118
Overall #	**4,681**	**27**	**16**	**53**

^ Healthcare Professional Admissions are excluded from response time figures.

 # Category was not available for one incident.

Table 2: Category by response time (Post-ARP)

- In the pre-ARP period, **three-quarters** of calls were categorised as requiring a **Red 2** response.
- Under the new ARP standards, the **majority** (80%) of calls were allocated a **Category 2** response.
- Stroke patients received a mean response of **14** minutes prior to ARP, with a median time of 8 minutes.
- The post-ARP mean response was **27** minutes from clock start to arrival of an appropriate response. The median time was 16 minutes.
- Comparing the time taken for a vehicle capable of transporting a patient to arrive on scene, the pre-ARP mean response was 23 minutes and the post-ARP mean response was 26 minutes.

2.4 On-scene times

The type of response dispatched to the scene by the LAS is based on the response category allocated. The highest priority patients will often receive a solo responder (i.e. a car, motorbike, cycles) to initially assess and treat the patient, followed by an ambulance that can convey the patient to hospital. Lower priority patients may still receive a solo responder but the aim is to dispatch an ambulance that can treat and convey the patient.

From the arrival of:	On-scene time, minutes ^		
	Mean	Median	90th Centile
First attending vehicle	34	30	52
First conveying ambulance	29	26	44

^ Non-conveyed patients (n=45) are excluded from on-scene time figures.

Table 3: On-scene times

- The overall mean **on-scene** time was **34 minutes** and the median time was 30 minutes, which is an improvement on last year by 2 minutes.
- When measured from arrival of the first ambulance vehicle, the mean on-scene time was 29 minutes. The median time was 26 minutes, which remains consistent with last year.

2.5 Patient assessment and care

2.5.1 Time of onset

Time of symptom onset	n (%)
Within 4.5 hours	7,584 (62.3%)
Over 4.5 hours	1,979 (16.3%)
Unknown	2,587 (21.3%)
Not documented	15 (0.1%)

Table 4: Onset of symptoms

- Documentation of the **symptom onset time is 99.9%**, an increase of 0.1% from 2016/17.
- Nearly **two-thirds** of patients had a **symptom** onset **within 4.5 hours** making them potentially eligible for thrombolysis.

2.5.2 Care bundle compliance

The care bundle includes the completion of all components of the Face, Arm and Speech Test, measurement of blood glucose and blood pressure.

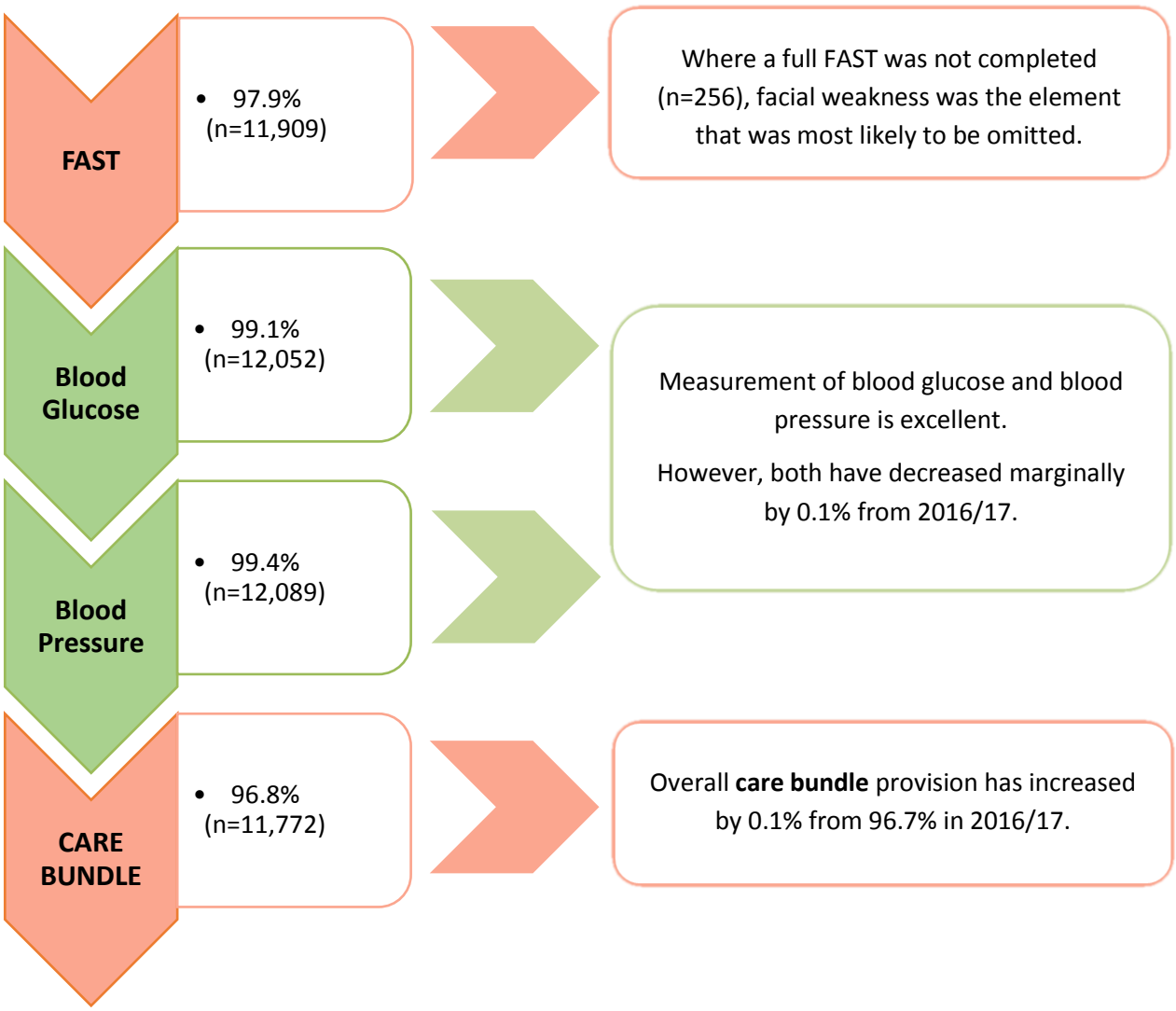

Figure 4: Care bundle administration

2.6 Conveyance

Stroke patients in London can be conveyed to a Hyper Acute Stroke Unit (HASU) for specialist care. In some instances the patient may be conveyed to an Emergency Department (ED) if the patient's condition is considered unstable by LAS clinicians or if a Health Care Professional has arranged admission at a hospital without HASU facilities.

2.6.1 Destination of patients

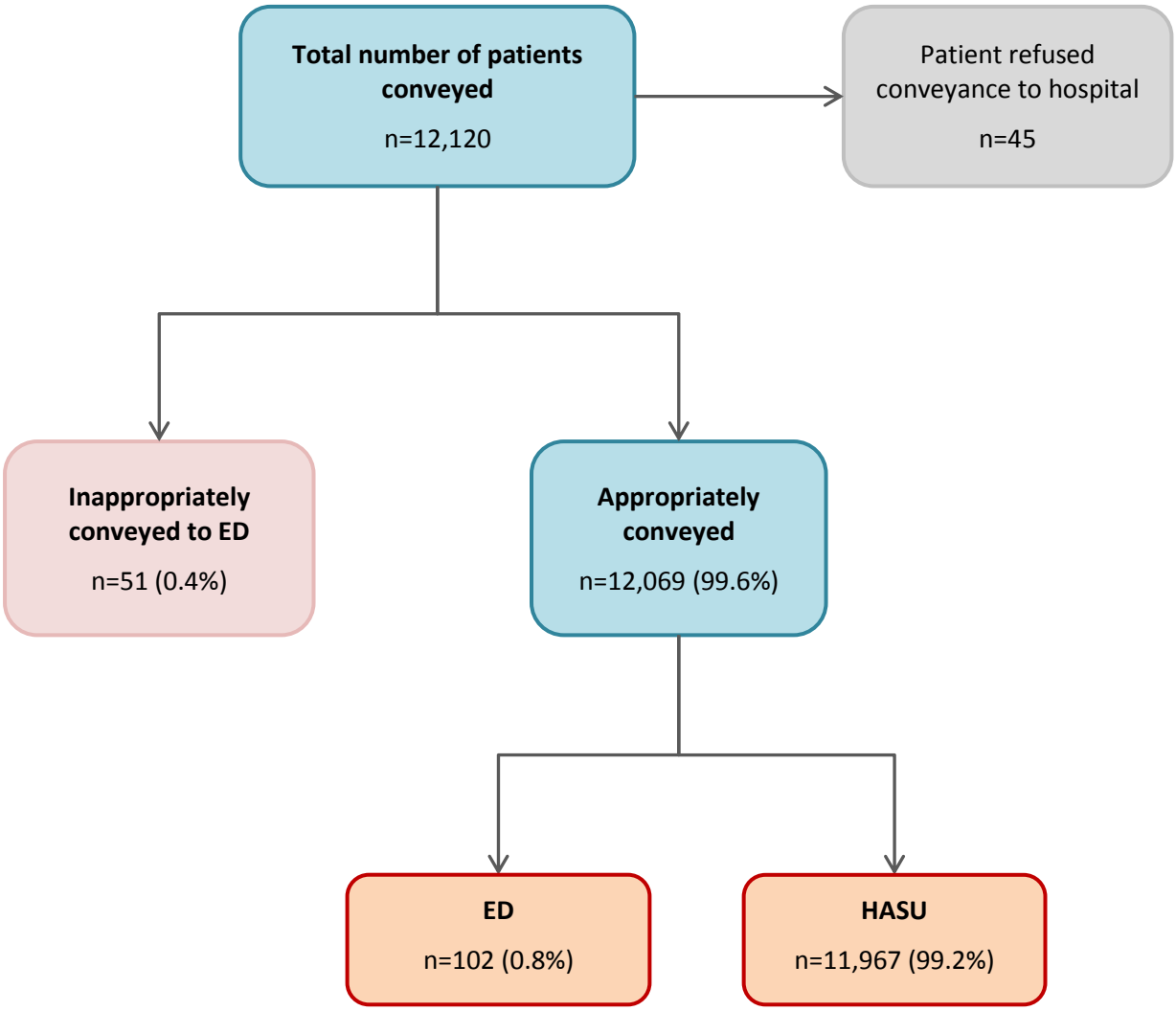

Figure 5: Patient destination

- The majority of stroke patients **(99.6%)** were conveyed to the most **appropriate destination** for their condition.
- **99.2%** of patients were conveyed to a **HASU**.

2.6.2 HASU utilisation

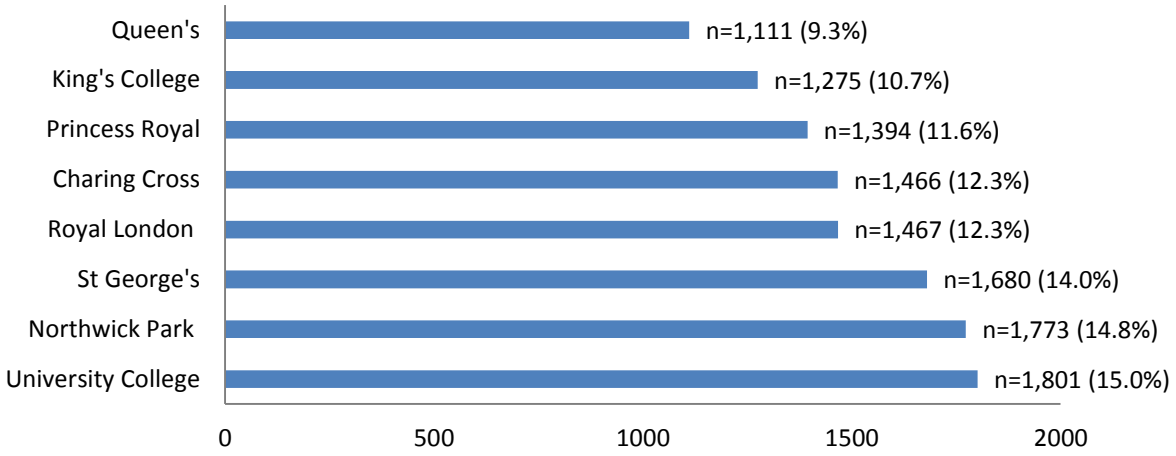

Figure 6: Number of patients conveyed to each HASU

- The majority of patients were conveyed to the HASU at University College Hospital (n=1801, 15%), closely followed by Northwick Park Hospital.

2.7 Journey and call to hospital times

Patients whose symptom onset falls within the thrombolysis treatment window of 4.5 hours are conveyed rapidly to a HASU following a pre-alert call to the stroke team. Patients whose symptoms are older than 4.5 hours are transported to a HASU under normal driving conditions.

Destination		Leave scene – arrive hospital, minutes ^			999 call – arrive hospital, minutes ^†		
		Mean	Median	90th centile	Mean	Median	90th centile
HASU	All HASU patients	18	15	31	72	63	109
	Patients with onset of symptoms ≤4.5 hours	15	14	25	62	58	91
Patients conveyed to an ED		17	15	30	93	76	193
Overall		18	15	31	72	63	110

^ Non-conveyed patients are excluded from the figures.

†999 Call to Hospital times have been calculated from the time the call was connected to the operator. Healthcare Professional Admissions are excluded from the figures.

Table 5: Journey and call to hospital times

- The mean **journey time** to hospital for patients was **18 minutes**.
- For those with a symptom onset **within 4.5 hours**, the mean journey time to a HASU was **quicker** by **3 minutes**. This was well within the 30 minutes target set by the London Stroke Network.
- The mean time from 999 **call to** arrival at a **HASU** was 72 minutes, which is 3 minutes later than the previous year. However, for patients with a symptom onset **within 4.5 hours**, the mean time from call to HASU arrival is **faster** by **10 minutes**, which is consistent with last year's findings.

3 Summary

The findings of this report show that the LAS has continued to provide excellent care to stroke patients in London. The LAS provided a comprehensive assessment as demonstrated by the excellent care bundle compliance, and ensured that nearly all patients were transported to an appropriate destination. Improvements still need to be made to reduce on-scene times and further increase the completeness of the FAST.

4 Looking forward

In the coming year, the LAS will focus on a number of initiatives to improve patient care:

- We will continue to highlight instances where the patient was not conveyed to an appropriate destination for investigation and feedback to staff.
- Details of all incidents where a full care bundle was not provided will be shared with local management teams for feedback and further learning.
- The LAS will continue to collaborate with NHS England in the ongoing development of Ambulance Quality Indicators for stroke patients to ensure that the metrics are appropriately defined.
- The LAS will work to source patient data from the Sentinel Stroke National Audit Project (SSNAP) to enable the reporting of outcomes and inform future initiatives to enhance stroke care by our staff.

Acknowledgements

CARU wishes to thank colleagues in the Medical Directorate for their ongoing support, particularly Neil Thomson.

Glossary of abbreviations and terms

Blood glucose (BM) – Blood glucose molarity is a measure of a patient's blood glucose level.

Blood pressure (BP) – Blood pressure is measured in systolic and diastolic units.

Care Bundle – The optimum combination of observations that ambulance crews should perform so that the patient receives the best possible care.

Category C – Calls which are not deemed immediately life-threatening (based on the information given by the caller regarding the patient's condition) are classed as Category C. Some patients subsequently diagnosed with a stroke receive this response, primarily where the patient has not reported any FAST symptoms or where other medical conditions were reported instead (e.g. collapse/ not alert).

Clinical Commissioning Group (CCG) – NHS organisations that govern the delivery of services within areas of England.

Computerised Tomography (CT) – A cross-sectional, three-dimensional view of internal organs made by combining multiple x-ray images. HASUs use a CT scan to identify where in the brain the suspected stroke is occurring, the type of stroke, how old it is, and how best it should be treated.

Face, Arm and Speech Test (FAST) – A diagnostic test developed in the UK in 1998 used by ambulance clinicians to help assess and detect the symptoms of a stroke. The FAST assesses for Facial drooping, Arm weakness and Speech difficulties as signs of a stroke. The 'T' can also refer to Time to emphasise the importance of rapid assessment and treatment. If a patient presents with one or more of these features they are known as FAST positive (in this report these patients are referred to as stroke patients).

First arriving vehicle – A resource dispatched to immediately life-threatening calls which can include a solo responder (such as a car, motorcycle, bicycle response) or an ambulance.

Hyper Acute Stroke Unit (HASU) – Specialist centres which patients suffering a stroke are taken directly to for rapid assessment and treatment.

Red category – Red calls (or category A) are those classed as immediately life-threatening, and should receive a response within 8 minutes of the initial 999 emergency call. The vast majority of patients diagnosed with a stroke receive a Red response.

Time of Onset – The potential time that the stroke occurred based on information available from patients and others. Where a time cannot be established the last time the patient was seen well is used as an alternative to help assist ambulance staff with decisions regarding rapid conveyance to HASU.

Thrombolysis – A form of treatment in which a drug that breaks down blood clots is used in an attempt to unblock the artery leading to the area of brain affected by the stroke.

Appendix 1: Incident information by area (as determined by the CCG of the incident)

CCG^	**Number of stroke patients**	**Journey times to a HASU** Mean (median), minutes	**Call to arrival at HASU~** Mean (median), minutes	**Call to arrival at HASU for patients who were potentially eligible for thrombolysis* ~** Mean (median), minutes
Barking and Dagenham	287	12 (11)	64 (56)	56 (54)
Barnet	559	24 (22)	80 (73)	71 (67)
Bexley	426	27 (25)	83 (74)	73 (65)
Brent	497	16 (14)	69 (60)	60 (56)
Bromley	571	13 (12)	65 (59)	59 (55)
Camden	304	12 (10)	65 (59)	58 (53)
Central London	325	13 (11)	63 (56)	58 (53)
City and Hackney	323	14 (12)	69 (62)	62 (58)
Croydon	627	21 (18)	77 (69)	68 (62)
Ealing	552	19 (16)	74 (65)	64 (58)
Enfield	433	36 (31)	99 (84)	82 (75)
Greenwich	329	26 (23)	77 (72)	69 (67)
Hammersmith and Fulham	255	9 (8)	63 (50)	53 (48)
Haringey	278	24 (22)	85 (74)	71 (65)
Harrow	362	11 (10)	62 (53)	57 (51)
Havering	459	10 (10)	63 (54)	56 (52)
Hillingdon	543	23 (20)	79 (69)	69 (64)
Hounslow	399	21 (19)	77 (66)	65 (60)
Islington	258	15 (13)	68 (58)	60 (55)
Kingston	529	11 (19)	71 (62)	62 (55)
Lambeth	374	11 (10)	63 (55)	53 (49)
Lewisham	406	17 (16)	69 (64)	63 (57)
Merton	283	12 (11)	57 (51)	50 (46)
Newham	347	18 (15)	74 (68)	66 (63)
Redbridge	412	18 (16)	75 (64)	64 (59)
Richmond	264	23 (21)	76 (69)	68 (63)
Southwark	398	11 (10)	63 (56)	56 (53)
Sutton	329	19 (16)	68 (62)	61 (55)
Tower Hamlets	277	9 (8)	64 (58)	56 (53)
Waltham Forest	365	26 (24)	88 (76)	75 (68)
Wandsworth	352	13 (11)	58 (52)	53 (48)
West London	306	13 (11)	62 (58)	56 (54)

^ For 6 cases the CCG was unknown.

~ Health Care Professional admissions are not included.

** Patients whose symptoms were less than four and a half hours old when leaving the scene of the incident, or where the time of onset of symptoms was not documented by the crew.*

Appendix 2: Care of patients by Group Station

Station Groups	**n**	**On-scene times (from first attending resource)** Mean (median), minutes	**Care bundle**	**Journey time to a HASU** Mean (median), minutes
Homerton	581	35 (32)	97%	13 (11)
Newham	818	34 (31)	98%	20 (17)
Romford	877	33 (29)	97%	13 (11)
North East	2,276	34 (31)	97%	15 (13)
Camden	519	35 (31)	98%	14 (13)
Edmonton	601	36 (32)	96%	30 (27)
Friern Barnet	473	35 (33)	96%	27 (24)
North Central	1,593	35 (32)	97%	24 (22)
Brent	981	31 (28)	98%	15 (13)
Fulham	592	32 (28)	97%	13 (11)
Hanwell	775	33 (30)	98%	21 (18)
Hillingdon	377	33 (29)	98%	23 (21)
Westminster	245	34 (30)	98%	14 (13)
North West	2,970	32 (29)	98%	17 (15)
Bromley	825	34 (30)	97%	16 (14)
Deptford	1072	34 (31)	97%	12 (11)
Greenwich	697	34 (31)	98%	26 (24)
South East	2,594	34 (31)	97%	17 (15)
Croydon	500	33 (29)	97%	20 (17)
New Malden	401	33 (31)	96%	21 (19)
St Helier	417	33 (29)	99%	17 (15)
Wimbledon	604	29 (26)	95%	15 (12)
South West	1,922	32 (29)	97%	18 (16)
PAS & VAS	345	43 (37)	98%	18 (15)
Other LAS[†]	465	33 (29)	86%	19 (16)
LAS-Wide	**12,165**	**34 (30)**	**97%**	**18 (15)**

[†] *Includes Hazardous Area Response, Special Events, Tactical Response Units and Training.*

London Ambulance Service
NHS Trust

Cardiac Arrest Annual Report: 2017/18

November 2018

Produced by:

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London Ambulance Service
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Cardiac Arrest Overview | 2017-18

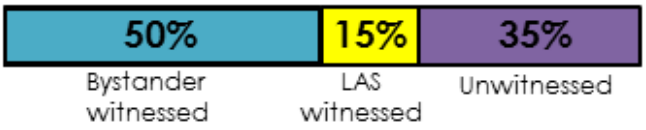
Patients

10,654
Total number of patients

41%
Resuscitation attempted

64%
62 years

36%
68 years



Outcomes

32.5%
Overall ROSC to hospital

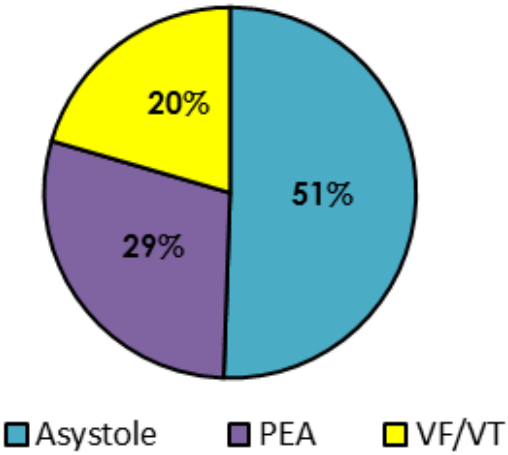
9.4%
Overall survival

56.6%
Utstein ROSC to hospital

31.9%
Utstein survival

Response

Initial rhythm



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1. Introduction

From 1st April 2017 to 31st March 2018, the London Ambulance Service NHS Trust (LAS) attended **10,654** patients who had suffered an out-of-hospital cardiac arrest. Our clinicians attempted to resuscitate **4,389** (**41.2**%) of these patients. Resuscitation efforts were not undertaken for **6,265** (**58.8**%) patients: 4,665 (74%) were recognised as deceased on arrival of the clinician, and for a further 1,600 (26%) a Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) order, advanced directive or similar equivalent was in place, or the patient's death was expected.

Data were sourced from the LAS' Cardiac Arrest Registry, which captures information from a range of clinical and operational sources including: Patient Report Forms (PRFs), vehicle Mobile Data Terminals (MDTs), emergency call logs and defibrillator data. Survival to hospital discharge information is collected from hospital patient records and national databases.

This report presents information regarding the clinical care provided and the outcomes of the **4,389** patients where resuscitation was attempted.

2. Profile of arrests

Gender □, n (%)	
Male	2,808 (64.0)
Female	1,578 (36.0)
Unknown	3 (0.1)

Age, mean (median) in years	
Overall	65 (69)
Male	62 (66)
Female	68 (74)

Race, n (%)	
White	2,570 (58.6)
Asian	377 (8.6)
Black	344 (7.8)
Mixed	36 (0.8)
Other	195 (4.4)
Unable to obtain	811 (18.5)
Not documented	56 (1.3)

Peak occurrence	
Time of day (hh:mm)	08:00-11:59 22.3% (n=977)
Day	Saturday 14.9% (n=655)
Month	December 10.4% (n=458)

Response times, median in minutes	
999 call – scene	07:26
999 call – LAS CPR*	09:18
999 call – LAS defibrillation*~	10:41

Location □, n (%)	
Private location	**3,272 (74.5)**
Home	3,027 (92.5)
Care home	245 (7.5)
Public location	**1,117 (25.4)**
Street	526 (47.1)
Work	94 (8.4)
Healthcare facility	150 (13.4)
Public transport	61 (5.5)
Social venue	57 (5.1)
Shop/bank	37 (3.3)
Park/wood/river	30 (2.7)
Hotel/Hostel	34 (3.0)
Leisure centre/sports club	37 (3.3)
Airport	24 (2.1)
Other	67 (6.0)

Chief complaints at the 999 call, n (%)□	
Cardiac arrest	2,418 (55.1)
Unconscious/fainting	546 (12.4)
Breathing problems	387 (8.8)
Falls	137 (3.1)
Other	801 (18.3)
111 NHS Transfers	63 (1.4)
HCP Admissions	37 (0.8)

□ *The total percentages do not equal 100% due to rounding.*

** Excludes LAS witnessed arrests.*

~ Based on an initial rhythm of VF/VT.

Table 1: Profile of cardiac arrests where resuscitation was attempted (n=4,389)

3. Response information

On 1st November 2017, the LAS implemented the new national ambulance standard for call categorisation and response times as defined by NHS England's Ambulance Response Programme (ARP). As the implementation of the new standards redefined the response categories and the way response times are measured, this section is sub-divided into two parts reporting LAS performance against the previous definitions (pre-ARP) and the new standards (post-ARP).

3.1. 1st April 2017 – 31st October 2017 (Pre-ARP)

During this period, calls were categorised as Red or Green calls. The highest priority (Red) response category was sub-divided into Red 1 and Red 2 (with Red 1 indicating those incidents which were immediately life-threatening). Red 1 responses were measured from the time the call was connected by the operator. The remaining categories allowed a period of time for information gathering by the EMD in order to assign the most appropriate response to each patient. For all categories, the clock stopped when the first resource arrived on scene. Red calls had a national target of 75% of patients receiving a response within 8 minutes.

Category	n (%)	Response time, mins		
		Mean	Median	90th Centile
Red 1	1,536 (66.7)	7	7	11
Red 2	608 (26.4)	7	6	13
Green	159 (6.9)	20	12	45
Overall*	**2,303**	**8**	**7**	**12**

** Category not available for 1 case.*

Table 2: Pre-ARP response times by category

3.2. 1st November 2017 – 31st March 2018 (Post ARP)

From 1st November 2017, calls were categorised into four groups from Category 1 for 'life-threatening illnesses or injuries' such as cardiac arrest through to 'less urgent conditions' in Category 4. For each category, the response time is measured using a set of rules that define the point at which the clock starts and the type of resource that is required to arrive on scene for the clock to stop (see below).

Category	Response standard (mins)		Definitions
	Mean	90th centile	
Category 1 (Life threatening)	7	15	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 30 seconds from the call connecting. Clock stop The arrival of the first LAS resource (whether a solo responder or an ambulance).
Category 2 (Emergency)	18	40	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 240 seconds from call connect Clock stop The arrival of the first LAS vehicle able to transport the patient to hospital.
Category 3 (Urgent)	120 (maximum time)		
Category 4 (Less urgent)	180 (maximum time)		

A set of pre-triage questions are used to help early recognition of life-threatening conditions, such as cardiac arrest.This enables a rapid dispatch of a resource to Category 1 calls. For lower priority response categories, Emergency Medical Dispatchers (EMDs) have additional time to triage the call so that the most appropriate response for the patient's condition is assigned.

Category	n (%)	Response time, mins		
		Mean	Median	90th Centile
Category 1	1,519 (72.8)	7	6	11
Category 2	469 (22.5)	16	13	28
Category 3	81 (3.9)	24	15	60
Category 4	17 (0.8)	76	46	239
Overall	**2,086**	**10**	**7**	**18**

Table 3: Post-ARP response times by category

- From 1st April 2017 to 31st October 2018 (pre-ARP), two-thirds **(66.7%)** of patients received a **Red 1** response, with **26.4%** allocated to a **Red 2** category. The mean response was **7 minutes** for those patients allocated a **Red** call.
- From 1st November 2017 to 31st March 2018 (post-ARP), nearly three-quarters **(72.8%)** of patients received a **Category 1** response. The mean response was **7 minutes** for those patients allocated to **Category 1**.
- For **all** cardiac arrest patients the mean time taken for a response to arrive was **7 minutes** overall.

4. Clinical presentation

4.1. Aetiology

Aetiology	n (%)	ROSC sustained to hospital n (%)	Survival to discharge† n (%)
Presumed cardiac	3,340 (76.1)	1,100 (32.9)	348/3,276 (10.6)
Other medical	473 (10.8)	141 (29.8)	30/463 (6.5)
Trauma	207 (4.7)	34 (16.4)	5/199 (2.5)
Asphyxial	231 (5.3)	95 (41.1)	7/224 (3.1)
Overdose	119 (2.7)	52 (43.7)	11/112 (9.8)
Drowning	18 (0.4)	6 (33.3)	1/17 (5.9)
Electrocution	1 (0.0)	0 (0.0)	0/1 (0.0)

† *Denominators exclude patients with unknown survival outcomes (n=97).*

Table 4: Patient aetiology with ROSC and survival

- **Presumed cardiac aetiology** was the predominant cause of cardiac arrest (76.1%).
- Both **overdose** and **asphyxial** aetiologies resulted in higher ROSC sustained to hospital than other aetiologies (43.7% and 41.1% respectively)
- **Presumed cardiac aetiology** presented with the highest survival to discharge (10.6%) of all aetiologies.

4.2. Initial rhythm

LAS recorded initial rhythm*	n (%)□	Change^	ROSC sustained to hospital		Survival to discharge†	
			n (%)	Change^	n (%)	Change^
Asystole~	2,203 (50.1)	↑0.5%	465 (21.1)	↑4.4%	29/2,179 (1.3)	↓0.3%
PEA	1,259 (28.7)	↑0.8%	456 (36.2)	↑3.6%	79/1,220 (6.5)	↑1.2%
VF/VT	889 (20.3)	↓1.5%	484 (54.4)	↑0.4%	283/860 (32.9)	↓0.2%

** Not documented in 38 cases.*

□ *The total percentages do not equal 100% due to rounding.*

^ *Increase or decrease in percentage from 2016/17.*

† *Denominator excludes patients with unknown survival outcomes (n=97).*

~ *Includes paediatric bradycardia (n=2).*

Table 5: Initial rhythm with ROSC and survival

- **Asystole (50.1%)** remains the predominant initial rhythm.
- **PEA** has increased slightly by 0.8% from 27.9% in 2016/17 to **28.7%** this year but has showed a large increase in ROSC sustained to hospital (3.6% from 32.6% in 2016/17) and are the only group to have an increase in survival to discharge (1.2% from 5.3%).
- The proportion of **VF/VT** has decreased by 1.5% to **20.3%** from 21.8% in 2016/17.

5. Bystander interventions

5.1. Bystander witnessed and CPR

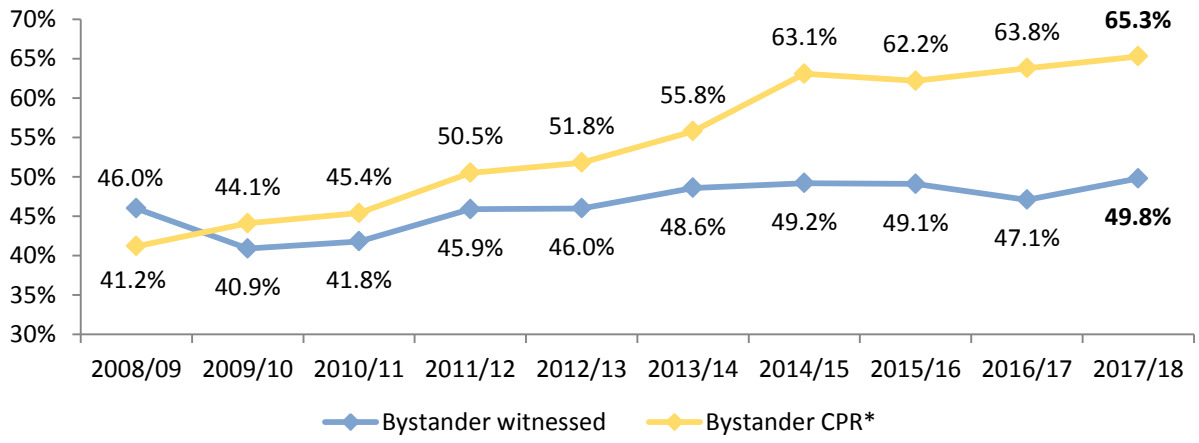


Figure 1: Bystander witnessed and CPR

**Excludes LAS witnessed arrests*

- **Both bystander witnessed** and bystander **CPR** rates are the **highest** observed over the last ten years.
- Nearly **half** (49.8%, n=2,186) of cardiac arrests where resuscitation was attempted were **bystander witnessed**.
- **65.3%** (n=2,431) of patients received **bystander CPR.**

5.2. Public Access Defibrillator (PAD)

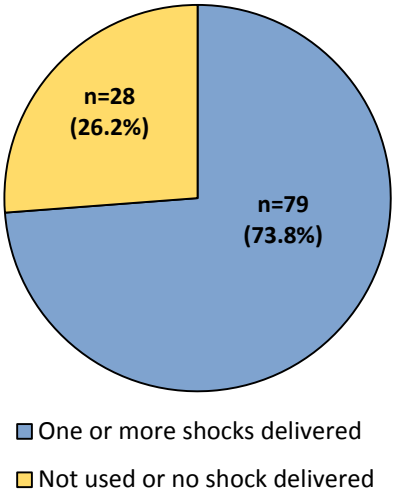


Figure 2: Deployment of a PAD

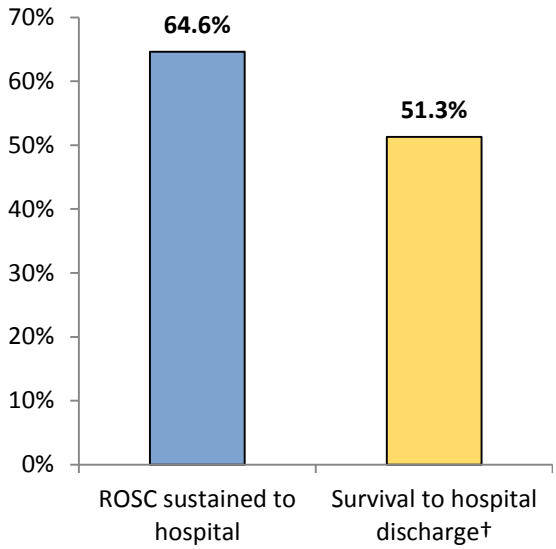


Figure 3: Outcomes post-PAD use

† *Excludes 3 patients with unknown outcomes.*

- A PAD was deployed for 107 cardiac arrests, with **one or more shocks** being delivered by members of the public in **79** cases.
- Of the 79 patients where a PAD was used to deliver a shock:
  - **94.9%** arrests (n=75) were **bystander witnessed**, which is a 1.9% increase compared with last year.
  - **All** patients received **bystander CPR**.
  - **64.6%** (n=51/79) had **ROSC** sustained to hospital (2.8% decrease from last year).
  - **Survival** to hospital discharge for these patients was **51.3%** (n=39/76), which is a marginal decrease of 0.5% compared to last year (51.8%).

6. Outcomes

6.1. Conveyance

Conveyance	n (%)
Conveyance to hospital	2,467 (56.2%)
Conveyed to an ED	1,921 (77.9%)
Conveyed to a HAC~	546 (22.1%)
Resuscitation terminated on-scene	1,922 (43.8%)

~ Includes all patients regardless of whether a STEMI was identified or if ROSC was obtained.

Table 6: Conveyance

- **More** patients (3.6%) were **conveyed** to hospital with either a Return of Spontaneous Circulation (ROSC) or ongoing CPR than last year.

6.2. ROSC and Survival

ROSC sustained to hospital arrival and survival to discharge figures are reported for two groups:

1. Overall group: all patients where resuscitation was attempted.

2. Utstein[1,2] comparator group: a sub-group of resuscitation attempted patients where the arrest was of a presumed cardiac cause, bystander witnessed, and in a shockable rhythm (VF/VT) on arrival of the LAS.

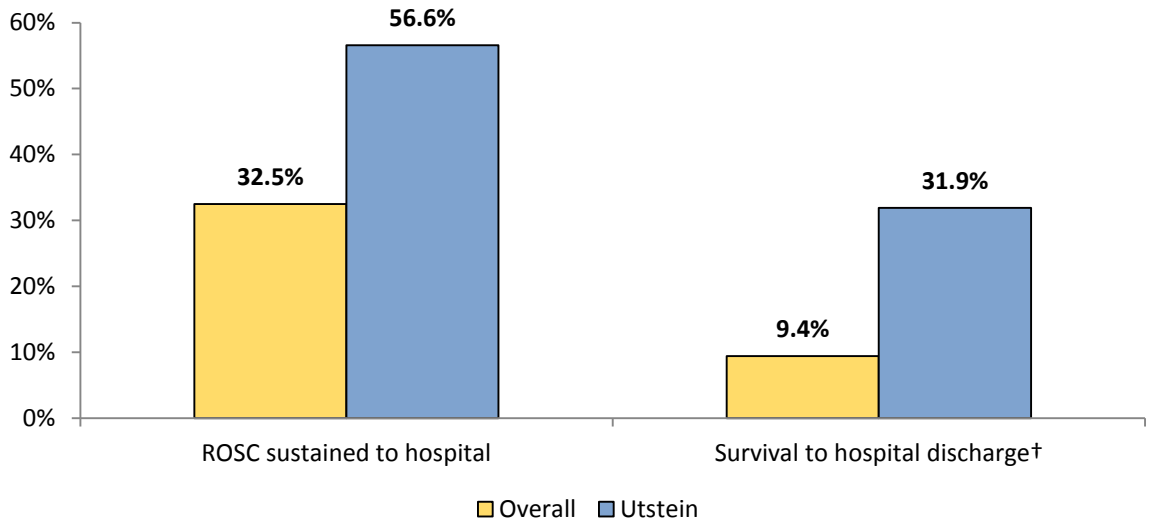


Figure 4: ROSC sustained to hospital and survival to hospital discharge for all resuscitation attempted patients ('overall') and the Utstein comparator group

† Excludes cases where the outcome was unknown from the overall (n=97) and Utstein (n=21) group

- The **overall ROSC** sustained to hospital rate was **32.5%** (n=1,428) - a 3.1% increase from last year and the highest ROSC rate achieved to date (see Figure 6).
- The **overall survival** to hospital discharge rate was **9.4%** (n=402/4,292), which is a very slight decrease (0.1%) from last year.
- For the **Utstein** comparator group, **ROSC** sustained to hospital arrival increased by 2.1% to **56.6%** (n=335/592).
- The **Utstein survival** rate of **31.9%** (n=182/571) is a 2.4% increase of from last year (see Figures 5 and 7).

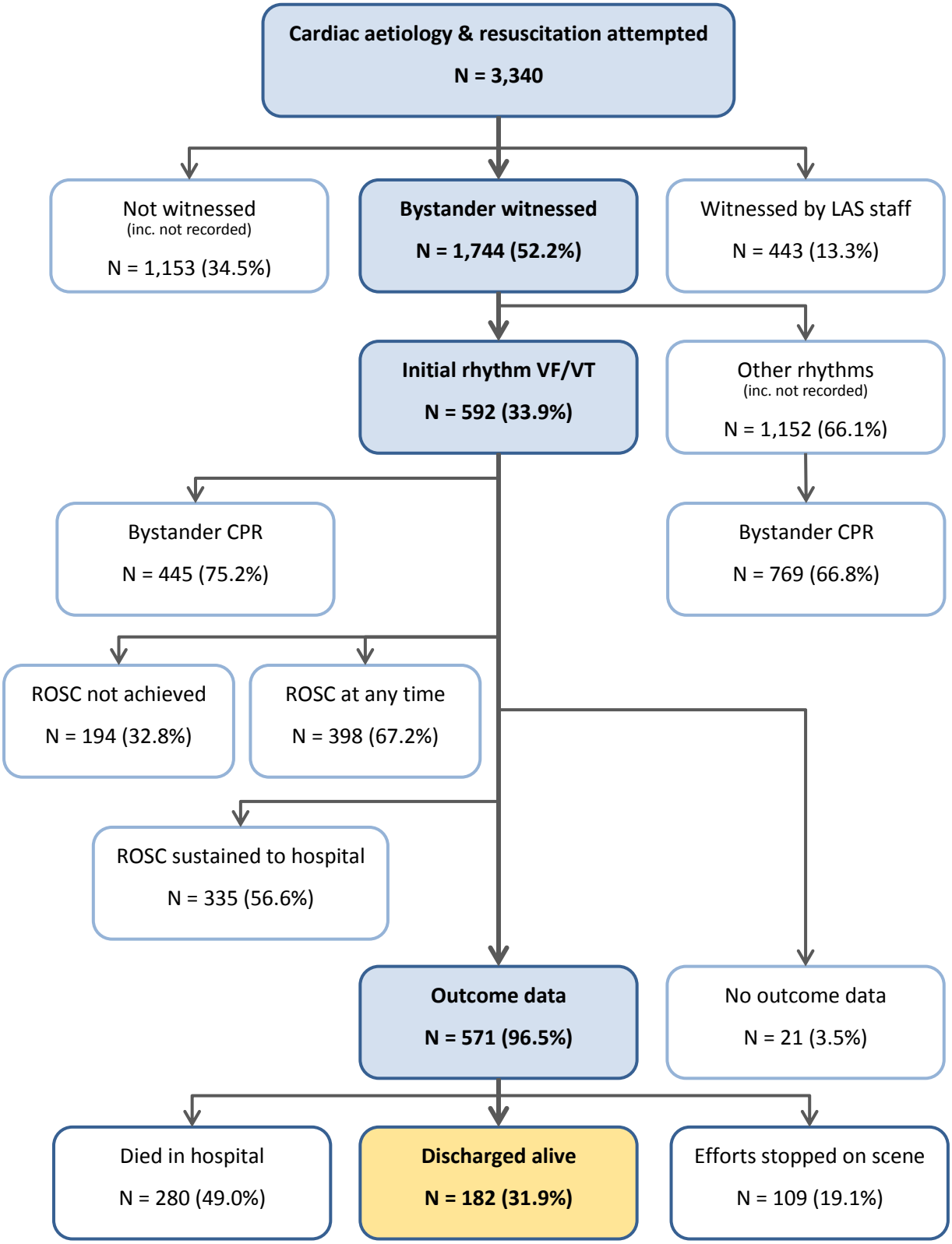


Figure 5: Outcomes for the Utstein comparator group

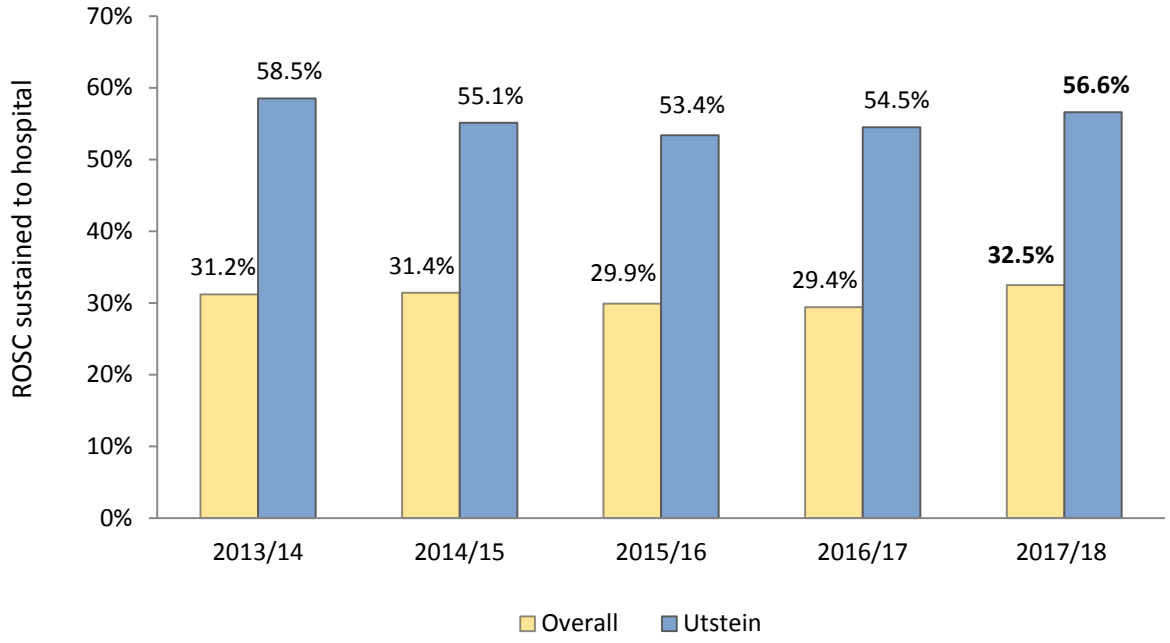


Figure 6: ROSC sustained to hospital per year for all resuscitation attempted patients ('overall') and the Utstein comparator group

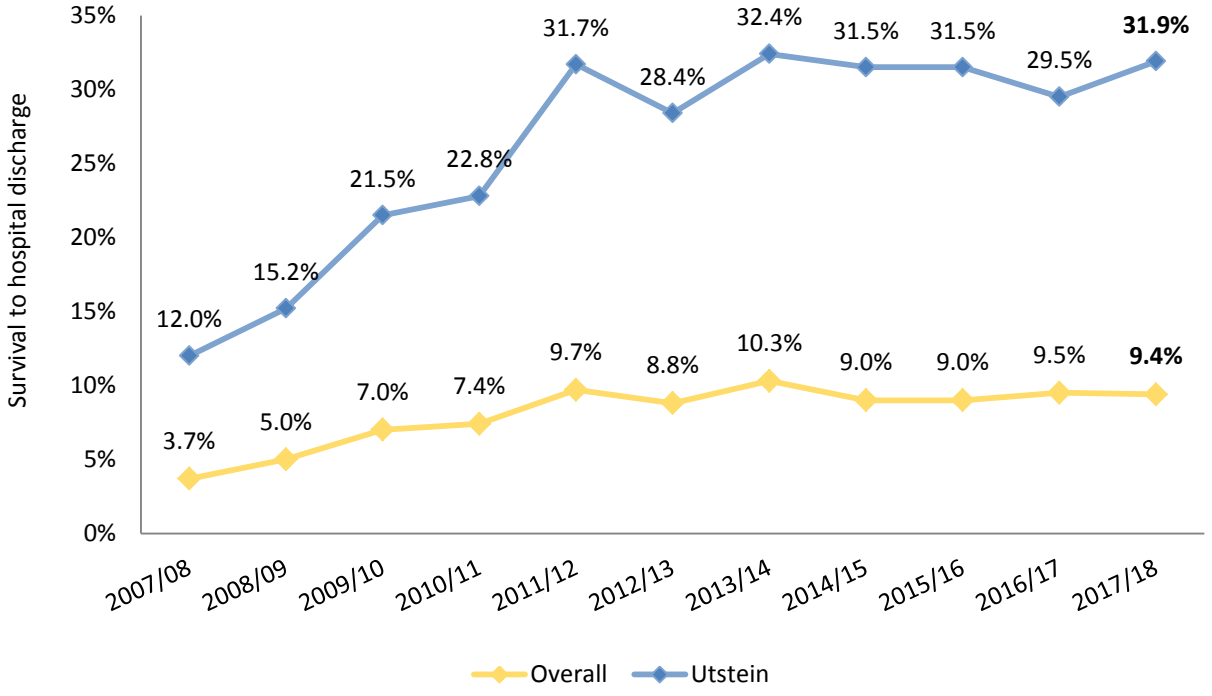
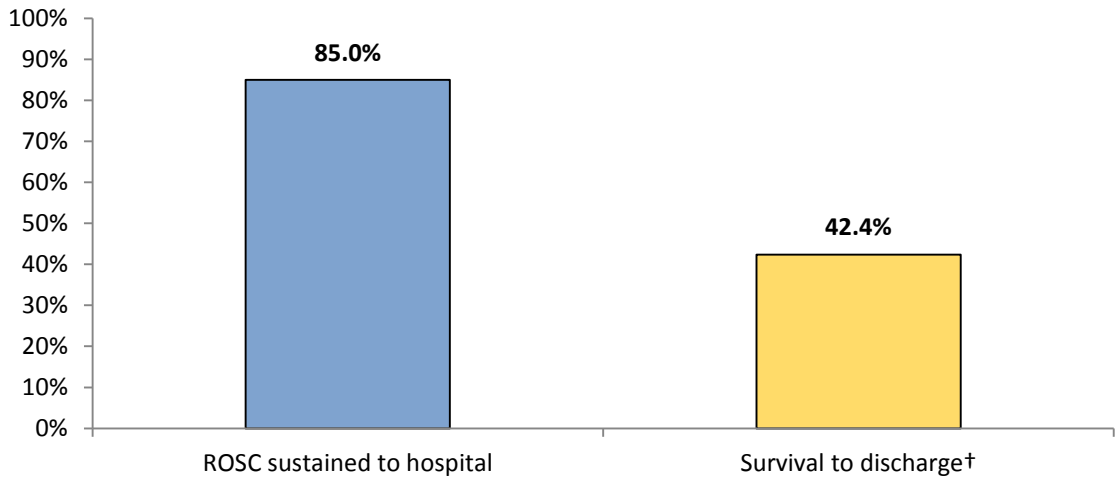


Figure 7: Survival to hospital discharge per year for all resuscitation attempted patients ('overall') and the Utstein comparator group

7. Resuscitated patients conveyed to a Heart Attack Centre (HAC) following a STEMI

Cardiac arrest patients who have a ST-elevation Myocardial Infarction (STEMI) and have achieved stable ROSC on-scene are conveyed to a HAC as part of a specialist pathway.



† Denominator excludes patients with unknown survival outcomes (n=17).

Figure 8: Outcomes of resuscitated patients conveyed to a HAC following a STEMI

- Of the 546 patients conveyed to a HAC, **420** patients had a suspected STEMI and, achieved ROSC and were transported to HAC following a cardiac arrest as part of the specialist pathway.
- The **majority** of these patients had an initial rhythm of **VF/VT** (67.9%, n=285) whilst asystole and PEA accounted for 16.4% (n=69) and 15.5% (n=65) of cases.
- **Survival** to hospital discharge for patients within this specialist pathway remains higher than other groups at **42.4%** (n=171/403)**,** but has decreased considerably by 8.3% from 50.7% in 2016/17.
- A breakdown of survival and initial rhythm for patients conveyed to specific London HACs can be found in Appendix 3.

8. Staff involvement

8.1. LAS witnessed arrests

LAS witnessed	n (%)*	ROSC sustained to hospital n (%)	Survival to discharge† n (%)
Asystole~	142 (21.4)	38 (26.8)	7/138 (5.1)
PEA	377 (56.7)	135 (35.8)	31/367 (8.4)
VF/VT	132 (19.8)	91 (68.9)	74/128 (57.8)
All patients	665 (15.2)	273 (41.1)	117/647 (18.1)

** Not documented in 14 cases.*

† Denominator excludes patients with unknown survival outcomes (n=18).

~ Includes paediatric bradycardia (n=2)

Table 7: Outcome of LAS witnessed arrests

- LAS clinicians witnessed **665** patients suffer a cardiac arrest.
- Overall, **ROSC** sustained to hospital **increased** by 2.6% from 2016/17. However, **survival** to discharge has **decreased** by 2.5%.
- Of note, compared to last year, less patients presented in an initial shockable rhythm (decrease of 3.5% to 19.8% in VF/VT) and more patients had PEA (up by 5.0% to 56.7%).

8.2. Advanced Paramedic Practitioners (APPs)

Advanced Paramedic Practitioners (APPs) manage resuscitation efforts and provide enhanced care to patients. APPs are dispatched to cardiac arrests either automatically or following a comprehensive triage by an APP based in the Emergency Operations Centre (EOC), who ensures APPs attend those who are most likely to benefit from advanced skills.

APP patient outcomes	n (%)	Change^
ROSC sustained to hospital	508 (39.7)	↑5.1%
Survival to discharge†	162 (13.1)	↑1.0%

† Denominator excludes patients with unknown survival outcomes (n=39).

^ Increase or decrease in percentage from 2016/17.

Table 8: APP skills and patient outcomes

- An **APP** was present and assumed primacy of care for **1,280** cases.
- **ROSC** sustained to hospital **(39.7%)** and **survival** to hospital discharge **(13.1%)** have increased from 2016/17 (30.7% and 12.1% respectively).
- In cases where an APP was present, ROSC and survival to discharge from hospital remained higher than the overall LAS figures. However, when an APP was in attendance, the rate of **VF/VT** was **29.6%**, which is 9.3% higher than the percentage reported for all resuscitation attempted patients.

9. Quality improvement activity

As part of our 5-year Clinical Strategy 2016-2021, we have committed to key initiatives to improve cardiac arrest survival. During 2017/18:

- We reviewed and updated our internal adult and paediatric cardiac guidelines including: clarity of when to attempt resuscitation, use of Automated External Defibrillation mode and instructions on how to use manual processes to ensure defibrillatory shocks are delivered as quickly as possible to VF/VT patients, amiodarone use after three defibrillator attempts, and manual uterine displacement in pregnant patients.

- The LAS has continued to provide educational updates to staff via Core Skills Refresher sessions, bulletins, and case studies in internal publications such as the Clinical Update and the learning from experience Insight magazine.

- We have in the past year improved defibrillator data availability to 14%, with a further target of 20% for 2018/19.

- During 2017/18, we supported public education and bystander interventions through:

    - Increasing the number of public access defibrillators in London to 4,972

    - Between 16th June – 30th October 2017, the Metropolitan Police co-responding initiative was rolled out across London with response cars equipped with defibrillators automatically dispatched to cardiac arrest calls

    - Community Resuscitation Training Officers delivering emergency life support training to over 6,000 members of the public

    - Ensuring that all volunteer LAS Emergency Responders are appropriately trained.

- During 2017/18, CARU sent out 1,260 letters to clinical staff who attended cardiac arrest patients, who survived to hospital discharge, in recognition of the lifesaving interventions provided at scene and en-route to hospital.

- Additionally, 315 letters were sent out to our Emergency Medical Dispatchers in appreciation of their crucial role in the early recognition of cardiac arrests and initiation of dispatcher assisted bystander CPR.

- Monthly care packs and $EtCO_2$ reports have been disseminated across the Trust to improve clinical care at a local level.

- The LAS recruited in total 2,102 patients to the Paramedic 2 trial – a randomised clinical trial investigating the effectiveness of adrenaline use during cardiac arrest and its impact on short and long-term patient outcomes. The trial was completed in October 2017 and the findings published in the New England Journal of Medicine[3].

10. Conclusion

This year, we have seen improvements in ROSC sustained to hospital for all patients where resuscitation was attempted and within the specific Utstein sub-group (32.5% and 56.6% respectively). The survival for the Utstein sub-group has increased to 31.9% (from 29.5% in 2016/17). However, the survival rate for the overall group has seen a marginal decrease of 0.1% to 9.4% in 2017/18.

Our improved ROSC sustained to hospital rates and Utstein survival rates reflect the ongoing efforts a wider system. Bystander witnessed and bystander CPR rates have increased to a 10 year high and are a commendable achievement by members of the public. The LAS has continued to provide a rapid response allowing for early interventions to successfully resuscitate patients prior to conveyance to hospital for ongoing treatment. It also reflects the contribution of London-wide hospitals and their ongoing treatment of patients in hospital.

11. Looking forward

In 2018/19, the LAS will progress a number of key objectives to improve patient care:

- A fundamental area for improvement is the downloading of defibrillator files with a target of 20% downloads set for 2018/19. The LAS will continue to pursue the technology and infrastructure to enable clinicians to download files directly from the defibrillators.

- The introduction of an Ambulance Quality Indicator (AQI) for post resuscitation patients to monitor the provision of care given to stabilise patients on-scene following ROSC. The AQI will focus on the recording of a 12 lead ECG, blood glucose, End-tidal Carbon Dioxide ($EtCO_2$) and blood pressure measurement, and delivery of oxygen and fluids.

- Continuing to increase our accredited defibrillator scheme and public education courses.

- With supportive findings from the ARREST pilot study[4], we have begun the roll out of a large-scale randomised clinical trial in collaboration with Guys & St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. We aim to fully determine the potential benefit of conveying all cardiac arrest patients, once ROSC is achieved on-scene, directly to a HAC.

12. References

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4. Patterson T, Perkins GD, Joseph J, et al. A Randomised tRial of Expedited transfer to a cardiac arrest centre for non-ST elevation ventricular fibrillation out-of-hospital cardiac arrest: The ARREST pilot randomised trial. Resuscitation. 2017; 115: 185-191.

Acknowledgments

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Glossary of abbreviations and terms

Advanced Life Support – Includes skills such as advanced airway management, manual defibrillation, cannulation and drug administration.

Basic Life Support – Includes skills such as CPR, manual airway positioning and AED use.

Bystander – A lay person or non-Emergency Medical Service personnel.

Chief Complaint – The primary medical reason that the caller has called 999 as defined by the call triage system.

Defibrillators – The LAS use portable defibrillators to help diagnose the heart's rhythm and deliver a pre-set charged shock of 360J.

Double sequential defibrillation – uses two defibrillators to provide multiple high energy shocks in refractory VF to help terminate the rhythm.

Electrocardiogram (ECG) – The LAS use 12-lead ECGs to diagnose STEMIs.

Emergency Medical Dispatchers (EMDs) – Staff based in the LAS Emergency Operations Centre that answer 999 calls and dispatch resources to patients.

End-Tidal Carbon Dioxide ($EtCO_2$) – Measurement of gas exchange in lungs which enables a clinician to accurately tell whether an airway device has been placed correctly, and allows other information such as effectiveness of compressions and ventilations to be ascertained. $EtCO_2$ measurement is compulsory for patients where an advanced airway has been placed.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for angiography and primary Percutaneous Coronary Intervention (pPCI).

Initial rhythm – The rhythm that the heart is in on initial presentation to LAS staff.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Paramedic – A majority of clinical staff are paramedics and are able to perform advanced airway management, cannulation and administration of drugs to cardiac arrest patients.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Return of Spontaneous Circulation (ROSC) – Refers to a return of cardiac output by the heart after a period of cardiac arrest. ROSC sustained to hospital is the most widely used measure for out-of-hospital cardiac arrests and indicates the patient had ROSC at handover to hospital staff.

Survival to Discharge – The patient was successfully discharged from a hospital to a non-hospital environment (therefore excluding transfers from one hospital to another).

Utstein – Refers to the internationally recognised criteria for outcomes. The patients in this group are all witnessed having a cardiac arrest by a bystander, all present with an initially shockable rhythm of VF or pulseless VT and have a presumed cardiac aetiology.

Witnessed – Either seen or heard by a bystander or seen by LAS staff.

Appendix 1: Patient characteristics, response times, and outcomes per Clinical Commissioning Group

Incident CCG*	Number of patients	Age (years)	Male % (n)		Median response^ (mins)	Bystander CPR# % (n)		Presumed cardiac % (n)		Shockable initial rhythm % (n)		ROSC sustained to hospital % (n)		Survived to discharge+ % (n)	
Barking & Dagenham	120	62	64.2%	(77)	07:23	70.7%	(70)	71.7%	(86)	16.7%	(20)	34.2%	(41)	9.5%	(11)
Barnet	188	68	64.4%	(121)	08:25	67.7%	(111)	83.5%	(157)	19.7%	(37)	28.7%	(54)	9.0%	(17)
Bexley	124	71	58.9%	(73)	07:56	65.7%	(67)	80.6%	(100)	24.2%	(30)	33.1%	(41)	6.8%	(8)
Brent	191	64	66.0%	(126)	07:42	60.6%	(103)	75.9%	(145)	24.6%	(47)	35.1%	(67)	9.1%	(17)
Bromley	158	66	61.4%	(97)	08:14	58.4%	(80)	85.4%	(135)	25.3%	(40)	34.2%	(54)	8.4%	(13)
Camden	114	60	71.1%	(81)	06:29	66.3%	(63)	71.9%	(82)	20.2%	(23)	36.0%	(41)	14.2%	(16)
Central London	121	62	73.6%	(89)	06:26	67.6%	(73)	74.4%	(90)	28.9%	(35)	33.1%	(40)	18.1%	(21)
City & Hackney	132	58	65.9%	(87)	07:11	67.5%	(79)	72.7%	(96)	21.2%	(28)	39.4%	(52)	13.3%	(17)
Croydon	186	67	58.6%	(109)	07:39	68.4%	(108)	73.1%	(136)	19.9%	(37)	31.2%	(58)	9.2%	(17)
Ealing	193	66	67.4%	(130)	07:20	66.1%	(113)	74.6%	(144)	16.6%	(32)	32.1%	(62)	7.8%	(15)
Enfield	180	64	63.9%	(115)	07:39	66.7%	(100)	78.3%	(141)	18.3%	(33)	26.7%	(48)	8.3%	(15)
Greenwich	133	61	54.9%	(73)	07:09	60.7%	(68)	74.4%	(99)	13.5%	(18)	31.6%	(42)	9.1%	(12)
Hammersmith & Fulham	81	66	69.1%	(56)	06:28	61.6%	(45)	69.1%	(56)	21.0%	(17)	28.4%	(23)	13.7%	(10)
Haringey	127	64	63.0%	(80)	07:09	61.5%	(64)	72.4%	(92)	18.9%	(24)	31.5%	(40)	6.4%	(8)
Harrow	124	66	58.1%	(72)	07:24	61.2%	(60)	84.7%	(105)	23.4%	(29)	34.7%	(43)	8.9%	(11)
Havering	145	69	64.8%	(94)	07:40	62.2%	(69)	79.3%	(115)	19.3%	(28)	27.6%	(40)	6.3%	(9)
Hillingdon	203	68	61.6%	(125)	07:52	73.3%	(118)	75.9%	(154)	23.6%	(48)	33.0%	(67)	11.9%	(24)
Hounslow	143	66	67.8%	(97)	07:00	66.1%	(80)	74.1%	(106)	18.9%	(27)	32.9%	(47)	8.1%	(11)
Islington	102	61	68.6%	(70)	07:24	58.6%	(51)	65.7%	(67)	20.6%	(21)	27.5%	(28)	7.8%	(8)
Kingston	70	70	65.7%	(46)	07:28	61.7%	(37)	75.7%	(53)	15.7%	(11)	40.0%	(28)	5.8%	(4)
Lambeth	155	62	61.9%	(96)	06:47	56.6%	(77)	74.2%	(115)	17.4%	(27)	35.5%	(55)	7.4%	(11)
Lewisham	137	62	61.3%	(84)	07:01	54.5%	(60)	70.8%	(97)	14.6%	(20)	34.3%	(47)	8.9%	(12)
Merton	98	68	59.2%	(58)	07:22	57.1%	(48)	79.6%	(78)	14.3%	(14)	32.7%	(32)	6.2%	(6)
Newham	169	60	59.8%	(101)	07:19	69.9%	(100)	74.6%	(126)	15.4%	(26)	26.6%	(45)	4.8%	(8)
Redbridge	156	71	66.7%	(104)	07:30	81.2%	(108)	80.8%	(126)	20.5%	(32)	37.8%	(59)	7.9%	(12)
Richmond	93	71	64.5%	(60)	07:15	64.6%	(51)	81.7%	(76)	22.6%	(21)	30.1%	(28)	6.8%	(6)
Southwark	173	60	70.5%	(122)	07:22	64.6%	(95)	73.4%	(127)	20.8%	(36)	32.4%	(56)	12.5%	(21)
Sutton	99	70	62.6%	(62)	07:04	62.9%	(56)	83.8%	(83)	16.2%	(16)	38.4%	(38)	12.2%	(12)
Tower Hamlets	111	57	67.6%	(75)	07:24	67.0%	(67)	74.8%	(83)	26.1%	(29)	31.5%	(35)	11.0%	(12)
Waltham Forest	117	63	64.1%	(75)	08:05	74.1%	(65)	77.8%	(91)	24.8%	(29)	26.5%	(31)	9.0%	(10)
Wandsworth	135	64	57.8%	(78)	07:08	72.2%	(83)	76.3%	(103)	24.4%	(33)	39.3%	(53)	11.3%	(15)
West London	101	63	67.3%	(68)	07:39	60.7%	(54)	67.3%	(68)	18.8%	(19)	29.7%	(30)	12.4%	(12)

** Patients conveyed to non-London CCGs (n=7) and where CCG was missing (n=3) are excluded from the table. # Figures exclude arrests witnessed by LAS staff.*
^Overall response times are measured from the time the call was connected by the operator. + Denominators exclude patients with unknown survival outcomes.

Appendix 2: Patients with ROSC sustained to hospital who survived to discharge

Hospital name	2015/16*			2016/17			2017/18		
	Number of patients	Survival with ROSC sustained to hospital+		Number of patients	Survival with ROSC sustained to hospital+		Number of patients	Survival with ROSC sustained to hospital+	
Barnet	42	25.0%	(3/12)	41	12.5%	(2/16)	50	26.1%	(6/23)
Barts Health^	124	53.5%	(54/101)	133	57.8%	(67/116)	125	55.8%	(53/95)
Charing Cross	40	18.2%	(4/22)	31	21.4%	(3/14)	34	9.1%	(1/11)
Chelsea & Westminster	33	35.7%	(5/14)	19	25.0%	(2/8)	33	27.8%	(5/18)
Croydon	123	10.4%	(5/48)	87	15.8%	(6/38)	69	14.7%	(5/34)
Darent Valley	10	50.0%	(2/4)	15	20.0%	(1/5)	11	0%	(0/4)
Ealing	54	12.5%	(3/24)	44	18.8%	(3/16)	56	16.7%	(5/30)
Hammersmith	76	53.8%	(35/65)	82	52.1%	(37/71)	88	47.0%	(31/66)
Harefield	30	56.0%	(14/25)	40	46.9%	(15/32)	61	54.2%	(26/48)
Hillingdon	83	25.6%	(10/39)	63	27.3%	(6/22)	68	15.8%	(6/38)
Homerton	43	4.8%	(1/21)	39	26.3%	(5/19)	44	4.8%	(1/21)
King's College	167	39.3%	(33/84)	189	41.7%	(45/108)	189	36.5%	(46/126)
King George	56	4.8%	(1/21)	47	0.0%	(0/17)	57	4.8%	(1/21)
Kingston	63	24.0%	(6/25)	56	8.3%	(2/24)	64	16.1%	(5/31)
Newham	77	6.7%	(2/30)	70	7.1%	(2/28)	80	10.3%	(3/29)
North Middlesex	119	8.0%	(4/50)	89	24.2%	(8/33)	107	17.3%	(9/52)
Northwick Park	126	22.8%	(13/57)	98	26.9%	(14/52)	110	9.6%	(5/52)
Princess Royal	66	17.9%	(5/28)	60	12.5%	(4/32)	59	3.1%	(1/32)
Queen Elizabeth	110	18.6%	(8/43)	101	18.6%	(8/43)	107	15.9%	(7/44)
Queen's Romford	129	4.7%	(2/43)	107	8.0%	(4/50)	119	9.6%	(5/52)
Royal Free	133	44.4%	(40/90)	132	47.7%	(41/86)	150	42.5%	(45/106)
Royal London	91	24.1%	(13/54)	78	22.6%	(7/31)	86	18.4%	(7/38)
St George's	183	39.0%	(41/105)	168	42.9%	(48/112)	184	36.4%	(47/129)
St Helier	41	21.4%	(3/14)	53	17.4%	(4/23)	44	10.0%	(2/20)
St Mary's	87	12.2%	(5/41)	76	23.7%	(9/38)	70	25.7%	(9/35)
St Thomas'	116	47.5%	(28/59)	129	38.5%	(30/78)	112	47.8%	(32/67)
University College Hospital	35	26.1%	(6/23)	33	40.0%	(8/20)	34	26.7%	(4/15)
University Hospital Lewisham	70	24.1%	(7/29)	51	11.5%	(3/26)	58	17.2%	(5/29)
West Middlesex	88	13.3%	(4/30)	66	0.0%	(0/24)	78	9.4%	(3/32)
Whipps Cross	86	17.1%	(6/35)	89	16.2%	(6/37)	76	16.7%	(5/30)
Whittington	39	21.4%	(3/14)	35	7.1%	(1/14)	32	18.8%	(3/16)

** Patients conveyed to non- London hospitals (n=12) are excluded from the table.*

^ Barts Health opened its Heart Centre at their St. Bartholomew Hospital site in April 2015.

+ Denominators exclude patients with unknown survival outcomes.

Appendix 3: Rhythm and survival per Heart Attack Centre for resuscitated patients with a STEMI

Heart Attack Centre	Number of patients	Initial rhythm			Survival to discharge+
		Asystole	VF/VT	PEA	
Barts Health	93	17.2% (16)	65.6% (61)	17.2% (16)	41.8% (38/91)
Essex Cardiothoracic Centre*	5	20.0% (1)	80.0% (4)	0% (0)	60.0% (3/5)
Hammersmith◆	69	13.2% (9)	70.6% (48)	16.2% (11)	37.9% (25/66)
Harefield	41	17.1% (7)	63.4% (26)	19.5% (8)	43.9% (18/41)
King's College	63	15.9% (10)	73.0% (46)	11.1% (7)	49.1% (27/55)
Royal Free	68	11.8% (8)	70.6% (48)	17.6% (12)	41.8% (28/67)
St George's	57	26.3% (15)	61.4% (35)	12.3% (7)	37.0% (20/54)
St Peter's Chertsey#	0	-	-	-	-
St Thomas'	24	12.5% (3)	70.8% (17)	16.7% (4)	50.0% (12/24)

** Essex Cardiothoracic Centre extended their catchment area and inclusion criteria in January 2017.*

◆ One patient conveyed to Hammersmith did not have their initial arrest rhythm documented.

 # St Peter's Chertsey accepted patients from the LAS in July 2016.

+ Denominators exclude patients with unknown survival outcomes.

Appendix 4: Cardiac arrest patients under 35 years old

	Under 1	1-8	9-18	19-35
Number of patients:	54	28	69	312
Gender:				
Male	51.9% (28)	53.6% (15)	66.7% (46)	75.6% (236)
Female	48.1% (26)	46.4% (13)	33.3% (23)	24.4% (76)
Unknown	-	-	-	-
Arrest location:				
Private	92.6% (50)	82.1% (23)	53.6% (37)	51.3% (160)
Public	7.4% (4)	17.9% (5)	44.9% (31)	48.7% (152)
Not documented	-	-	1.5% (1)	-
Witnessed[◊]:				
Bystander	16.7% (9)	46.4% (13)	44.9% (31)	39.7% (124)
LAS staff	16.7% (9)	10.7% (3)	11.6% (8)	15.4% (48)
Unwitnessed	66.7% (36)	39.3% (11)	43.5% (30)	44.6% (139)
Not documented	-	3.6% (1)	-	0.3% (1)
Bystander CPR[#]:				
Yes	71.1% (32/45)	80.0% (20/25)	73.8% (45/61)	72.0% (190/264)
No	28.9% (13/45)	20.0% (5/25)	26.2% (16/61)	28.0% (74/264)
Initial rhythm[◊]:				
Asystole	77.8% (42)	71.4% (20)	62.3% (43)	56.4% (176)
PEA	13.0% (7)	14.3% (4)	24.6% (17)	27.6% (86)
VF/ Pulseless VT	0% (0)	7.1% (2)	8.7% (6)	13.8% (43)
Not Documented	9.3% (5)	7.1% (2)	4.3% (3)	2.2% (7)
ROSC sustained to hospital:				
Yes	24.1% (13)	32.1% (9)	24.6% (17)	29.5% (92)
No	75.9% (41)	67.9% (19)	75.4% (52)	70.5% (220)
Survived to discharge[+]:				
Yes	8.0% (4)	13.0% (3)	16.2% (11)	9.5% (28)
No	92.0% (46)	87.0% (20)	83.8% (57)	90.5% (268)

◊ Totals for <1 years old within the witnessed group and <1 years old, 1-8 years and 9-18 years within the initial rhythm group do not equal 100% due to rounding.

[#] Figures exclude arrests witnessed by LAS staff.

+ Denominators exclude patients with unknown survival outcomes.

London Ambulance Service
NHS Trust

ST Elevation Myocardial Infarction Annual Report 2017/18

November 2018

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Contents

London Ambulance Service
NHS Trust

STEMI Overview | 2017-18

Patients

3,536 Total number of suspected STEMI's

74% **59** years

26% **71** years

Assessment and treatment

45% Anterior

74% Care Bundle

Triage and outcomes

99.8% Appropriately triaged

98% Conveyed to a specialist heart attack centre (HAC)

89% Confirmed STEMI and received pPCI treatment

Timings

999 call to arrive scene	Overall on-scene	Journey to HAC	999 call to pPCI
16 mins	41 mins	18 mins	127 mins

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1 Introduction

From 1st April 2017 to 31st March 2018, the London Ambulance Service NHS Trust (LAS) attended 3,536 patients with a suspected ST-Elevation Myocardial Infarction (STEMI).

When attending a STEMI patient, LAS staff will carry out a range of assessments including a 12 lead electrocardiogram (ECG), before commencing treatment as appropriate. Suspected STEMI patients should be transported directly to a Heart Attack Centre (HAC) to enable cardiac specialists at the catheter laboratory to perform immediate angiography and reperfusion procedures as required.

This report presents information regarding the clinical care provided and the outcomes of STEMI patients. Data has been sourced from the LAS' Acute Coronary Syndrome (ACS) registry, which captures clinical information from Patient Report Forms (PRFs) and 12 lead ECG strips, and operational information from vehicle Mobile Data Terminals and emergency call logs. Outcome data is collected from hospital patient records and the Myocardial Ischaemia National Audit Project (MINAP) database.

2 Findings

2.1 Patient demographics

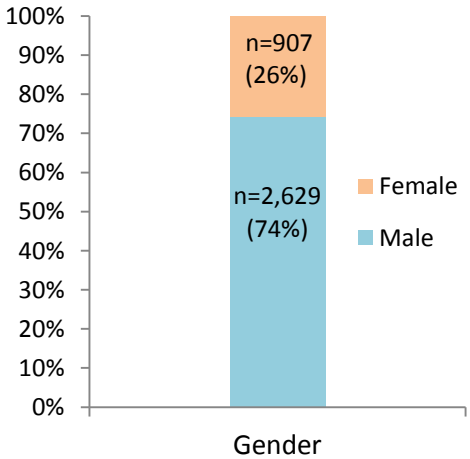


Figure 1: Gender distribution

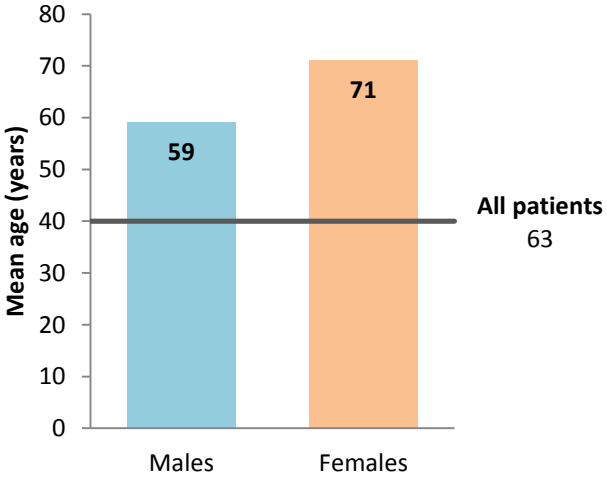


Figure 2: Age of STEMI patients by gender

- As in previous years, three-quarters of patients were male.
- The mean patient age was 63 years, with males being 12 years younger than females.

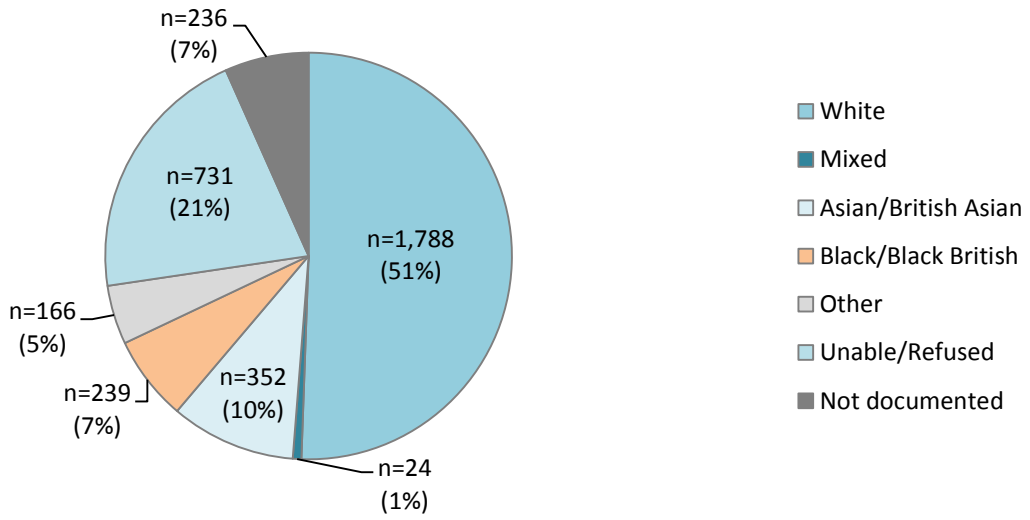


Figure 3: Breakdown of patient race

- Half of all patients were of a white race.
- A fifth of patients either refused or were unable to provide information regarding their race.

2.2 Call information

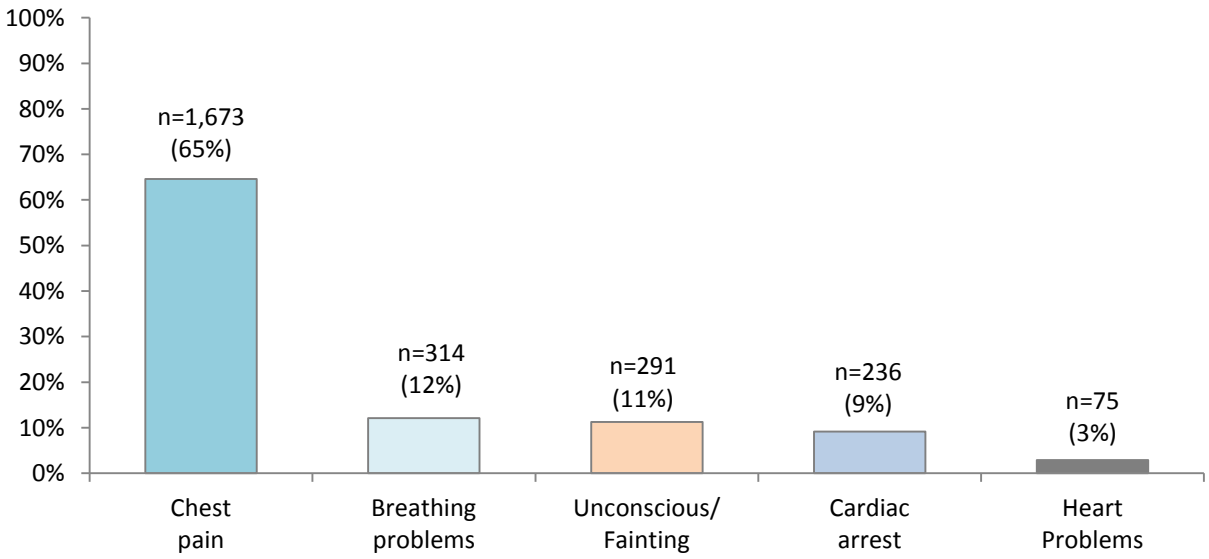


Figure 4: Top 5 chief complaints from emergency calls from members of the public

- 88% (n=3,113) of calls were from members of the public; an increase of 7% from 2016/17.
- Based on the information provided by the caller, chest pain was identified from the emergency call as the chief complaint for 54% of patients; a notable decrease of 6% from last year.
- Calls from 111 providers and Health Care Professionals (e.g. GPs) accounted for 12% (n=423) of patients attended by the LAS.

2.3 Infarct details

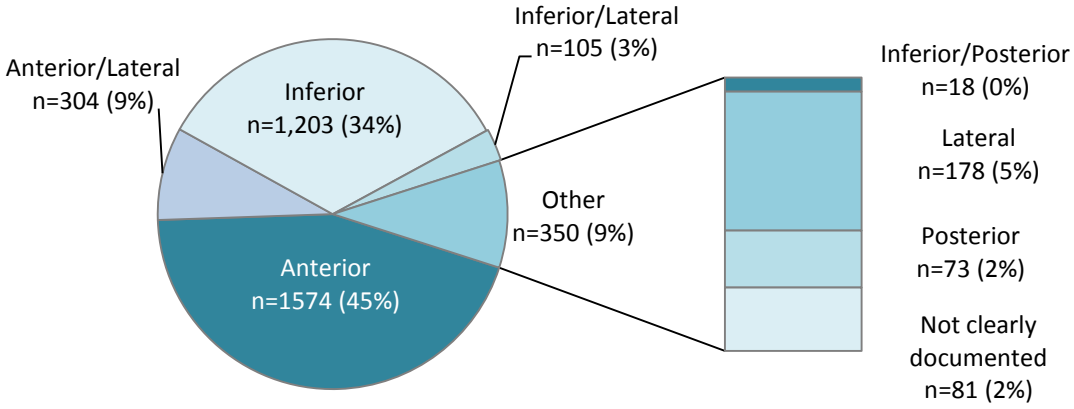


Figure 5: Location of infarct

- In line with previous years, the most prevalent location for the infarct was the anterior region of the heart (45%), followed by the inferior region (34%).
- For 2% of cases, the infarct location was not clearly documented.

2.4 Response information

On 1st November 2017, the LAS implemented the new national standard for call categorisation and associated response times as defined by NHS England's Ambulance Response Programme (ARP). As the new standards redefined response categories and the way response times are measured, this section is divided into two parts representing performance against the previous definitions (pre-ARP) and the new standards (post-ARP).

2.4.1. 1st April 2017 – 31st October 2018 (Pre-ARP)

During this period, calls were categorised as Red or Green calls. The highest priority (Red) response category was sub-divided into Red 1 and Red 2 (with Red 1 indicating those incidents which were immediately life-threatening). Red 1 responses were measured from the time the call was connected by the operator. The remaining categories allowed a period of time for information gathering by the EMD in order to assign the most appropriate response to each patient. For all categories, the clock stopped when the first resource arrived on scene. Red calls had a national target of 75% of patients receiving a response within 8 minutes.

Category	No. (%)	Response time, minutes		
		Mean	Median	90th Centile
Red 1	168 (8%)	7	7	10
Red 2	1,674 (84%)	8	7	14
Green	160 (8%)	29	20	64
Overall†	**2,004**	**10**	**7**	**16**

†*A specific category was not allocated to two incidents.*

Table 1: Category by response time (Pre-ARP)

2.4.2. 1st November 2018 – 31st March 2018 (Post-ARP)

From 1st November 2017, calls were categorised into four groups from Category 1 for 'life-threatening illnesses or injuries' such as cardiac arrest through to 'less urgent conditions' in Category 4. For each category, the response time is measured using a set of rules that define the point at which the clock starts and the type of resource that is required to arrive on scene for the clock to stop (see overleaf).

Category	Response standard (minutes)		Definitions
	Mean	90th centile	
Category 1 (Life threatening)	7	15	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 30 seconds from the call connecting. Clock stop The arrival of the first LAS resource (whether a solo responder or an ambulance).
Category 2 (Emergency)	18	40	Clock start The earliest time that: • the call is assigned a chief complaint; or • the first resource is dispatched; or • 240 seconds from call connect Clock stop The arrival of the first LAS vehicle able to transport the patient to hospital.
Category 3 (Urgent)	120 (maximum time)		
Category 4 (Less urgent)	180 (maximum time)		

A set of pre-triage questions are used to help early recognition of life-threatening conditions. This enables a rapid dispatch of a resource to Category 1 calls. Emergency Medical Dispatchers (EMDs) have additional time to continue to further triage lower priority response category calls so that the most appropriate response for the patient's condition can be assigned.

Category	No. (%)	Response time, minutes		
		Mean	Median	90th Centile
Category 1	197 (13%)	9	6	11
Category 2	1,228 (80%)	21	15	42
Category 3	87 (6%)	55	29	152
Category 4	19 (1%)	74	74	161
Overall†	**1,531**	**22**	**14**	**45**

† *One incident has been excluded as, although it occurred on 1st November 2017, it was before the ARP standards were operational.*

Table 2: Category by response time (Post-ARP)

- In the pre-ARP period, 84% of calls were categorised as requiring a Red 2 response.
- Under the new ARP standards, the majority of calls were allocated a Category 2 response.
- During the pre-ARP period, STEMI patients received a mean response of 10 minutes, with a median time of 7 minutes.
- The post-ARP mean response was 22 minutes from clock start to arrival of an appropriate response. The median time was 14 minutes.
- Comparing the time taken for a vehicle capable of transporting a patient to arrive on scene, the pre-ARP mean response was 20 minutes and the post-ARP mean response was 25 minutes.

2.5 On-scene times

The type of response dispatched to the scene is based on the response category allocated. The highest priority patients will often receive a solo responder (i.e. a car, motorbike, cycles) to initially assess and treat the patient, followed by an ambulance that can convey the patient to hospital. Lower priority patients may still receive a solo responder, but the aim is to dispatch an ambulance that can treat and convey the patient.

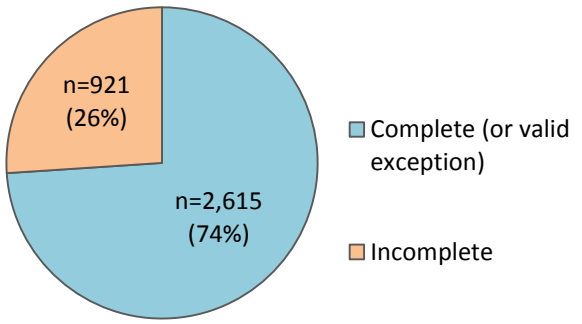
From the arrival of:	On-scene time, minutes		
	Mean	Median	90th centile
First attending vehicle	41	38	62
First conveying ambulance	35	32	54

Table 3: On-scene times

- The mean on-scene time from the arrival of the first attending vehicle to the conveying ambulance leaving scene decreased by 2 minutes from last year to 41 minutes.
- When measuring on-scene times from the arrival of the first vehicle capable of conveying the patient to the time the transporting ambulance left scene, the mean was 35 minutes (1 minute longer than in 2016/17).

2.6 STEMI patient care

2.6.1 Care bundle compliance



Full care bundle components:

- ✓ Aspirin
- ✓ GTN
- ✓ Two pain assessments (pre- and post-treatment)
- ✓ Analgesia

Figure 6: Full care bundle administration

- 74% of patients received a complete care bundle or had a valid exception; a 1% increase from last year
- Further details regarding the performance against the specific components of the care bundle are provided in section 2.6.2 and 2.6.3.

2.6.2 Aspirin and glyceryl trinitrate (GTN)

Patients presenting with a STEMI should be administered aspirin and GTN as soon as possible to increase the blood flow to the heart.

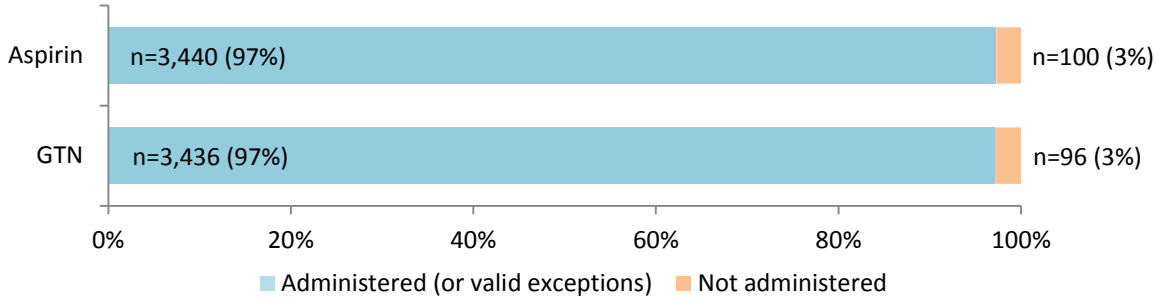


Figure 7: Aspirin and GTN administration

- Administration of both aspirin and GTN remained at a high level, with 97% of patients receiving each drug.

2.6.3 Pain assessment and management

Patients should have their level of pain assessed to ensure that the appropriate treatment is provided. Ideally, the pain will be quantified using a numerical rating scale (scored from 0 to 10), or where this is not possible, a qualitative assessment describing the pain experienced.

Where a patient is pain-free (either as a result of an atypical presentation or as a result of the administration of aspirin and GTN), analgesia is exempted. Where pain has been described as mild (a score of 1 to 3), Entonox is the indicated drug. For higher levels of pain, patients should be provided with morphine. Entonox is also an option for patients with moderate to severe pain where it is not possible to administer morphine (e.g. where intravenous access is unsuccessful or where there is no paramedic available), or as a precursor to morphine administration.

Pain should be reassessed in order to determine the effectiveness of the treatment and whether the patient has any further analgesic needs.

2.6.3.1 Pain assessment

- Overall, 96% of patients (n= 3,404) received a pre- and post-treatment pain assessment (or had a valid exception).
- 4% of patients (n=132) did not receive two pain assessments and there were no valid reasons documented for this.

2.6.3.2 Analgesic drugs administered

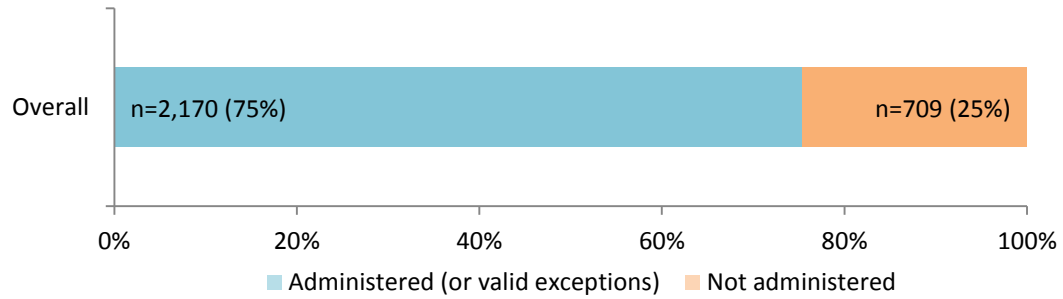


Figure 8: Administration of analgesia

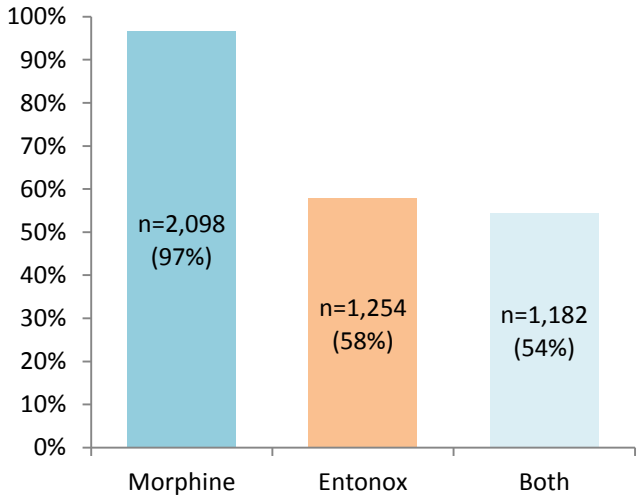


Figure 9: Type of analgesia administered

- 81% of patients (n=2,879) reported they were in pain, and three-quarters received at least one form of analgesia (or had valid exceptions to both). This is a decrease of 6% from last year.
- When analgesia was administered, morphine was the most prevalent drug used.
- Further details regarding the pain level reported by the 709 patients who did not receive analgesia can be found in 2.6.3.3.

2.6.3.3 Pain level of patients not receiving analgesia

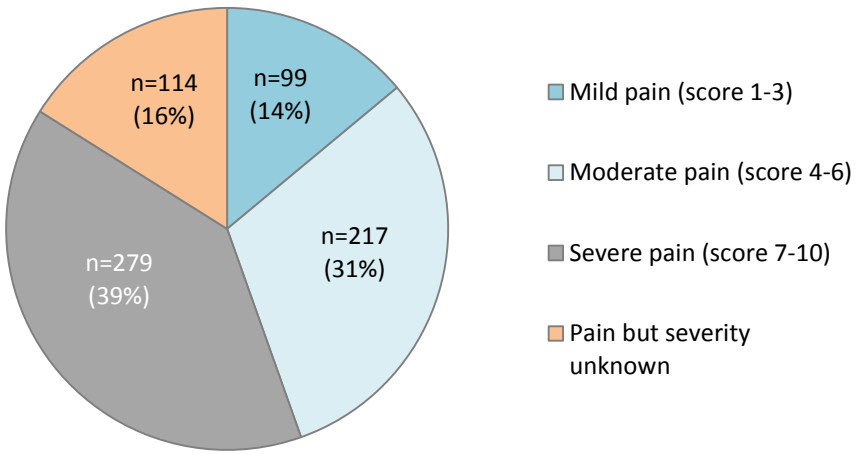


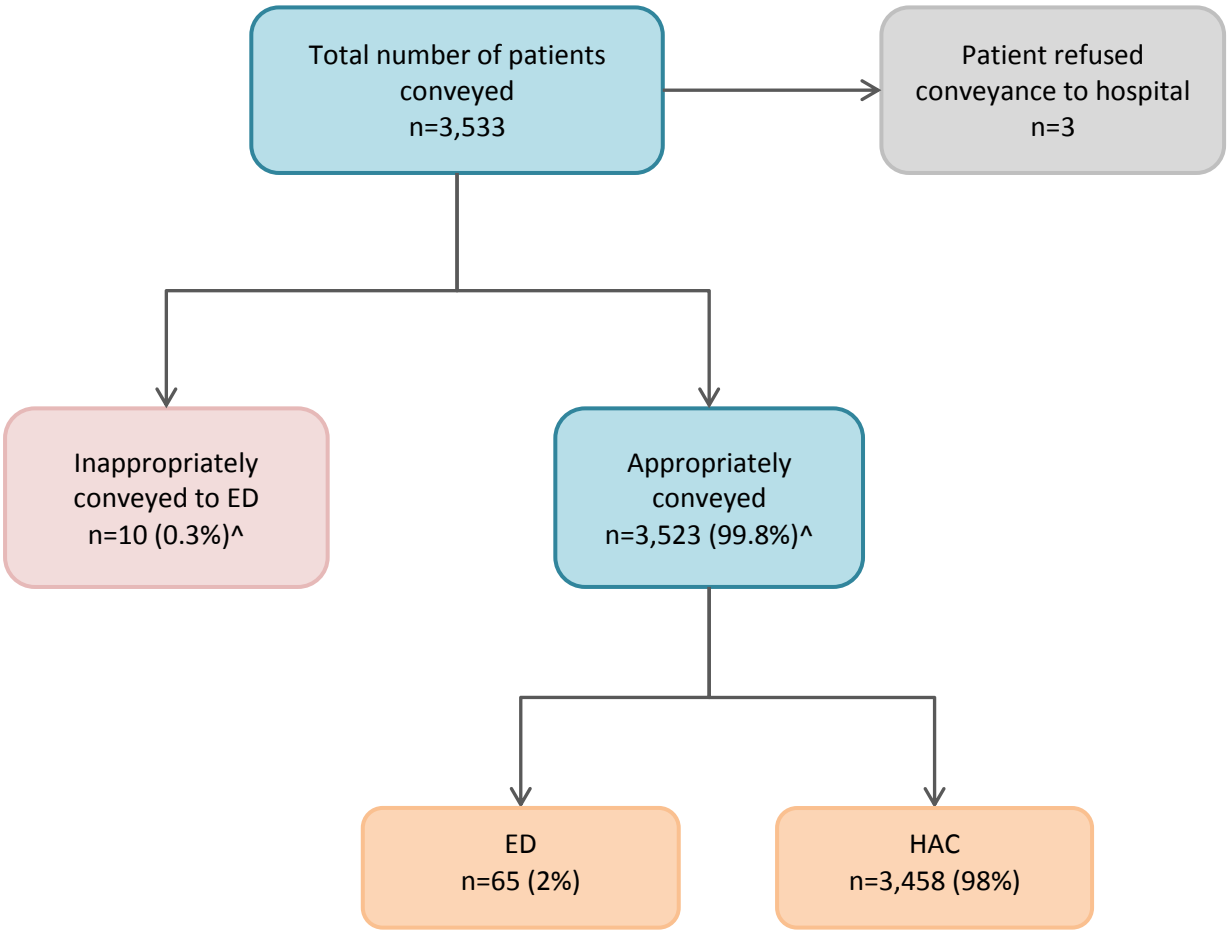
Figure 10: Pain level of patients not receiving analgesia

- 709 patients did not receive any analgesia despite being in pain (following aspirin and GTN administration), and over a third (39%, n=279) were in severe pain.

2.7 Conveyance

There are nine specialist Heart Attack Centres (HACs) to which the LAS can directly convey STEMI patients 24 hours a day, 7 days a week. On occasion, there may be circumstances where it is more appropriate for the patient to be conveyed to an Emergency Department (ED), including where the airway is unmanageable, the patient has uncontrolled seizures, where a patient may refuse conveyance to a HAC, or where there are operational infrastructure issues within the HAC itself.

2.7.1 Destination of STEMI patients



^ Percentages do not equal 100% due to rounding.

Figure 11: Patient destination

- Nearly 100% of patients were conveyed to an appropriate destination, which is consistent with 2016/17.
- 98% of patients were transported to a HAC, which is also the same as last year.

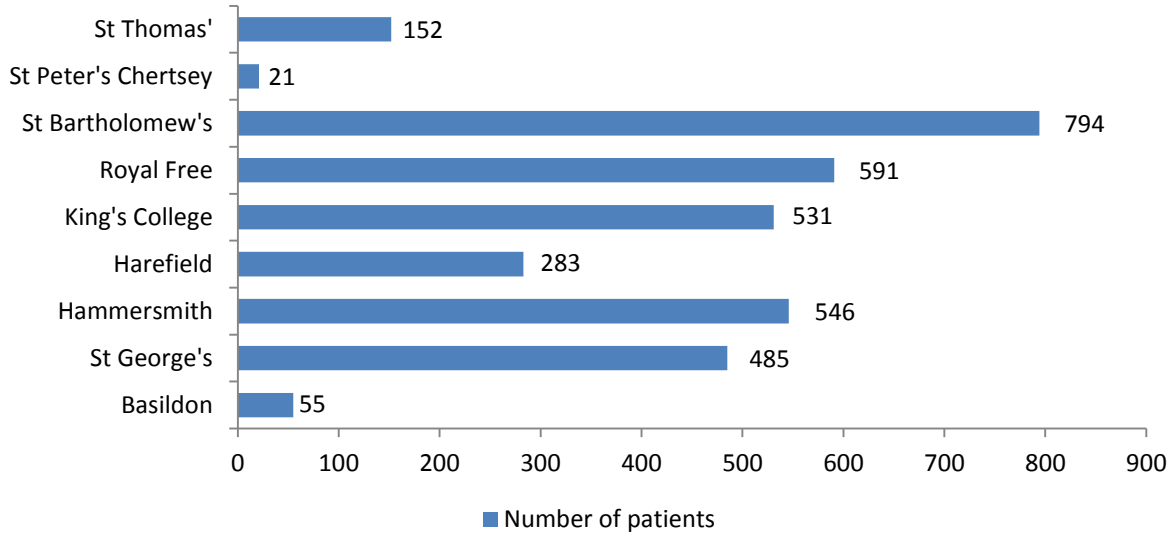


Figure 12: Number of patients conveyed to each HAC

- The majority of patients were conveyed to Barts Health.
- Small numbers of patients are conveyed to St Peter's and Basildon Hospitals due to their limited catchment areas.

2.7.2 Journey and call to hospital times

Destination	Leave scene – arrive hospital, minutes			999 call – arrive hospital[†], minutes		
	Mean	Median	90th centile	Mean	Median	90th centile
HAC	18	17	29	75	70	105
ED	12	10	23	80	72	133

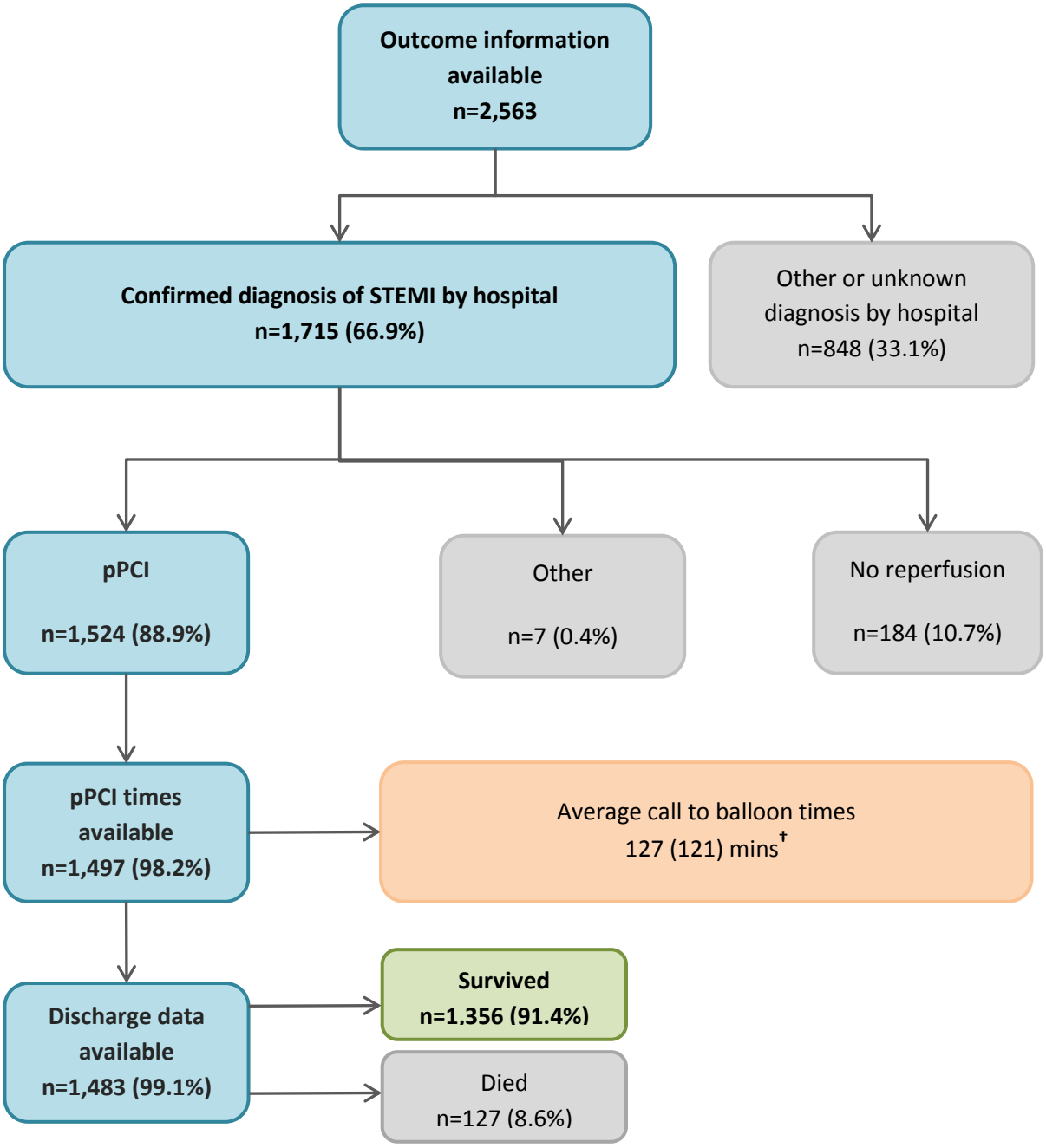
[†] *999 call to hospital times shown have been calculated from call connect time.*

Table 5: Journey and call to hospital times

- Patients conveyed directly to a HAC had a mean journey time (leave scene to arrival at hospital) of 18 minutes.
- The mean call to hospital arrival time to a HAC was 75 minutes.

2.8 Reperfusion and patient outcomes

The majority of patients who receive reperfusion treatment undergo Primary Percutaneous Coronary Intervention (pPCI) whereby the artery is unblocked via the insertion of a catheter, inflation of a small balloon and placing of a stent to ensure the artery remains open. However, in a small number of cases, patients may receive thrombolytic drug treatment to dissolve the blockage.



† Mean (median) based on 999 call connect time.

Figure 13: Outcomes for patients who received reperfusion at a HAC

- A diagnosis of STEMI was confirmed at hospital for 67% of patients conveyed to a HAC.
- 89% of those with a confirmed STEMI received pPCI treatment.
- The mean time from the 999 call to balloon insertion time was 127 minutes, well within the target of 150 minutes[1].
- 91% of patients were discharged from hospital alive, a 2% decrease from last year.

3 Quality Improvement activity

During 2017/18, the LAS continued to implement measures aimed at improving the care received by STEMI patients, including:

- Providing ongoing training in the interpretation of ECGs to assist crews in the recognition of a STEMI and subsequent decision making.
- Where patients were identified as having been conveyed to an inappropriate destination, details were forwarded to local management to enable feedback to be provided to the crews involved.
- Local quality improvement measures were also undertaken to improve the delivery of analgesia.

4 Summary

The LAS continues to maintain a high standard of care, with a good level of pain assessment and treatment using aspirin and GTN. The LAS recognises that, for the care bundle provision to improve, a greater focus on delivering appropriate analgesia to patients is needed. We have continued to demonstrate excellent compliance with specialist conveyance pathways. Our patient outcomes show that patients continue to receive pPCI treatment well within the national time targets.

5 Looking forward

In the coming year, the LAS will focus on a number of initiatives to improve patient care:

- An infographic poster outlining to clinicians the four elements of the care bundle, including which circumstances constitute an exception will be produced and made available to all staff.
- Details of all incidents where a full care bundle was not provided will be shared with local management teams for investigation and individual feedback.
- Collaborating with NHS England in the development of the Ambulance Quality Indicators to include working with MINAP to support data linkage within the pre-hospital and hospital system to enhance the quality of the patient outcome data we can source.

References

1. Treatment of Heart Attack National Guidance – Final Report of the National Infarct Angioplasty Project (NIAP), Crown, 2008.

Acknowledgements

CARU wishes to thank colleagues in the Medical Directorate for their ongoing support, particularly Mark Whitbread and Jo Nevett.

Glossary of abbreviations and terms

Aspirin – Aspirin thins the blood and improves its flow through the arteries.

Call Connect – The time the 999 call is connected to the ambulance service.

Call to Balloon Time – The overall time taken from the initial 999 emergency call to the point of balloon inflation in a primary Percutaneous Coronary Intervention (pPCI) procedure performed at hospital.

Cardiac Catheter Laboratory (Cath Lab) – The area within a specialist Heart Attack Centre where patients receiving reperfusion will be treated.

Care Bundle – The optimum combination of observations and treatments that ambulance crews should perform so that the patient receives the best possible care.

Clinical Commissioning Group – NHS organisations that govern the delivery of services within areas of England.

Entonox – A mix of 50% nitrous oxide and 50% oxygen (also known as “gas and air”).

First arriving vehicle – A resource dispatched to immediately life-threatening calls which can include a solo responder (such as a car, motorcycle, bicycle response) or an ambulance.

Glyceryl Tri-Nitrate (GTN) – A drug which allows blood vessels to relax and widen, thus allowing improved blood flow and reducing the workload of the heart.

Heart Attack Centre (HAC) – Specialist centres in London hospitals to which patients suffering a STEMI are taken directly for primary Percutaneous Coronary Intervention (pPCI).

Medical Priority Dispatch System (MPDS) – A medically approved system used by call handlers to triage patients based on their responses to pre-determined questions.

Mobile Data Terminal (MDT) – The device used by clinical staff to receive incoming call information and navigate to the location.

Morphine – An analgesic which can be administered (usually intravenously) by a paramedic.

Myocardial Infarction (MI) – Commonly known as a 'heart attack'. A myocardial infarction refers to a blockage of the coronary artery that limits blood flow to an area of the heart.

Myocardial Ischaemia National Audit Project (MINAP) – A national registry maintained by hospitals containing details of patients who were taken to Heart Attack Centres, reperfusion treatment performed and patient outcomes.

Numerical rating scale – A method of rating a patient's pain based on a score from zero (no pain) to 10 (the worst pain imaginable).

Pain assessment – An observation which should be taken both pre- and post-treatment to assess the patient's level of pain.

Paramedic – A type of clinical staff that are able to perform advanced skills such as cannulation to allow for the delivery of drugs intravenously.

Patient Report Form (PRF) – The document used by the LAS to record all aspects of patient care and treatment.

Primary Percutaneous Coronary Intervention (pPCI) – A surgical procedure performed at a Heart Attack Centre which seeks to unblock arteries by means of insertion of a catheter into the affected artery and inflating a small balloon to re-open it. The opened artery is then held in place with a small stent.

ST-Elevation Myocardial Infarction (STEMI) – A type of myocardial infarction. ST-Elevation refers to a particular pattern seen on a 12-Lead ECG which indicates a complete blockage in a coronary artery.

Thrombolysis – A form of reperfusion which breaks down blood clots by pharmacological means (also known as "clot busting"). It is now generally only used in a small number of patients who are not suitable for primary Percutaneous Coronary Intervention treatment and is undertaken at hospital.

Appendix 1: On-scene times and care bundle provision by Clinical Commissioning Group of incident location

Incident CCG	Mean (median) on-scene times, minutes		Care Bundle			
	Arrival of first vehicle	Arrival of first conveying vehicle	Yes/ Exception		No	
			n	%	n	%
Barking & Dagenham	40 (37)	33 (30)	70	77%	21	23%
Barnet	41 (37)	36 (32)	111	73%	42	27%
Bexley	42 (42)	37 (35)	81	81%	19	19%
Brent	40 (34)	35 (31)	129	72%	50	28%
Bromley	45 (44)	40 (37)	76	72%	30	28%
Camden	40 (37)	36 (32)	58	62%	35	38%
Central London	38 (34)	35 (30)	72	67%	35	33%
City & Hackney	42 (37)	37 (34)	69	70%	29	30%
Croydon	42 (38)	35 (30)	115	74%	40	26%
Ealing	40 (36)	34 (31)	124	79%	33	21%
Enfield	41 (38)	34 (31)	113	75%	38	25%
Greenwich	40 (37)	36 (34)	68	79%	18	21%
Hammersmith & Fulham	41 (40)	36 (34)	45	66%	23	34%
Haringey	42 (38)	35 (29)	67	67%	33	33%
Harrow	39 (36)	34 (31)	101	78%	29	22%
Havering	41 (38)	35 (31)	96	87%	15	13%
Hillingdon	44 (40)	33 (30)	134	75%	45	25%
Hounslow	42 (40)	32 (32)	86	75%	28	25%
Islington	42 (40)	37 (34)	52	64%	29	36%
Kingston	39 (38)	32 (31)	48	69%	22	31%
Lambeth	38 (36)	34 (33)	78	77%	24	23%
Lewisham	44 (41)	41 (40)	88	79%	23	21%
Merton	39 (33)	34 (29)	49	74%	17	26%
Newham	41 (38)	34 (31)	78	67%	39	33%
North West Surrey	26	26	1	100%	0	0%
Redbridge	41 (39)	35 (31)	109	77%	33	23%
Richmond	38 (35)	33 (31)	59	78%	17	22%
Southwark	43 (40)	41 (38)	74	74%	26	26%
Surrey Downs	26	26	1	100%	0	0%
Sutton	37 (34)	32 (28)	67	76%	21	24%
Tower Hamlets	45 (43)	38 (35)	85	74%	30	26%
Waltham Forest	43 (40)	35 (29)	75	72%	29	28%
Wandsworth	35 (33)	31 (31)	72	72%	28	28%
West London	38 (36)	33 (32)	64	76%	20	24%

Appendix 2: On-scene times and care bundle provision by LAS Group Station

LAS Group Station	Mean (median) on-scene times, minutes		Care Bundle			
	Arrival of first vehicle	Arrival of first conveying vehicle	Yes/ Exception		No	
			n	%	n	%
Homerton	42 (39)	36 (33)	118	67%	58	33%
Newham	41 (39)	34 (31)	191	76%	62	24%
Romford	41 (38)	35 (31)	198	78%	56	22%
North East	41(39)	35 (31)	507	74%	176	26%
Camden	40 (37)	35 (31)	125	69%	56	31%
Edmonton	40 (38)	34 (30)	161	72%	64	39%
Friern Barnet	41 (36)	36 (32)	92	70%	40	30%
North Central	40 (37)	35 (31)	378	70%	160	30%
Brent	40 (36)	35 (32)	244	75%	80	25%
Fulham	39 (35)	33 (31)	133	72%	52	28%
Hanwell	41 (38)	33 (31)	172	76%	55	24%
Hillingdon	41 (40)	31 (30)	98	75%	32	25%
Westminster	39 (38)	34 (32)	61	70%	26	30%
North West	40 (37)	34 (31)	708	74%	245	26%
Bromley	43 (40)	37 (33)	124	73%	47	27
Deptford	41 (38)	38 (35)	213	74%	74	26%
Greenwich	43 (41)	38 (36)	143	82%	31	18%
South East	42 (39)	38 (35)	480	76%	152	24%
Croydon	43 (40)	37 (35)	89	76%	28	24%
New Malden	40 (36)	33 (32)	81	77%	24	23%
St Helier	37 (34)	32 (29)	87	70%	38	30%
Wimbledon	37 (34)	31 (28)	109	73%	40	27%
South West	39 (36)	33 (30)	366	74%	130	26%
PAS & VAS	50 (45)	43 (36)	78	72%	30	28%
Other LAS[†]	41 (39)	36 (32)	98	78%	28	22%

[†] *Includes Hazardous Area Response, Special Events, Tactical Response Units and Training.*

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Report of the Trust Secretary – policies			
Agenda item:	17			
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 presents the Board with proposed amendments to two existing Board-level policies and recommends the adoption of a new policy relating to conflicts of interest.

Recommendation:

The Trust Board is asked to approve the proposed policies as set out in the report.

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

N/A

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

This paper supports the achievement of the following Business Plan Workstreams:

Ensure safe, timely and effective care	☐
Ensuring staff are valued, respected and engaged	☐
Partners are supported to deliver change in London	☒
Efficiency and sustainability will drive us	☒

Proposed policy amendments

Policy for Managing the Conflict of Interest

1. The Trust does not currently have an explicit policy relating to conflicts of interests and declarations of gifts/hospitality, relying instead on the Standing Orders of the Board to set out its position on these.

2. Earlier in the year NHS England (NHSE) published update guidance on managing conflicts of interest, together with a model policy. The draft policy set out at Annex A to this report is in line with this NHSE model policy, the purpose of which is to set out the actions which staff and office holders should take in respect of declaring interests (including the receipt of hospitality/gifts/rewards or other inducements) in order to safeguard themselves and the Trust against any perceived or actual impropriety. It is proposed that compliance with this policy should be reviewed and reported to the Board on a quarterly basis.

3. The Board is asked to confirm it is content to adopt the proposed Policy for Managing Conflicts of Interest.

Fit and Proper Person Policy

4. The Trust's Fit and Proper Person Policy (attached at Annex B to this report) currently requires that compliance with this policy should be checked on an annual basis. It is proposed that alongside the quarterly review of declarations of interests (including gifts and hospitality), compliance with the Fit and Proper Person Policy should also be reviewed, rather than on the annual basis currently set out in the policy.

5. In February 2018, the Trust's Internal Auditors reviewed its Fit and Proper Person Policy and made the following observation and recommendation:

   From our review of the Department of Health Publication 'Strengthening corporate accountability in health and social care: consultation on the fit and proper person regulations', a key area of focus was the consequences of non-compliance with the Fit and Proper Persons verification and policy. Currently within the Trust's Fit and Proper Person Policy there is no detail of the consequences of, 'failure to comply' and any subsequent appeals process. The Trust should include a section within the Fit and Proper Policy which outlines consequences of, 'Failure to Comply', which should also detail any appeals process.

6. In light of this recommendation, it is proposed to add the following section to the Fit and Proper Person Policy:

   <u>Failure to Comply</u>

   The London Ambulance Service requires all those subject to this policy to take all practicable steps to comply with it. Compliance with this policy will be periodically monitored by Internal Audit. Any known or suspected instances of non-compliance will be reported to the Audit Committee for full investigation and appropriate disciplinary action.

   A person's failure to provide relevant and timely information required for assessing their fitness and propriety is considered serious misconduct and will result in disciplinary action which may lead to dismissal.

7. Board members are asked to confirm if they are content to approve the proposed amendments to the Fit and Proper Person Policy, together with minor amendments to reflect changes to job titles and departments.

Policy for the Development and Implementation of Procedural Documents

8. Attached at Annex C to this report is a proposed re-drafted policy for the development and implementation of procedural documents. It has been re-drafted in line with guidance from NHS Resolution and benchmarked against other Ambulance Trusts, with a view to ensuring that it is much clearer and easier to implement than the previous policy.

9. Board members are asked to approve the proposed amendment of this policy.

10. A key change in the policy is the dis-establishment of the Trust's Policy Monitoring and Approval Group. Rather, it is proposed that the following should be decision-makers with regard to the adoption and amendment of Trust procedural documents, with a view to simplifying the decision-making process:

	Responsible	**Endorser**	**Approver**	**Informed**
Strategies	Director	Executive Committee Board Assurance Committee (where relevant)	Trust Board	N/A
Key organisational policies reserved for Board approval	Director	Executive Committee Board Assurance Committees (where relevant)	Trust Board	N/A
Organisational policies not reserved to the Board	Director	Board Assurance Committee (where relevant)	Executive Committee	Trust Board
Organisational policies not reserved to the Board or ExCo	Director	At least one other Director	Director	Executive Committee

11. Subject to the Board's approval of this policy, a systematic review of Trust policies will be undertaken to ensure that they are relevant and appropriate.

Philippa Harding
Director of Corporate Governance

London Ambulance Service NHS
NHS Trust

Policy for Managing the Conflict of Interests

Contents

1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…

• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
 	
• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent
 	
• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
 	
• **NOT** misuse your position to further your own interests or those close to you
 	
• **NOT** be influenced, or give the impression that you have been influenced by outside interests
 	
• **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money
	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
	
	• Identify a team or individual with responsibility for:
	  ○ Keeping this policy under review to ensure they are in line with the guidance.
	  ○ Providing advice, training and support for staff on how interests should be managed.
	  ○ Maintaining register(s) of interests.
	  ○ Auditing this policy and its associated processes and procedures at least once every three years.
	
	• **NOT** avoid managing conflicts of interest.
	
	• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

2 Introduction

The London Ambulance Service NHS Trust and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

3 Purpose

This policy should be reviewed in conjunction with section 15 of the Trust's Standing Orders, Reservation and Delegation of Powers of the Trust Board Directors

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

4 Key terms

A 'conflict of interest' is:

> "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[*] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[†] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6 Staff

At London Ambulance Service NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money

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[*] This may be a financial gain, or avoidance of a loss.

[†] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

- Members of advisory groups which contribute to direct of delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

A declaration of interest(s) form is available at:
https://thepulseweb.lond-amb.nhs.uk/search/?q=la033

Declarations should be made to: The Corporate Secretary/Committee Services team

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.2 Proactive review of interests

We will prompt decision making staff quarterly to review declarations they have made and, as appropriate, update them or make a nil return.

9 Records and publication

9.1 Maintenance

The organisation will maintain registers for the declaration of interests, and for registering gifts and hospitality.

All declared interests that are material will be promptly transferred to the register by the Corporate Secretary/Committee Services team.

9.2 Publication

We will:

- Publish the interests declared by decision making staff quarterly, following Board meetings.
- Refresh this information annually.
- Make this information available on the Pulse and the London Ambulance Service NHS Trust website.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Corporate Secretary/Committee Services team to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

London Ambulance Service NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:
http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and London Ambulance Service NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the London Ambulance Service NHS Trust not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

11.1.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

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* The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

- Staff should declare any existing outside employment (including self-employment) on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

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* The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.3.1 What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the organisation.

- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

11.8.1 What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

11.9.1 What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the organisation.
    - Nature of their involvement in the sponsored research.
    - relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises[*] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[†]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

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[*] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[†] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

11.11.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies London Ambulance Service NHS Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Trust Board
- The Executive Committee

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to Freedom to Speak Up / Whistleblowing policy.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised Freedom to Speak Up / Whistleblowing policy.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for

staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
    - Informal action (such as reprimand, or signposting to training and/or guidance).
    - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Pulse and Trust's website as appropriate, or made available for inspection by the public upon request.

14 Review

This policy will be reviewed annually unless an earlier review is required. This will be led by the Corporate Secretary/Committee Services team.

15 Associated documentation

Freedom of Information Act 2000
ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
ABHI Code of Business Practice
NHS Code of Conduct and Accountability (July 2004)

London Ambulance Service NHS Trust

Fit and Proper Person Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To provide assurance that the LAS will ensure that all persons appointed as directors satisfy the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Sponsor Department: Corporate Governance

Author/Reviewer: Director of Corporate Governance/Trust Secretary
To be reviewed by: December 2017

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
15/12/2016	1.1	IG Manager	Further minor amendments
01/12/2016	1.0	Head of Governance and Assurance	Document Profile and Control Update
18/11/2016	0.2	IG Manager	Document Profile and Control Update and other minor changes
14/11/2016	0.1	Sandra Adams	Formal policy to replace the current process

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
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The Pulse	15/12/16	Governance Administrator	G&A
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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

1.1 The Fit and Proper Person policy outlines the commitment of the London Ambulance Service NHS Trust ('the Trust') to ensuring that all persons appointed as directors satisfy the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activity Regulations'). The Trust has responsibility to ensure these requirements are met and the Care Quality Commission (CQC) role is to monitor and assess how well this responsibility is discharged.

1.2 There is an expectation that senior leaders will set the tone and culture of the organisation, which leads to staff adopting a caring and compassionate attitude and adds weight to the importance of the Fit and Proper Person requirements.

2. Scope

2.1 The Trust confirms that the following roles fall within the scope of the relevant provisions of the Regulated Activity Regulations:

- Trust Chair
- All Non-Executive and Associate Non-Executive Directors
- Chief Executive
- Director of Finance and Performance
- Medical Director
- Chief Quality Officer
- Director of Operations
- Director of Corporate Governance/Trust Secretary
- Director of Transformation and Strategy
- Director of Workforce and Organisational Development
- Director of Strategic Communications
- Director of Performance
- Any other board member (regardless of voting rights) not listed above
- Any other person who performs the functions of, or functions equivalent or similar to, those of a director.

2.2 The individual falls under the requirements of the Regulated Activity Regulations regardless of whether they undertake the above role via a temporary, secondment or interim basis. The individual does not have to be an employee of the Trust to fall within the scope of this policy.

3. Objectives

3.1 Under the Requirements, the Trust must not appoint to a post under the scope of the Regulated Activity Regulations without first satisfying itself that the individual:

- Is of good character
- Has the necessary qualifications, competence, skills and experience

- Has the appropriate level of physical and mental fitness
- Has not been party to any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity
- Is not deemed unfit under the Regulated Activity Regulations' provisions
- Can provide the personal information as set out in the Regulations which must be available to be supplied to the CQC when required.

3.2 These requirements must be held at the point of commencing the role and on an ongoing basis.

3.3 The CQC's definition of 'good character' is not the objective test of having no criminal convictions but rather a judgement to be made as to whether a person's character is such that they can be relied upon to do the right thing under all circumstances. The Trust will use its discretion in reaching a decision regarding character.

3.4 The Trust has no discretion in relation to the requirement that the individual is not deemed unfit under the Regulated Activity Regulations and such individual is automatically prevented from holding any of the positions listed under paragraph 2 above.

3.5 In the event that an individual ceases to be a fit and proper person, the individual may be summarily dismissed and the Trust will notify the individual and the Trust's regulator.

3.6 **Appendix 1** provides information on what constitutes a fit and proper person under the Regulated Activity Regulations.

3.7 **Appendix 2** contains the self-declaration form which all directors and director-equivalents will be required to fill out.

4. Responsibilities

4.1 Trust Chair

- To take overall responsibility and accountability for ensuring all those required to confirm that they meet the requirements of the Regulated Activity Regulations do so at appointment and as an ongoing requirement.

4.2 Those within the scope of the Fit and Proper Person requirement

- To hold and maintain suitability for the role they are undertaking
- To respond to any requests of evidence of their ongoing suitability
- To disclose any issues which may call into question their suitability for the role they are undertaking.

4.3 Trust Secretary

- In conjunction with the Workforce and Organisational Development directorate to ensure all appointment checks (as outlined in Appendix 2) are undertaken for Directors and ensure the results are recorded and evidenced within the individual's file
- To liaise with the appointments team of NHS Improvement on appointment of the Chair and Non-Executive Directors to the Trust
- In conjunction with the Workforce and Organisational Development directorate to undertake an annual refresh of suitability (as outlined in Appendix 2) for all Directors.

4.4 Procurement

- To ensure all agencies/candidate providers understand their responsibilities and comply with the requirements of this policy.
- The requirements of this policy must be communicated to any prospective agency/candidate provider prior to their engagement.

4.6 Agency Providers

- To ensure the necessary checks have been outlined in this policy and make those checks available as and when required.

5. Compliance at the point of recruitment

5.1 The Trust has robust policies in place with regard to the appointment of directors, including:

- Confirming the status of specific qualifications as outlined within the relevant job description/person specification
- Identity checks
- Qualification and registration checks
- Right to work checks
- Disclosure and Barring Service (DBS) checks
- References (covering at least three years of employment, one of which must be from the current/most recent employer)
- Search of insolvency and bankruptcy register
- Review of full employment history seeking any explanation for gaps in employment
- Health questionnaire and occupational health clearance
- Values-based recruitment – the candidate's understanding of the Trust's and NHS values will be included as part of the interview process
- A search of the individual through internet search engines to note any relevant information in the public domain that may then be put to the candidate

- A self-declaration from the individual (Appendix 2)
- An explicit clause within the contract of employment/service level agreement to ensure the individual accepts the requirements of the Regulated Activity Regulations at the point they commence with the Trust.

5.2 All of the above will be recorded and held on the individual's personal file.

6. Assessment of continued compliance

6.1 The Trust is responsible for ensuring the continued compliance of those persons to whom the Regulated Activities Regulations apply. It is intended this requirement will be fulfilled through a number of processes including:

- The completion of an annual self-declaration by all directors
- Introduction of annual checks for credit, bankruptcy and registration
- Formal appraisal processes
- Maintenance of the register of declared interests.

IMPLEMENTATION PLAN				
Intended Audience	All directors			
Dissemination	Available on The Pulse and on the website under 'About Us' http://www.londonambulance.nhs.uk/about_us/how_we_are_run.aspx			
Communications	To be sent to all Directors; Workforce and OD; Procurement			
Training	N/A			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Employment checks Annual self-declaration Appraisal Register of Interests for Board members/ Directors	Annual self-declaration Review of declaration of interests at each Board meeting Annual update of Declared Interests	Director of Corporate Governance/Trust Secretary and Director of Workforce and OD – Workforce and OD committee and Trust Board	Trust Board	ELT and Trust Board

Appendix 1

FIT AND PROPER PERSON DECLARATION

1. Fitness to carry out the role of Director (or Director-equivalent post) in the London Ambulance Service NHS Trust (the Trust) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 ('the Regulated Activities Regulations').
2. By signing the declaration in Appendix 2, a director is confirming that they do not fall within the definition of an 'unfit person' or any other criteria set out below, and that they are not aware of any pending proceedings or matters which may call such a declaration into question.
3. It is a condition of employment that those holding Director (or equivalent) posts in the Trust provide confirmation in writing on appointment and thereafter on demand, of their fitness to hold such posts.
4. The Chair and Non-Executive Directors are also required to meet the Fit and Proper Persons test for Directors.
5. The Trust shall not appoint, or permit to continue as a director, any person who is an unfit person.
6. The Trust will ensure that its contracts of employment with its Directors contain a provision permitting summary termination in the event of a Director being, or becoming, an unfit person. The Trust will enforce the provision promptly upon discovering any Director to be an unfit person.

Regulated Activities Regulations

7. 'Regulated Activities' covers the provision of:
    - Personal care
    - Accommodation for person who require nursing or personal care
    - Accommodation for persons who require treatment for substance misuse
    - Treatment of disease, disorder or injury*
    - Assessment or medical treatment for persons detained under the Mental Health 1983 Act
    - Surgical procedures
    - Diagnostic and screening procedures*
    - Management of blood and blood derived products
    - Transport services, triage and medical advice provided remotely*
    - Maternity and midwifery services
    - Termination of pregnancy services
    - Services in slimming clinics
    - Nursing care
    - Family planning services.

    *denotes the Activities the Trust is regulated to provide.

8. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The CQC document 'Regulations 5: Fit and Proper Persons: directors – Information

for NHS Bodies, March 2015' as amended from time to time provides further guidance on the requirement.

9. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:
   a) The individual is of good character
   b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position for the work for which they are employed
   c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed
   d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
   e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

'Serious misconduct' includes assault, fraud and theft.
'Mismanagement' includes mismanaging funds and/or not adhering to recognised practice, guidance or processes regarding care quality.
'Privy to' means evidence that could lead the Trust to conclude that the individual was aware of some serious misconduct or mismanagement but did not take appropriate action to address it.

10. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:
    a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
    b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order made to like effect in Scotland or Northern Ireland
    c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (Debt relief orders) of the Insolvency Act 1986
    d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
    e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
    f) The person is prohibited from holding the relevant office or position, or in the case of an individuals for carrying on the regulated activity, by or under any enactment.

11. In assessing good character, the matters to be considered must include those listed in Part 2 of Schedule 4 to the Regulated Activities Regulations which are:
    a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence

b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator or health care or social work professionals.

Appendix 2

FIT AND PROPER PERSON
(to be completed and returned pre-appointment in post and annually thereafter)

1. Fitness to carry out the role of Director (or Director-equivalent post) in the London Ambulance Service NHS Trust (the Trust) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activities Regulations').

2. This document forms part of your contract of employment and by signing the declaration below, you are confirming that you do not fall within the definition of an 'unfit person' or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

3. It is a condition of your employment that you provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post.

4. The Chair and Non-Executive Directors are also required to meet the fit and proper persons test for Directors.

5. The Trust shall not appoint, or permit to continue as a Director, any person who is an unfit person.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The CQC document 'Regulations 5: Fit and Proper Persons: directors – Information for NHS Bodies, March 2015' as amended from time to time provides further guidance on the requirement.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:
   a) The individual is of good character

   b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position for the work for which they are employed

   c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed

   d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or

not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

    a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
    b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order made to like effect in Scotland or Northern Ireland
    c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (Debt relief orders) of the Insolvency Act 1986
    d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
    e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
    f) The person is prohibited from holding the relevant office or position, or in the case of an individuals for carrying on the regulated activity, by or under any enactment.

9. In assessing good character, the matters to be considered must include those listed in Part 2 of Schedule 4 to the Regulated Activities Regulations which are:
    a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence
    b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator or health care or social work professionals.

I acknowledge the extracts from the Regulated Activities Regulations above.

I confirm that I comply with the requirements as set out in Section 7 above, having regard also to matters in section 9 above.

I confirm that I do not fit within the definition of an 'unfit person' as listed in Section 8 above.

I confirm that there are no other similar grounds under which I would be ineligible to be appointed to/continue in post.

I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a 'fit and proper person' or any grounds under which I would ineligible to continue in post come to my attention.

Name:

Signed:

Position:

Date:

Pre-employment: Yes/No

Annual declaration: Yes/No

Appendix 3

Due Diligence

Professional Registration	
Bankruptcy and Insolvency Registers	The Trust has searched the England and Wales Bankruptcy and Insolvency Register on (X Date) and can confirm that (Name) does not appear on the register. www.gov.uk/search-bankruptcy-insolvency-register The Trust searched the Insolvency Service of Ireland register on (X Date) and can confirm that (Name) does not appear on the register. www.isi.gov.ie/en/ISI/Pages/Registers
Disqualified Directors Register	The Trust searched the disqualified directors register via the Companies House register on (X Date) and can confirm that (Name) does not appear on the register. https://beta.companieshouse.gov.uk/
Internet based web search	The Trust conducted an internet based web search on (Name). the following search engines and websites were used: www.google.com and www.bing.com Word searches that were used were:
Social Profiles	The following websites were used: www.linkedin.com www.facebook.com www.twitter.com (for example)
Proof of Identity	Passport checked and verified on (Date)
Referees	

London Ambulance Service NHS Trust

POLICY FOR THE DEVELOPMENT AND IMPLEMENTATION OF PROCEDURAL DOCUMENTS

INTRODUCTION AND POLICY OBJECTIVE

1. Organisations need formal written documents which communicate standard organisational ways of working. These help clarify strategic and operational requirements and bring consistency to day to day practice. In addition they can improve the quality of work and increase the successful achievement of objectives.

2. The London Ambulance Service NHS Trust (LAS) is committed to ensuring that its people, patients and partners are fully aware of its objectives and the way those who work for it need to operate to achieve these objectives. This policy aims to define the standard approach to communicating these requirements.

SCOPE AND DEFINITIONS

3. This policy applies to all LAS-wide procedural documents. Other than as set out in paragraph 29, it does not apply to local/team procedures.

4. For the purposes of this policy, the term "procedural document" refers to (and this policy applies to) the following document types:

   Strategy: A long term plan for achieving organisational success.

   Policy: A statement of an agreed organisational position, the governing principles and aims which staff must follow and cannot be varied except with the approval of the Trust Board, delegated Committee, or Director with delegated authority.

   Procedure: A set of actions which is the official or accepted way of doing something, usually in support of a policy. A Standing Operating Procedure (SOP) is a laid-down procedure for doing something. Very often SOPs are written to minimise risks to patients or health and safety risks. They should include information about how to obtain authority for any proposed deviation from the SOP (usually from senior management).

   Guidance: A document setting out a preferred method of operation. Unlike with procedures, other methods are not prohibited but a reason for deviation from guidance should be fully justifiable and line management agreement sought in all cases of any doubt.

5. In general, strategy and policy define **what** an organisation wants to do whilst procedure and guidance define **how** the organisation wants to do it. One document may contain all or a combination of the above. The Corporate Governance Team will advise if required.

ACCOUNTABILITIES AND RESPONSIBLITIES

Trust Board:

6. Responsible for approving all corporate strategies and some key organisational policies.

7. The Trust Board is responsible for the effectiveness of this policy and for ensuring that sufficient resources are available to support its implementation.

Board Assurance Committees

8. Responsible for seeking and providing assurance by considering and commenting on relevant strategies and policies.

Executive Committee (ExCo)

9. Responsible for endorsement of corporate strategies and key organisational policies that require approval by the Board. Responsible for approving other organisational policies that do not require Board approval and appropriate key procedural and guidance documents.

10. The Executive Committee is responsible for monitoring the effectiveness of this policy and for ensuring that the Trust Board is kept informed.

Directors/Senior Managers

11. Responsible for developing, proposing and implementing strategies, policies, procedures and guidance relevant to their areas of accountability which are compliant with the Policy for the Development and Implementation of Procedural Documents. Responsible for approving some organisational policies that do not require Board or Executive Committee approval and appropriate procedural and guidance documents.

Managers

12. Responsible for contributing to the development of strategies, policies, procedures and guidance (including following the consultation and impact analysis processes referred to in this policy), as well as ensuring their implementation, monitoring and reporting of exceptions and adverse experiences as appropriate.

Employees and Other Workers

13. Responsible for contributing to the development of strategies, policies, procedures and guidance, as well as following all applicable policies, procedures and guidance and reporting any adverse experiences as appropriate.

THE APPROVAL AND IMPLEMENTATION OF POLICIES AND PROCEDURES

Authorisation to develop a policy or procedure:

14. The requirement for a policy can be identified by any manager in the Trust. When a need has been identified, the instigator must obtain approval to develop the policy or procedure from the relevant/lead Director for the policy category and agree:

    14.1. The Lead Director and Lead Manager (Author) for the policy.

    14.2. If and why the policy is needed.

    14.3. Target audience of policy.

    14.4. Whether anyone else in the Trust is likely to be dealing with the same or similar issue(s) with whom liaison will be necessary, or whether a similar policy already exists which will be superseded by the new policy.

    14.5. Ensure that an Equality Impact Assessment is carried out (electronic copies available from the Trust Intranet and Corporate Governance Team).

    14.6. Who should to be involved in the policy development e.g. patients, partner organisations, staff, staff side, “experts” and whether any external input is necessary.

    14.7. Timescale of when the policy will be developed by and proposed review frequency.

    14.8. What form it should take, for example a standalone policy document or a policy backed up by procedure(s).

    14.9. Whether the procedure(s) associated with the policy are protocols or guidelines.

Format and Style

15. In addition to the style and format minimum requirements set out in Appendix 2, the following are emphasised for importance.

    15.1. **Accountability and Responsibility** should clearly define who is responsible for what. Where relevant, the responsibilities of partner organisations and/or other external organisations must be included.

    15.2. **Definitions** of terminology should be clear within the policy.

15.3. The policy should detail what is required under the policy. In addition all documents used in the development of the policy, whether referred to in the main body or not, should be included in the reference section (as per template document). Please consider the following for referencing

- Trust supporting procedures and associated policies.
- National Guidance
- DH Standards
- Approved Codes of Practice
- Legislation

Where possible electronic links to the above should be included.

15.4. **Other Trust Policies, Procedures, Guidance etc.** that are associated with the document should be clearly identified and the reader pointed in the direction of where to easily obtain copies.

15.5. **External Expertise and Accountability** should refer to external expertise, legislation, national policies, etc., adopted in the policy and any accountabilities and responsibilities that external organisations may have.

15.6. **Competence (Education and Training)** should

- Refer the reader to the Trusts Training Needs Analysis
- Include the process for provision of expert advice with developing the TNA and relevant training plans.
- Detail any other competence required that is not included in the TNA.

15.7. **Review** within a maximum of three years of publication and be revised, updated, consulted upon and re-submitted for approval.

Where a policy/procedure has a review date in excess of 2 years, an individual must be designated the responsibility to regularly review the subject matter etc.

A small number of policies and strategies must be reviewed annually depending on their content to keep up to date with legislation and training changes.

15.8. **Approval** will be via the Board, Executive Committee, or Director with delegated authority who will be informed of any notable changes or reviews.

15.9. **Format**: policies must be written in a way that is suitable for publication on the intranet and should include the minimum requirements identified in Appendix 2. A word document template is available on the Trust Intranet or from the Corporate Governance Team.

15.10. **Monitoring and Reporting** should include:

- The process for monitoring and evaluating the effectiveness of the policy, including testing levels of awareness.
- Obtaining evidence of the policy being put into practice (compliance) this will include, how it is to be done, when, frequency and what will be done to rectify areas of noncompliance.

15.11. **Document control information** should be shown on the covering page of each procedural document. This must include:

- Policy Reference and Version
- Date Approved
- Approval Body
- Implementation Date
- Review Date
- Lead Director
- Author
- Equality Impact Assessment Statement
- Distribution

Equality Impact Assessments:

16. In line with the Public Sector Equality Duty, every procedural document will be screened by the person responsible for its development, to consider whether there is an equality dimension or whether any adjustments are necessary to comply with the duty to promote equality and diversity. This should involve consultation with stakeholders appropriate to the aims of the individual document. The equality screening process and any wider impact assessment should be recorded within the document, using the heading "Equality Impact Assessment".

Consultation:

17. In developing a policy, consultation must take place with key groups and individuals, in particular:

17.1. Patients, carers and patient/carer representatives on policies that relate to services/care that directly affect them. For advice on reaching patient and public groups please see the Trust's Patient and Public Involvement Strategy policy. Further advice is available from the Chief Quality Officer.

17.2. Partner and other external organisations as appropriate.

17.3. Staff Side on all employment related policies. This should be done in accordance with the Partnership Agreement and by presenting draft documents to the Director of People and Culture.

17.4. Where there is a relevant Board Assurance or Corporate

Committee, certain draft documents should be presented to that committee for review, in line with the Procedural Document Approval Routes set at Appendix 1.

Approval:

18. Once consultation and impact analyses have been undertaken, policy approval should be sought from the appropriate body. The approving body will consider the document proposed and approve it or recommend changes as appropriate. For further information about which body is the approving body for each procedural document see the Procedural Document Approval Routes set at Appendix 1

19. The draft document in the correct format (Appendix 2) should be sent to the Corporate Governance Team, who will ensure correct format document and will log as a draft document on the Policy Register.

20. The draft document should be discussed at appropriate working group / committee meeting(s) and if staff related, will be required to be discussed at the Staff Council. It will be sent to them for information purposes only in other instances.

21. Once consultation has taken place, the draft document should then to be taken to the Board, Executive Committee or Director with delegated authority for approval (see Appendix 1)

22. On approval, the lead manager will forward the document to the Corporate Governance Team who will add a reference number to the document and provide it with a published version number and then issue the new or updated document (if appropriate) on the Trust's internet and intranet sites and remove the old document from the database.

23. The master copy of the document will be archived and retained by the Corporate Governance Team as per the Records Management Policy.

Policy Register

24. All procedural documents will be recorded on a Policy Register which is to be maintained and kept up to date by the Corporate Governance Team. The Register will be available to employees via the intranet and will also available to all external stakeholders via the website.

25. Directors/Senior Managers responsible for a procedural document must ensure that the Corporate Governance Team is notified when a new document is proposed, or amendments are proposed to an existing document, in order to ensure that appropriate approvals are obtained and the Register remains up-to-date.

Communication of Procedural Documents

26. A copy of every approved policy and procedure will be posted on the Trust internet and intranet sites.

27. On induction every member of staff will be advised of the location of the most up to date version of policies on the Trust intranet site. Policies and Procedures may be printed and placed on Trust premises for staff to refer to. These may not be the most recent document therefore staff are advised to always check the intranet for the current version.

28. Staff will be advised of the introduction of new polices through various media
    - Management briefings
    - RIB
    - Trust Intranet site
    - Whilst attending Trust training and education courses.

LOCAL/TEAM PROCEDURES

29. Managers are responsible for the development, maintenance and implementation of procedures specific to their area. As a minimum, such procedures should be:
    - Developed in consultation with team members
    - Brought to the attention of all team members and others who may be affected by the procedure e.g. another team
    - Supported by training, if necessary
    - Given a clear title (and possibly a unique identifier)
    - Dated, including a review date
    - Recorded on a list which is kept up to date, including those procedures which have lapsed or been replaced or withdrawn, and posted on the intranet
    - Posted on the intranet
    - Archived on the intranet

IMPLEMENTATION PLAN

30. The policy will be posted on the Trust internet and intranet site and all staff will be made aware of its existence via the Routine Information Bulletin (RIB).

COMPETENCE (EDUCATION AND TRAINING)

31. The Director of Corporate Governance will ensure the provision of advice for managers developing policies. A formal training programme will not be organised.

MONITORING COMPLIANCE, EFFECTIVENESS AND REPORTING AND POLICY REVIEW

Topic/ Objective	How	Who	When
Style and Format	Check made when the document is in draft form as well as prior to publication	Corporate Governance Team	As each document is produced and prior to adding to intranet
Definition of Terms used	Checks to ensure clear and simple language used and/or definitions are in place	Corporate Governance Team	As each document is presented
Consultation Process	Change sheet checked to ensure correct process followed	Corporate Governance Team, Approving body	As each document is presented
Ratification Process	Change sheet checked to ensure correct process followed	Corporate Governance Team, Approving body	As each document is presented
	Visual check of Policy, Procedure and Strategy database will identify policies outside of process	Corporate Governance Team	Monthly
	Monthly updates on progress of relevant documents ratification process and notification of documents due for review	Corporate Governance Team, relevant Directors	Monthly
Review arrangements	Change sheet checked to ensure review date is identified	Corporate Governance Team	As each document is presented
	Authors/Owners are notified their policy is due for review within 3 months of its review date	Corporate Governance Team	As required by policy.
	Policy Register is monitored	Corporate Governance Team	Monthly
Control of Documents inc archiving	Reports will be produced for Executive Committee review	Corporate Governance Team	Quarterly
Associated Documents and references	Change sheet checked to ensure correct process followed for linking and referencing documents	Corporate Governance Team, Approving body	As each document is presented

EQUALITY IMPACT ASSESSMENT STATEMENT:

32. This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

    32.1. Eliminate discrimination, harassment and victimisation.

    32.2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

    32.3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

33. The Act sets out nine protected characteristics that apply to the equality duty, which must be considered in the writing of all documents.

OTHER TRUST POLICIES, PROCEDURES, GUIDANCE ETC.

34. This policy links to TP/029 - LAS Records Management & Information Lifecycle Policy.

EXTERNAL EXPERTISE AND ACCOUNTABILITY

35. This policy has drawn on guidance from:

    35.1. Plain English Campaign Guidelines
    http://www.plainenglish.co.uk/

    35.2. Royal Institute for the Blind Guidelines
    http://www.rnib.org.uk/xpedio/groups/public/documents/code/InternetHome.hcsp

    35.3. NHS Resolution risk management guidance
    http://www.nhsla.com

    35.4. Equality Act 2010
    https://www.gov.uk/guidance/equality-act-2010-guidance

Appendix 1 Approval of Procedural Documents

TO FOLLOW

Appendix 2 - Procedural Document Format

MINIMUM REQUIREMENTS FOR A PROCEDURAL DOCUMENT

(Documents should be written in Microsoft Word and use Word formatting functions).

Policies should be written in line with the Plain English Campaign reporting guidelines:

- The Trust template including the Trust Banner (which should remain on the top of the cover sheet) is available on the Trust Intranet site in word format.
- Organise reports into sections.
- Use everyday English whenever possible.
- Avoid Jargon and legalistic words, and explain any technical terms.
- Keep sentence length to an average of 15 to 20 words.
- Use active verbs.
- Always check that report is accurate, clear, concise and readable.
- The grammar check from the 'Word' toolbar should be used to check all documents meet the above requirements by:
- Going into 'tools', spelling,
- Tick the 'check grammar' box.

Formatting should be kept as simple as possible to comply with Royal National Institute for Blind clear print guidelines for those with impaired vision.

- Font size to be 12 point Arial (14 point Arial in requested cases).
- Black text on white background provides best contrast
- Avoid highly stylised typefaces.
- Avoid use of capitals for continuous text.
- Avoid underlining and use of italics.
- Avoid justified text.

As a minimum policies must include: (see also policy template)

- Document Control tables (change record)
- Introduction and policy objectives
- Scope and definitions (explain the reason for the policy, who and what it applies to, definitions are important as the reader may not have a great deal of knowledge in this area)
- Accountabilities and Responsibilities (if somewhere in the document it states a person or committee 'must, should, will' then it should be clearly identified in this section)
- Implementation Plan
- Competence (Education and Training)
- Monitoring Compliance (how will you ensure the policy is complied with? Who will do this? When? And how often? What will happen if compliance is not being achieved?)
- Effectiveness and Reporting (how are you going to make sure the policy is effective? Who is going to do it and when are they going to do it?)
- Policy review (who is going to do it and when, include who will be keeping an eye on current changes in case an earlier review is required and remember to add to their responsibilities)
- Equality Impact Assessment Statement
- References (anyone should be able to find the evidence you have used)

TEMPLATE

London Ambulance Service NHS Trust

Document Title

DOCUMENT CONTROL.

Document Reference	
Version	
Approved by	
Lead Director/Manager	
Author	
Distribution list	
Issue Date	
Review Date	

CHANGE HISTORY.

Date	Change	Approved by/Comments

1. INTRODUCTION – POLICY OBJECTIVES

2. SCOPE AND DEFINITIONS

3. ACCOUNTABILITIES AND RESPONSIBLITIES

4. HEADING – POLICY CONTENT

This is where the author writes the details of the specific document. There will be instances where for clarity of governance or administrative convenience a policy and procedure are combined into one document.

5. IMPLEMENTATION PLAN

6. COMPETENCE (EDUCATION AND TRAINING)

7. MONITORING COMPLIANCE

8. EFFECTIVENESS AND REPORTING

9. POLICY REVIEW

10. EQUALITY IMPACT ASSESSMENT STATEMENT

11. REFERENCES

Appendix 3 – Allocation of Unique Identifiers for Procedural Documents

Each procedural document will be given a unique identifier. The first figures will be letters determined by the subject of the document, in accordance with the list below, followed by the next available sequential number for such documents starting with 01, e.g. TP08.

Prefix	Document subject
ST	Strategy
TP	Policy
OP	Procedure
GU	Guidance

- **T**rust **P**olicies and procedures will commence with **TP**
- **O**perational **P**rocedures will commence **OP**
- Service forms will be allocated a new **LA** number
- **H**uman **R**esource will commence **HR**
- **H**ealth and **S**afety will commence with **HS**
- **Pl**ans will commence with PL
- **St**rategies will commence with ST
- **Gu**idance will commence with GU

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report title:	Trust Board Forward Planner			
Agenda item:	18			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	This planner is based upon previous years' Board agendas and guidance relating to best practice in the construction of Trust Board agendas			
Status:	☒	**Assurance**	☒	**Discussion**
	☐	**Decision**	☒	**Information**

Background / Purpose:

This report provides the Board with an updated forward plan for Board meetings until the end of the 2018/19 financial year. It is based upon the business conducted by the Board in previous years and upon best practice in the construction of Board agendas.

This is intended to be a framework document, setting out the minimum business to be conducted at Board meetings during the forward plan period. It will be updated regularly to reflect the business needs of the organisation.

Recommendation(s):

The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2018/19 financial year.

This report relates to the following Board Assurance Framework (BAF) or other risk:

Failure to ensure that the Board spends its time at meetings appropriately could result in an inability to conduct its business and result in poor governance.

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

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

Trust Board forward planner: 2018/19

Area	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 Carter Report - implications for LAS
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 Quality Account & Quality Priorities - biannual report
Strategy & Planning	
Governance	
	Report from the Trust Secretary Trust Board forward planner FTSU 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:	27 November 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 October's position in relation to quality performance.

Recommendation(s):

The Trust 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	☒

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Quality Report

Report for discussion at the Trust Board

Analysis based on October 2018 data, unless otherwise stated

Contents Page

Executive Summary

NHS London Ambulance Service NHS Trust

Quality Domain	Quality Priority Areas	Status	Overall Summary	Overall Status
Safe	*90% implementation of Health Assure functionality by December 2018.*	🟡	Rate of patient adverse events per 1000 incident is 2.9 Safeguarding Rapid Response meetings attended as a percentage of requests was below the target of 75%. Since launching the practical manual handling training there has been an increase in reporting of no Harm/Near Miss incidents, inline with there is reduction of Moderate Harm has been noted.	🟡
	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.	🟡		
	100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations.	🟢		
	Increase the number of defibrillator downloads year-on-year to 20% by end of 2019.	🟢		
Effective	*Root and branch independent training review completed. Implementation plan developed by September 2018.*	🟢	In June, ROSC on arrival at hospital for both the overall and Utstein comparator group was above average at 38% and 70%. Similarly the survival to hospital discharge figures for both groups were higher than average at 11% and 34%. Defibrillator downloads decreased by 8% to 14% (from a high of 22% last month). LAS CPI completion in September increased to 84% after a sudden drop in completion in August, with the LAS achieving their highest completion rate in three months.	🟢
	New quality Indicators developed and being reported via performance scorecards by December 2018.	🟢		
	QI training plan agreed and 100% of identified key cohorts trained by September 2018.	🟢		
	At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019.	🟡		
Caring	*Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline.*	🟢	The Mental Health Joint Response Car launches on 26/11; we have recruited three paramedics and the team will spend 5 days training together before the car is launched. Implementation of new response profile for Health Care Professional (HCP) requests for maternity emergencies	🟢
	Evidence of patient involvement in all QI and service re-design programmes.	🟢		
	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	*We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP.*	🟢	In October we received 89 complaints, in line with the average per month (83). We anticipate a trajectory of 1000+ complaints for 2018/19. Enquiries to the department currently average 368 per month. The complexity of a number of these PALS enquiries meant that 112 were unable to be concluded within 24 hours.	🟢
	Over 75% of complaints letter being responded to within the 35 day timescale.	🟡		
Well Led	*85% compliance with statutory and Mandatory training 2018-19.*	🟢	The Frequent Callers under a one borough project in Bexley. During the month of May 2018 there were 22 callers identified. All calls were reviewed and actions taken. Five months later the call rate had reduced across the whole CCG. For October 2018, there were 9 frequent callers with only three of these patients having a negative impact on resources.	🟢
	Leadership programme developed and implementation plan in place.	🟢		
	Continue to implement the P&OD strategy and progress implementation of the Quality Improvement Plan and Quality Improvement capability across the organisation.	🟡		

🟢 Priority area on or ahead of target | Domain area on track

🟡 Priority area off target but no escalation | Domain area off target but no escalation

🔴 Priority area off target escalation required | Domain area escalation required

Note: Overall status includes the quality priority areas and the status across a number of additional KPIs

Executive Summary - Quality Summary Scorecard

NHS London Ambulance Service NHS Trust

October 2018

Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Current Perfomance: Target	Current Perfomance: Latest Month	Current Perfomance: Year To Date Actual	Trajectory: FY18/19 Trajectory	Benchmarking: National Data	Benchmarking: Best In Class	Benchmarking: Ranking (out of 10)
Rate of Patient related Adverse Events per 1,000 Incidents	Rate	Oct-18			5.0	2.9	2.8				
Patient related Adverse Events - NO HARM	Count	Oct-18			233	211	794				
Patient related Adverse Events - LOW	Count	Oct-18			25	31	127				
Patient related Adverse Events - MODERATE	Count	Oct-18			16	19	63				
Patient related Adverse Events - SEVERE	Count	Oct-18			N/A	7	19				
Patient related Adverse Events - DEATH	Count	Oct-18			N/A	12	38				
Medication Errors as % of Patient Adverse Events	%	Oct-18			N/A	7.5%	7.0%				
Needle Stick Injuries as % of Staff Adverse Events	%	Oct-18			N/A	0.8%	1.0%				
Never Events	Count	Oct-18			0	0	1				
ROSC at Hospital (AQI)	%	Jun-18			30%	38%	37%				
ROSC at Hospital UTSTEIN (AQI)	%	Jun-18			N/A	70%	63%				
STEMI call to Angiography (AQI)	hh:mm	Jun-18			N/A	02:18	02:10				
STEMI care bundle (AQI)	%	Apr-18			N/A	75%	70%				
Stroke to HASU within 60 minutes (AQI)	%	Mar-18			N/A	52%	67%				
Stroke Call to Arrival at Hospital (AQI)	hh:mm	Jun-18			N/A	01:13	01:10				
Stroke on scene time (CARU continual audit)	hh:mm	Sep-18			00:30	00:31	00:31				
Survival to Discharge (AQI)	%	Jun-18			N/A	11%	10%				
Survival to Discharge UTSTEIN (AQI)	%	Jun-18			N/A	34%	38%				
STEMI- On scene duration (CARU continual audit)	hh:mm	Jun-18			N/A	00:39	00:39				

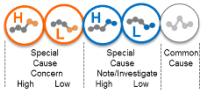
KPI on or ahead of target

KPI off target but within agreed threshold

KPI off target and outside agreed threshold

KPI not reported / measurement not started

Variation Indicators



Executive Summary - Operational Context

London Ambulance Service NHS Trust

The scorecard below provides an overview of the Operational performance of the Trust in October. The Trust's response time performance was under the 7 minute target for C1 mean, and within all targets in all other categories. C1 and C2 performance year to date is well under target for year to date figures as better performance becomes consistent.

NHS 111 call answering within 60 secs was below target for both NEL and SEL, with NEL having only 75% of calls answered within 60 seconds.

October 2018

					Current Perfomance			Trajectory	Benchmarking		
Indicator (KPI Name)	Basis	Data From Month	**Target Status**	**Statistical Process Control Icon**	Target	**Latest Month**	**Year To Date Actual**	**FY18/19 Trajectory**	National Data	Best In Class	**Ranking (out of 10)**
Category 1 response - Mean	mm:ss	Oct-18			07:00	06:12	06:53	07:00	07:13	06:12	1
Category 1 response - 90th centile	mm:ss	Oct-18			15:00	10:14	11:20	11:18	12:33	10:14	1
Category 2 response - Mean	mm:ss	Oct-18			18:00	17:36	18:43	18:30	21:18	12:04	4
Category 3 response - 90th centile	h:mm:ss	Oct-18			2:00:00	1:56:25	2:09:39	2:10:30	2:21:52	1:12:42	3
Category 4 response - 90th centile	h:mm:ss	Oct-18			3:00:00	2:31:32	2:20:57	2:14:06	3:11:57	2:03:55	3
Call answering - 999 (less than 5 seconds)	%	Oct-18				83%	85%				
SEL Call answering - NHS 111 (less than 60 seconds)	%	Oct-18			95%	86%					
NEL Call answering - NHS 111 (less than 60 seconds)	%	Oct-18			95%	75%					

KPI on or ahead of target

KPI off target but within agreed threshold

KPI off target and outside agreed threshold

KPI not reported / measurement not started

Variation Indicators

1. Safe

We must ensure we protect our patients and staff from abuse and avoidable harm. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

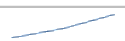
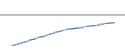
- Patient Safety
- Infection Control
- Medicine Management
- Safeguarding
- Health and Safety

Outstanding Characteristic: *People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.*

1. Safe

Trust-Wide Scorecard

Exec Lead: Trisha Bain

Measures	Target / Range	YTD 18/19	Aug-18	Sep-18	Oct-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
Hand Hygiene OWR compliance	90%	95%	97.0%	93.0%	93.7%	↑			LQ16	✓	
Rate of Patient related Adverse Events per 1,000 Incidents	5	2.9	3.3	2.6	2.9	↑					
Patient related Adverse Events - NO HARM	233	1422	230	187	211	↑					
Patient related Adverse Events - LOW	25	221	46	17	31	↑					
Patient related Adverse Events - MODERATE	16	109	12	15	19	↑					
Patient related Adverse Events - SEVERE		38	8	4	7	↑					
Patient related Adverse Events - DEATH		66	7	9	12	↑					
Rate of Staff related Adverse Events per 1,000 Incidents	3	3.3	3.3	3.2	2.7	↓					
Staff related Adverse Events - **NONE**		1136	142	134	131	↓					
Staff related Adverse Events - **LOW**		988	159	147	122	↓					
Staff related Adverse Events - **MODERATE**		31	5	4	4	↔					
Staff related Adverse Events - **SEVERE**		3	1	0	1	↑					
Controlled Drugs - Other Reportable Incidents		518	80	105	81	↓					
Controlled Drugs - Unaccountable Losses (LIN Reportable)	0	0	0	0	0	↔					
Percentage of Incidents reported within 4 days of incident occurring	85%	0%	88%	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		26	4	0	0	↔					
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%	5.6%	6.9%	7.5%	↑					
Needle Stick Injuries as % of Staff Adverse Events		1%	2.3%	1.1%	0.8%	↓					
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%	2%	2%	4%	↑					
Failure of Device/Equipment/Vehicle Incidents as % of all reported incidents		9%	10%	8%	8%	↑					

Patient Safety

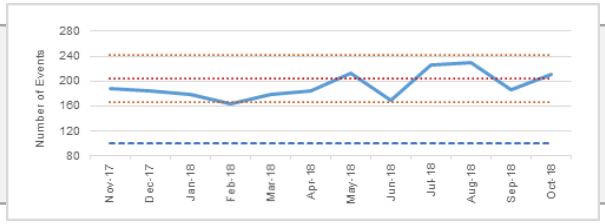
Owner: Michael Ward | Exec Lead: Dr Trisha Bain

The total number of adverse patient events was 282 resulting in 2.9 events per 1000 incidents. The breakdown of these events is shown in the analysis below:

Monthly Trend

No Harm/Near Miss

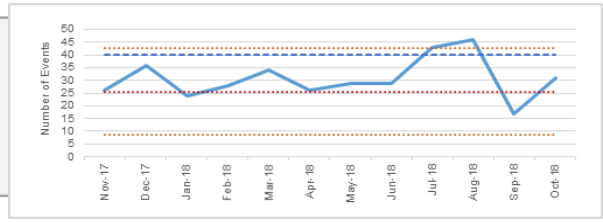
Latest Month: **221**



Monthly number of events continues to be in line with increased reporting expected during this FY, however it is in line with the performance and variability achieved in FY17/18.

Low Harm

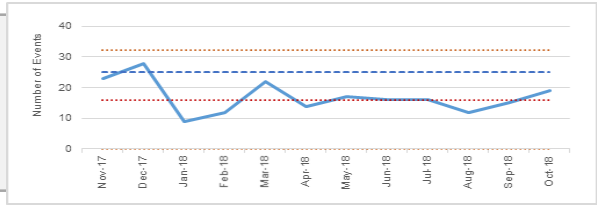
Latest Month: **31**



The number of reported low harm incidents remains within normal variation. Whilst significant improvements in the rate of incident reporting have been observed, the governance team continue to work with a number of key working groups and leaders across the organisation to further encourage the reporting of all incidents in order to maximise the potential for learning.

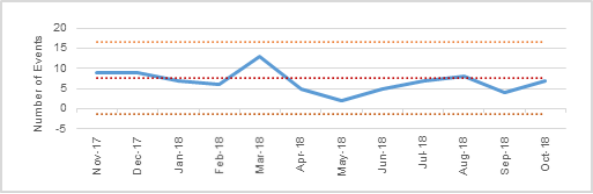
Moderate Harm

Latest Month: **19**



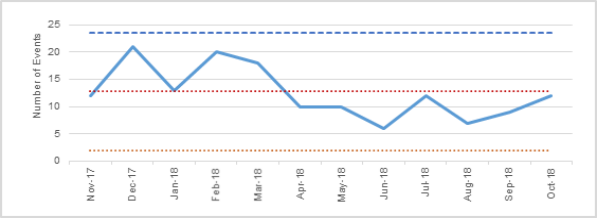
Severe

Latest Month: **7**



Death

Latest Month: **12**



No significant variation when compared to mean and limit thresholds

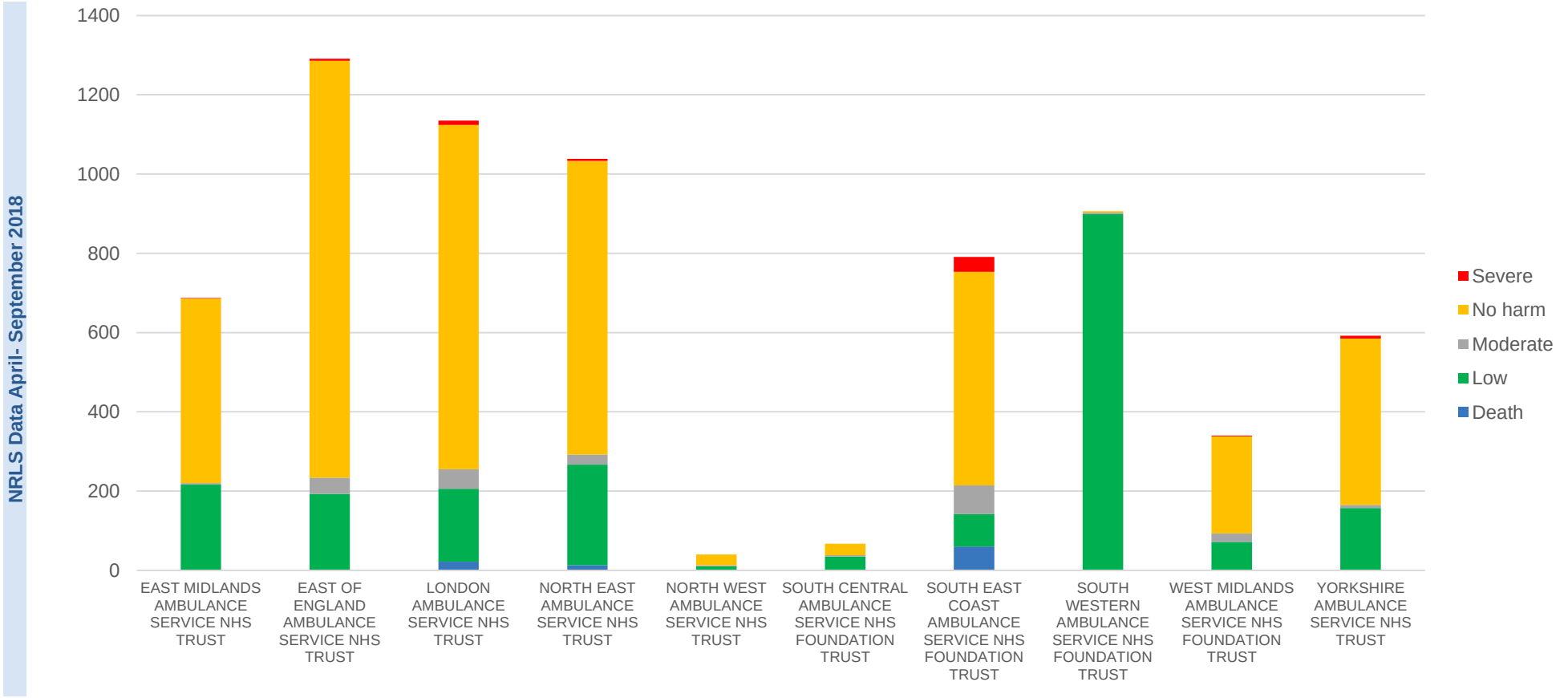
Data Source:

CHART KEY
- Monthly value
- Target
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Owner: Michael Ward | Exec Lead: Dr Trisha Bain

This NRLS Data is published monthly based on a 12 month rolling data extract from the National Reporting & Learning System (NRLS).
Data for the latest 12 month period is refeshed and subject to change. The NRLS is a dynamic database, incident reports can be updated after initial submission to the NRLS. This includes the reported degree of harm if, for example, further information becomes available or following an investigation.
The data published is based on the date the incident report was submitted to the NRLS and not the date the incident was reported to have occurred.
Organisations are encouraged to report patient safety incidents to the NRLS at least once a month, however, in practice there is usually a delay between an incident occurring and it being reported to the NRLS

NRLS Analysis



Data Source: NRLS

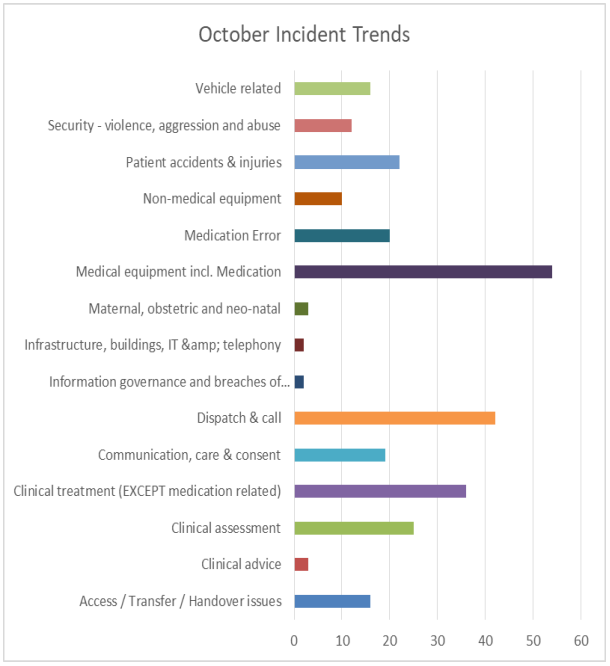
Owner: Michael Ward | Exec Lead: Dr Trisha Bain

We must ensure we report, track and respond to serious incidents appropriately – the below analysis highlights the current trends around where our serious incidents are being reported, the current status of our response and where we still have outstanding actions to address as a Trust.

Incident Themes

Medication, dispatch and call management and clinical treatment issues are a recurrent theme.
There is an emerging trend relating to Abloy key losses and breakages which is being monitored.
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.

Incidents by Category

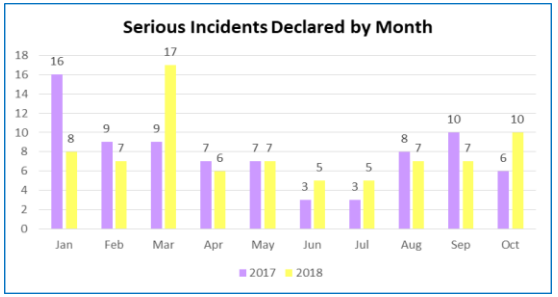


Serious Incidents

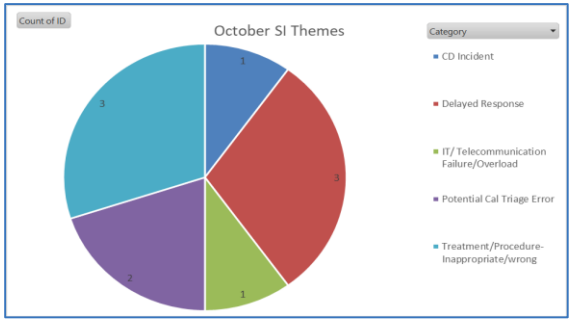
During October 2018, 10 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). The monthly distribution graph below show the number of declared SIs across the Trust compared to the previous year.

The SI categories in October included a CD incident, delayed responses, a potential call triage error, Inappropriate treatment and a IT/Telecommunication failure

Monthly Analysis



SI Categories

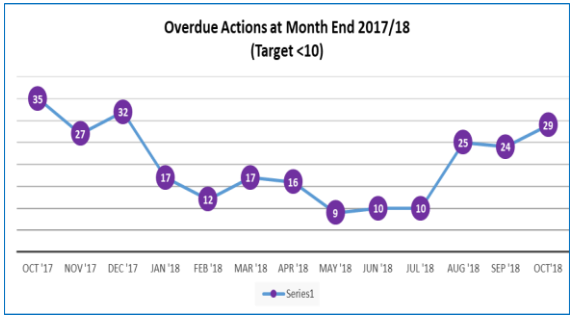


SI by Sector and Outstanding Actions

There are currently 29 outstanding actions, see below graph and tables for further information.
Expediting Actions:

1. A reminder email is sent to the action owner weekly.
2. From 20 November 2018 the email will be copied to the action owners manager.
3. Actions which are overdue from months before current month will be escalated to QOG for reporting at a senior level for expediting.

Overdue Actions



Overdue Actions

Area	Number
EOC/Chub	11
Operations	11
Governance	1
IT	1
LAS 111	3
Logistics	2
Total	29

Due by (month 2018)	Number
May	1
June	1
July	1
Aug	7
Sept	7
Oct	12
Total	29

Data Source: Datix

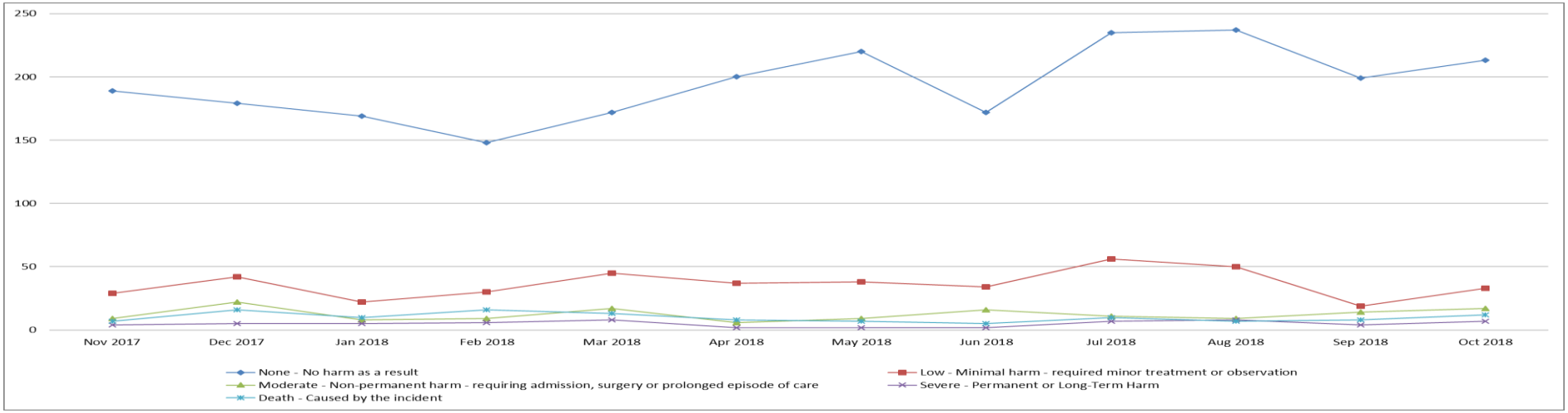
Owner: Michael Ward | Exec Lead: Dr Trisha Bain

The Trust has reported 3,094 patient safety incidents over the last 12 months and below is some analysis of this data. The number of no harm incidents being reported remains higher than other severities. The number of incidents being reported by sectors appears to be steadily increasing although it is worth noting that North Central have seen a decrease over the last 4 months. An increase in reporting is linked to a strong governance and learning culture within an organisation.

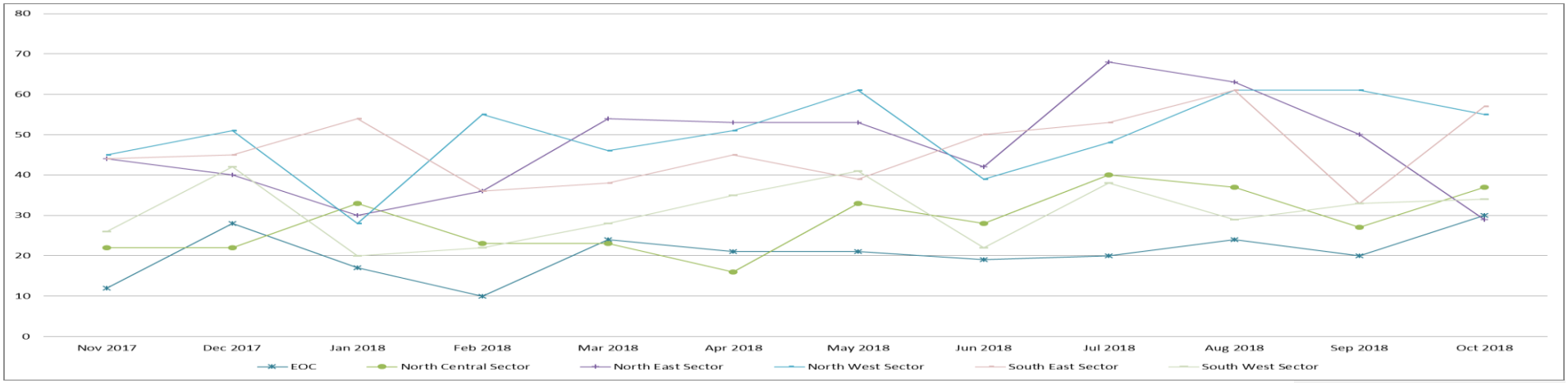
The top 5 incidents categories have been included on all reported incidents. The top 5 contributory factors (following RCA investigations have been included as these are recorded for Serious Incidents. These will be looked into in more detail and areas of improvement identified and shared for learning purposes.

Incident Analysis

Incidents by Severity



Incidents by Sector



Data Source: Datix

Owner: Michael Ward | Exec Lead: Dr Trisha Bain

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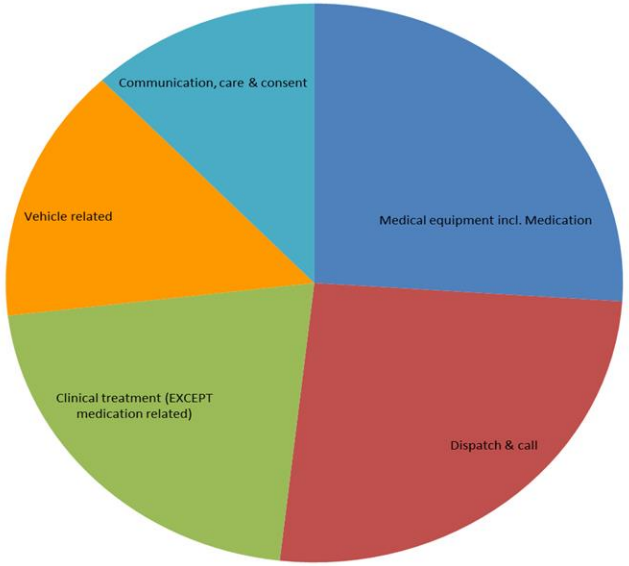
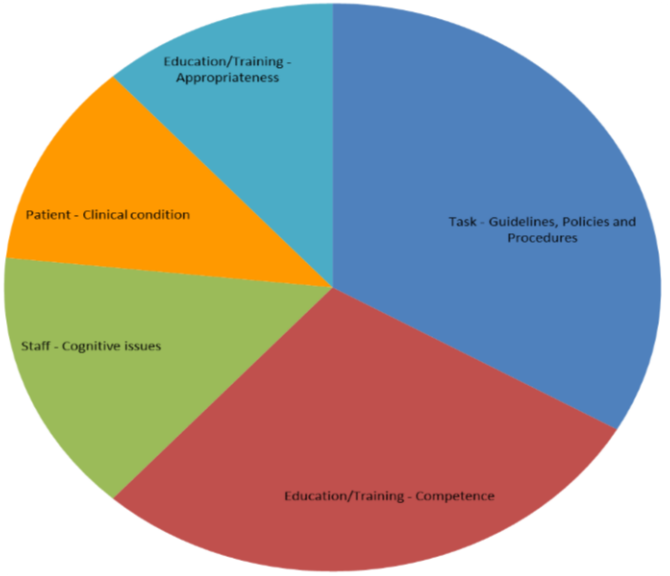
The top 5 incidents categories have been included on all reported incidents. The top 5 contributory factors (following RCA investigations have been included as these are recorded for Serious Incidents. These will be looked into in more detail and areas of improvement identified and shared for learning purposes.

Incident Analysis

Top 5 Categories of Incidents



Top 5 SI Contributory Factors



Data Source: Datix

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Monthly IPC Training Compliance October 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 October 2018:

- Level 1 – 93.98% compared to September 2018 (92.94%) an increase from the previous month and exceeding set target of 90%

- Level 2 – 97.18% compared to September 2018 (95.19%), an increase from the previous month and exceeding set target of 90%

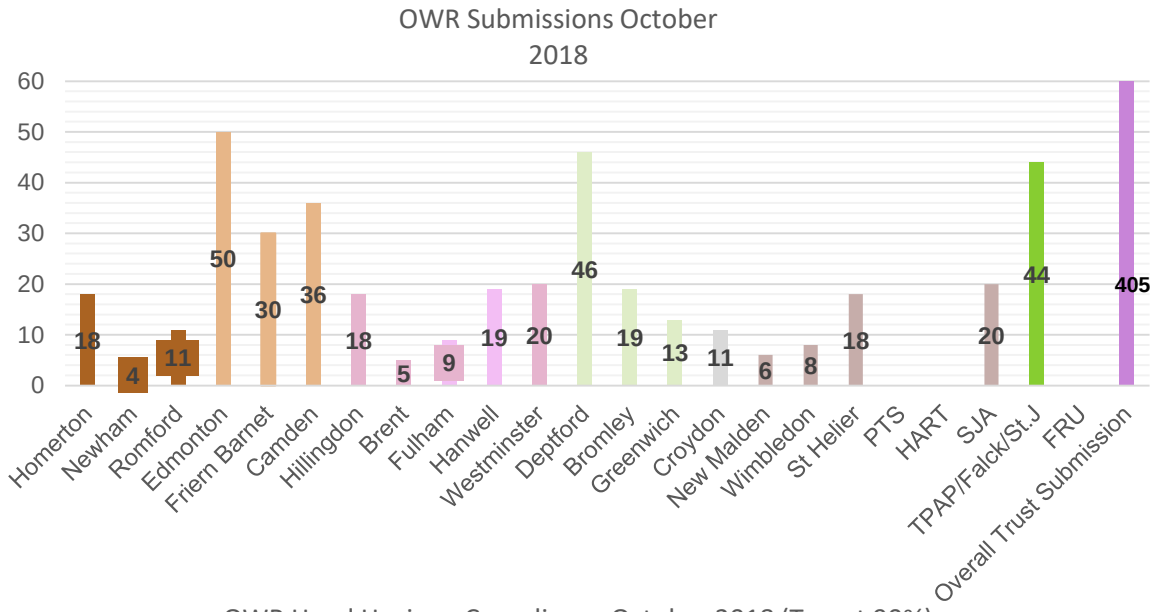
Assurance:

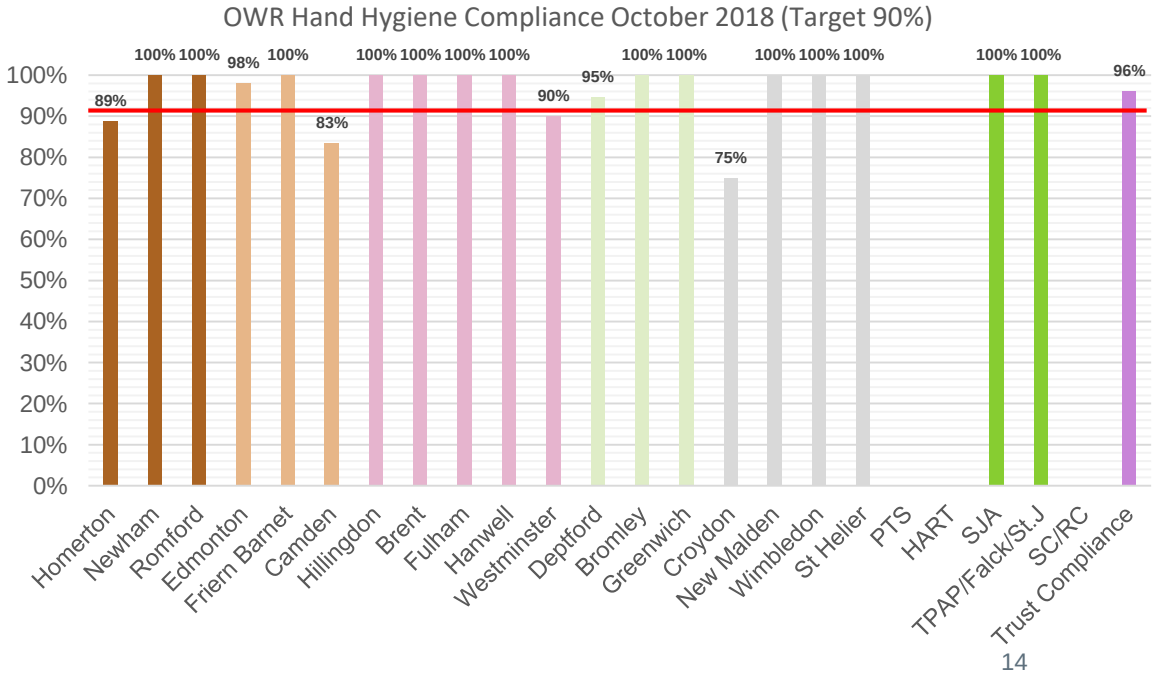
- Monitored via ESR
- Monthly Quality reporting
- Oversight at Quarterly ICDG, IPCC and QOG

Actions taken:

- Monitoring process in place

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley





Hand Hygiene Performance

- 21 group stations submitted their OWR data for hand hygiene , compared to 22 group station submissions in September 2018.
- Of the 21 submissions, the Trust compliance for October 2018 was 96% an increase from 94% in September

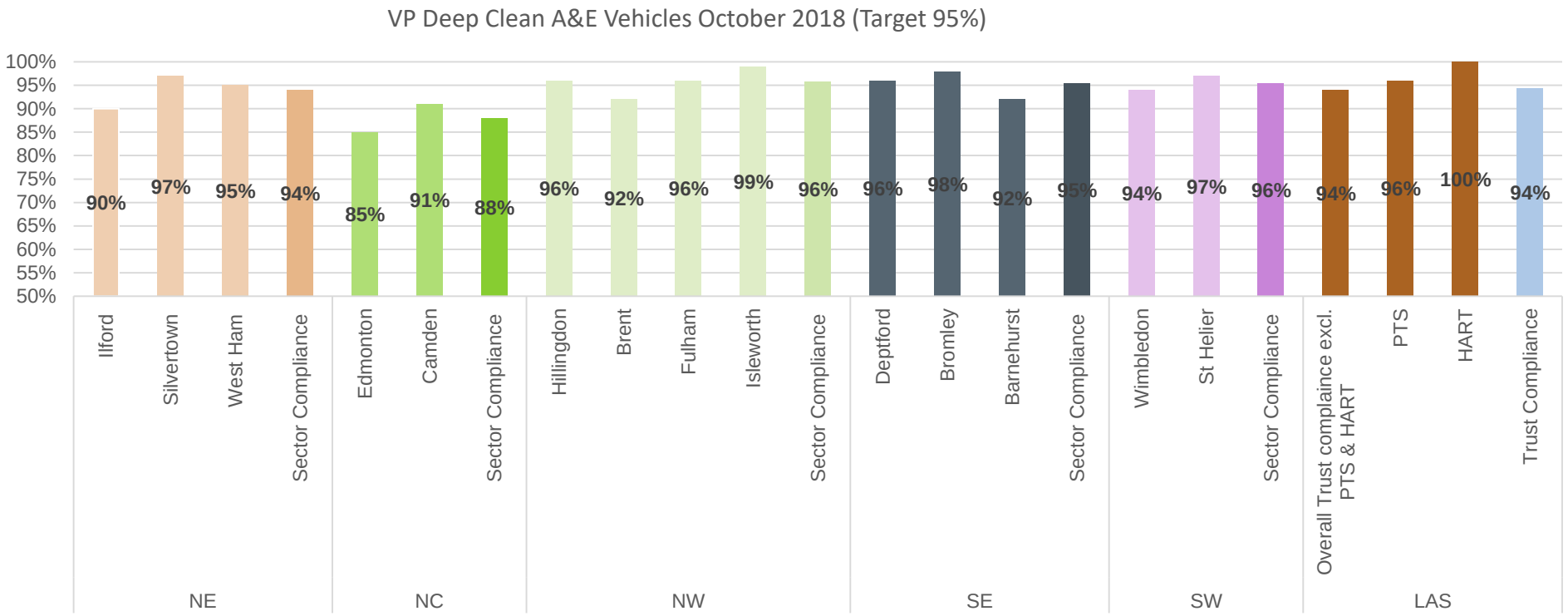
Assurance

- 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- this will be raised at IPC Committee in November 2018
- Report to Sector Quality Meeting
- Discuss submission compliance and denominator figures for Operational Workplace Reviews at November IPCC meeting

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Performance

- Data for each Hub including PTS and HART (16) submitted by the VP Contract Manager.
- Trust compliance for October was 94% , which is below the contractual target of 95%.
- Notable scores requiring attention : Edmonton scored 85%, a decrease from 92% in August. Ilford scored 90%, a decrease from 97% in August.

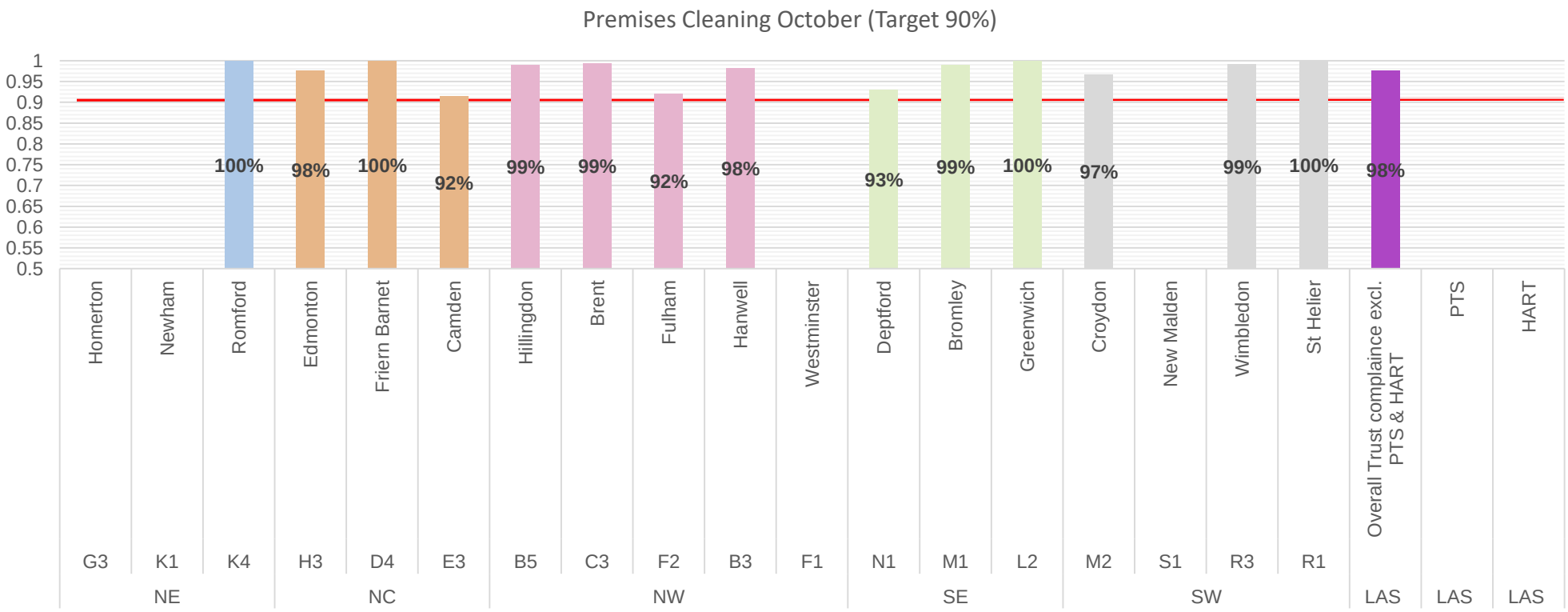
Assurance

- 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.

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley



Performance

- 14/20 Group Stations/Services submission received by IPC team for analysis (Submissions not received from Homerton, Newham, Westminster and New Malden).
- Overall Trust compliance for October was 98%, a slight increase from September (97%).

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- this will be raised at the IPC Committee in November
- IPC continue to undertake validation audits, monitor monthly to provide additional assurance
- Report performance to Sector Quality Meeting

Owner: Eng-Choo Hitchcock | Exec Lead: Dr. Fenella Wrigley

Sharps and Body Fluid Exposure (BFE) incidents April – October 2018

Type of incident	Q1 (April-October)
Bite	3
Contact with sharps (including needles)	9
Contact with sharps (non-medical sharps injury)	6
Exposure to bodily fluids	95
Injury involving broken ampoules / vials	17
Lancets - clean	1
Needlestick - cannula clean	2
Needlestick - IM clean	4
Razors - clean	8
Lancet - contaminated	3
Needlestick cannula - contaminated	8
Needlestick - IM contaminated	4
Needlestick subcutaneous contaminated	5
Razor - contaminated	2
TOTAL	**171**

Performance
- Cumulative incidents for year to date (April to October) – 171
- 95/171 (55%) were BFE incidents

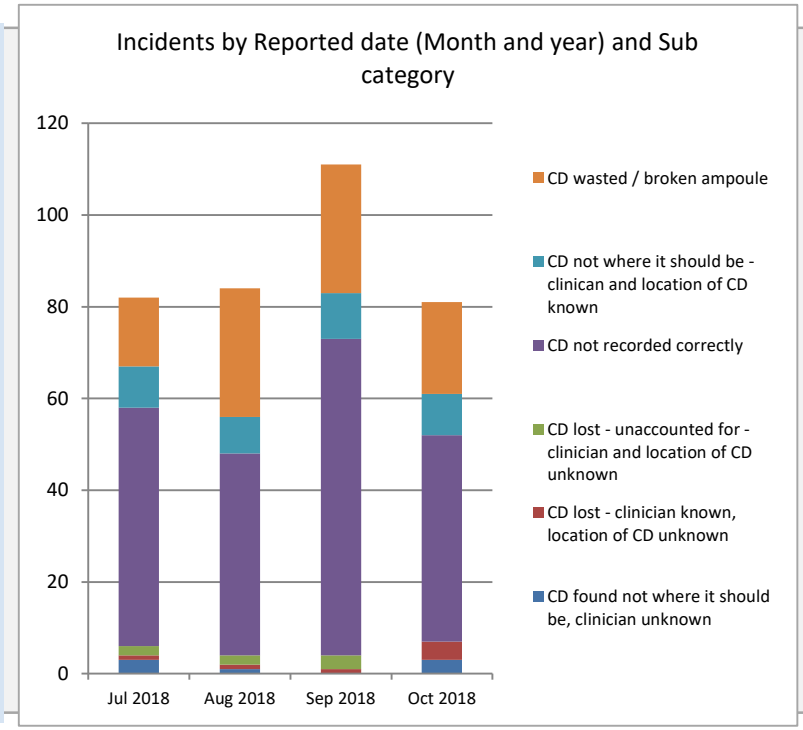
Assurance
- Monthly oversight by IPC team, Monthly Quality Reports, Quarterly Sector Report, Quarterly ICDG/IPCC/QOG oversight
- Regular Bulletins e.g. safe practice in administration for IV fluids through cannula port
- Enhanced personal PPE implementation
- Datix incident follow-up and Datix Risk Reporting
- Completion of Immunisation status project and immunisation catch-up programme ongoing.

Actions:
- Daily review of incidents and appropriate investigations and feedback; prompt risk reporting and provision of bulletins as appropriate
- DATIX subcategories will be reviewed and streamlined to ensure IPC receive the incidents that relate specifically to IPC. Currently IPC are receiving non IPC Health and Safety incidents, Medication incidents and many others, which is presenting challenges with extracting relevant data
- IPC data/ audit team are booked to receive DATIX training, in order that the IPC team can run reports throughout the month to identify themes/ trends in a timely way
- % of incidents relating to exposure to Blood and bodily fluids incidents is concerning and will be discussed at IPCG & IPCC in November, with the aim of trying to understand the root cause/s and addressing identified issues/ challenges accordingly

Medicines Management

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

Medicines Management



- No unaccounted for losses of injectable morphine
- Total of 74 other controlled drug (CD) incidents including
  - Morphine retained off duty (n=5)
  - Suspected diversion of oral morphine (oramorph) (n=1)
  - CD register documentation errors (n=44)
  - Lost drug packs (n=2)
  - CD safe malfunction (n=2)
  - CDs found unsecured (n=2)
  - CD breakages (n=18)

- Non-controlled drugs incidents
  - Kitprep discrepancies or malfunction (13)
  - Sharps left in drugs bag (n=2)
  - Unsecured medical gases (n=1) or drugs (n=1) and drug breakages (n=1)
  - Abloy key loss or breakages (n=2)
  - Adrenaline wrong dose (n=1) , wrong route (n=1) other HCP error (n=1)
  - Diazepam rapid administration (n=1), wrong dose (n=2), excessive doses by hospital team (n=1)
  - Inappropriate doses aspirin (n=1), chlorphenamine (n=2), diazepam (n=2), morphine (n=2), paracetamol (n=5), salbuatmol (n=2) & ketamine (n=1)

Actions

- Investigations ongoing in relation to oral morphine – discussion regarding operational management of oral morphine as schedule 2 drug.
- Core skill refresher medicines management session tailored to trends identified including requirement for reduction in ampoule breakages and incorrect administration of adrenaline
- Monitoring of emerging trend relating to Abloy key losses and breakages

Assurance

- Morphine retained off-duty identified in a timely fashion in all cases

Data Source: Datix

Safeguarding

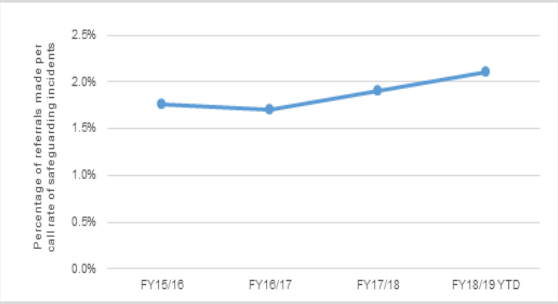
Owner: Alan Taylor | Exec Lead: Dr Trisha Bain

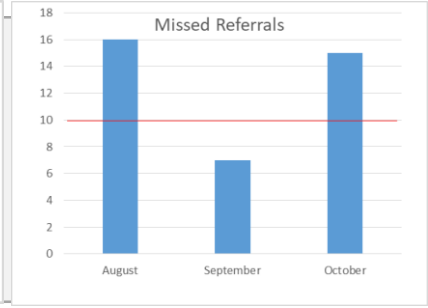
Safeguarding KPIs remain on track and are monitored closely by the Safeguarding Assurance Group.

Referrals

Monthly Rate: 2.1%

Missed Referrals: 15





The referrals rate for October was 2.1%. The referral rate is within the expected level of between 1.8% and 2.5%.

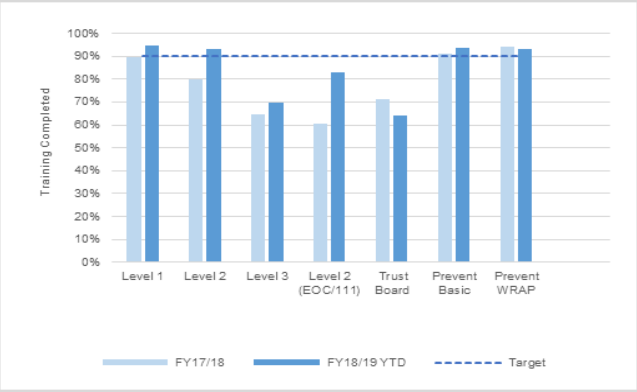
Missed Referrals (Shadow KPI) 14 children 1 adults.

Delivery of Training

Level 1: 95%

Level 2: 93%

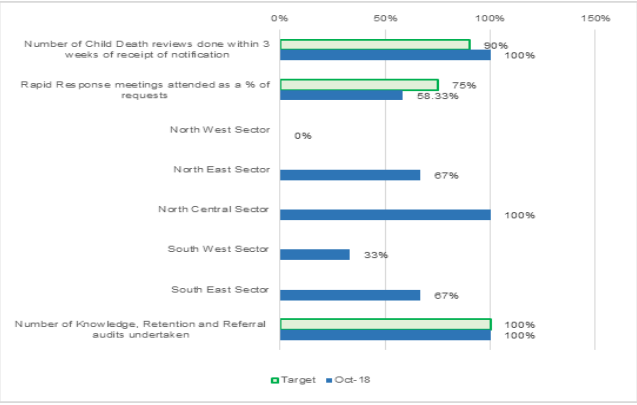
Level 3: 70%



Safeguarding Training level 3 reduced due to new members of staff being added to requirement. L2 Control services are currently running CSR including safeguarding.

Trust Board arranged for end of October and figures should be reflected in next month report only 1 member left to attend.

Review, Response and Audit



Rapid Response meetings attended as a percentage of requests was below the target of 75%. NW 0/1, NC 2/2, NE 2/3, SE 2/3, SW 1/3.

Local Partnership Working. Compliance has dropped this month as a result of lack of clarity of who in operations is dealing with these requests overall Trust still above 75% target.

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%.

Data Source:

Health and Safety

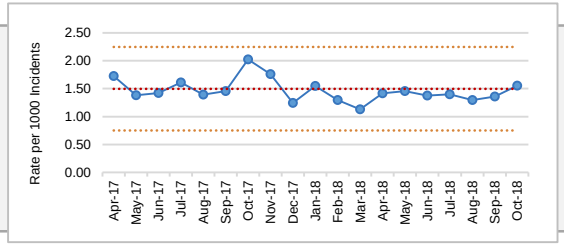
Owner: Julie Parham | Exec Lead: Dr Trisha Bain

*The total number of H&S incidents was 280 resulting in **2.92 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below:*

No Harm / Near Miss

Month: 1.55

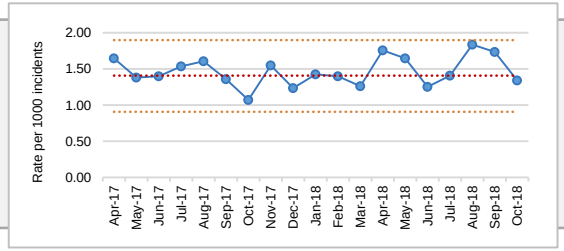
Monthly Trend



149 (53%) of the H&S related incidents reported during October - 2018 were resulted in No Harm/Near Miss.

Low Harm

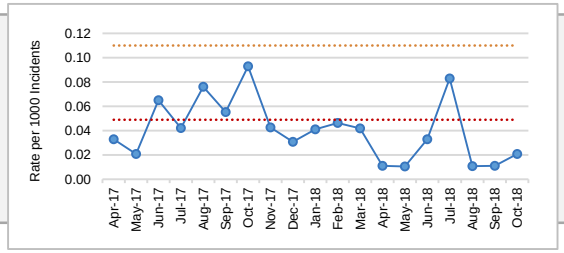
Month:1.34



129 (46%) of the H&S related incidents reported during October - 2018 resulted in Low Harm.

Moderate

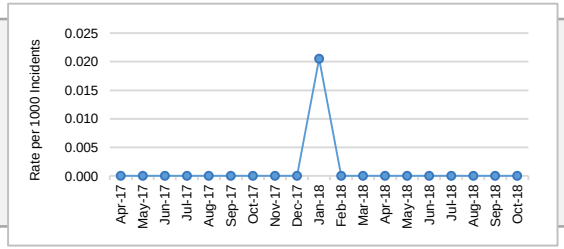
Month: 0.02



2 (1.0%) of the H&S related incidents reported during October resulted in Moderate Harm. Since launching the practical manual handling training there has been an increase in reporting of no Harm/Near Miss incidents, inline with there is reduction of Moderate Harm has been noted. The risk relating to manual handling injuries on the risk register has been down graded from 15 to 12 to reflect the above.

Severe

Month: 0



There is no incident reported as Severe Harm during October - 2018.

Data Source:

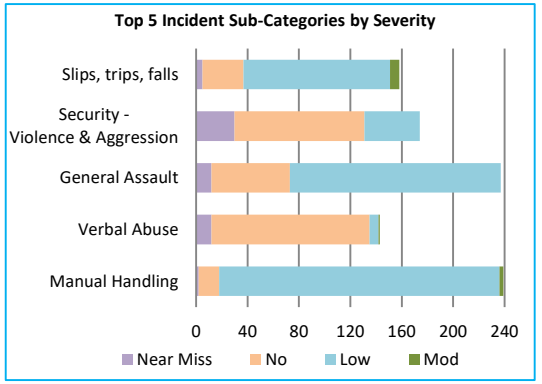
CHART KEY
- Monthly value
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Owner: Julie Parham | Exec Lead: Dr Trisha Bain

Understanding the cause of the health and safety events that occur for our staff can help us ensure we put in place the necessary training and actions to ensure we manage any risks to the well being of our staff – the analysis below looks at **1)** Incident Causes **2)** Assaults on Staff and **3)** RIDDOR Incidents

Incident Causes

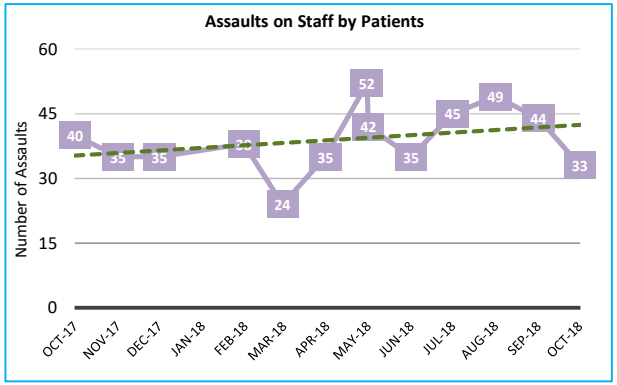
Top 5 Incident Causes



- Manual Handling – lifting patients (MH), General Assault and Security (violence, aggression & verbal abuse), incidents account for the highest number of incidents reported during October 2018.
- Practical manual handling training is now an annual requirement for all frontline staff.

Assaults on Staff

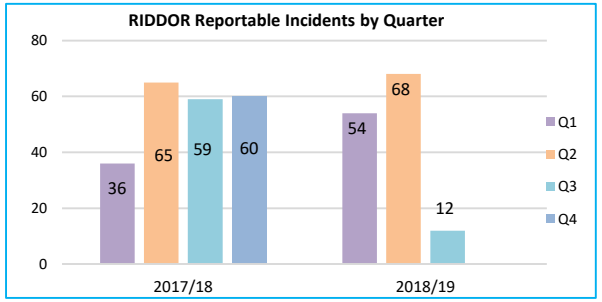
Assaults on Staff



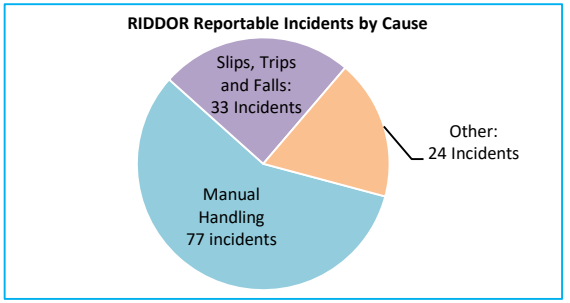
- There was a slight decrease in the number of assault on staff by patient related incidents in October 2018.
- The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.
- Forming a staff safety and security group which will report it to Corporate Health and safety Committee.

RIDDOR Incidents

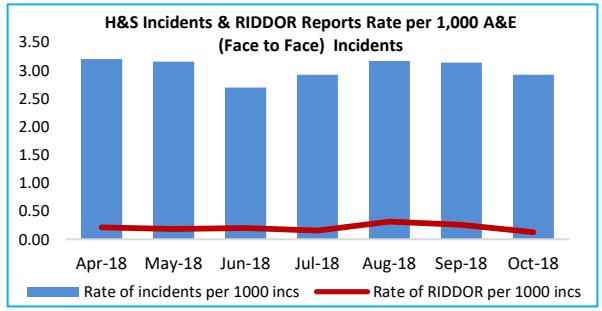
Number of incidents



RIDDOR by cause

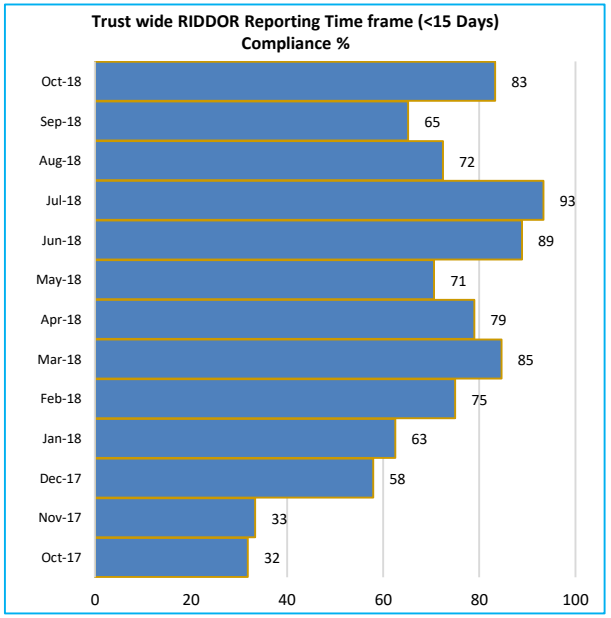


Rate of Incidents



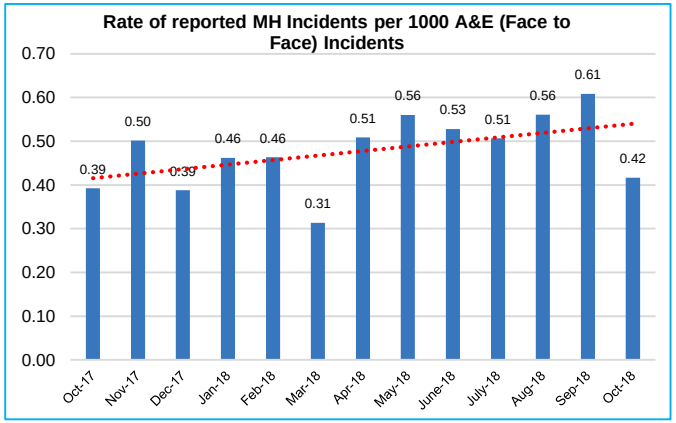
- Total of 134 RIDDOR incidents were reported to the HSE during 2018/19.
- 12 RIDDOR incidents were reported in October 2018.
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in October 2018 was **83%.**
- **2** out of the 12 RIDDOR incidents were reported out of time in Oct-2018
- Manual Handling incidents account for the highest number of RIDDORs reported across the Trust during 2018/19.

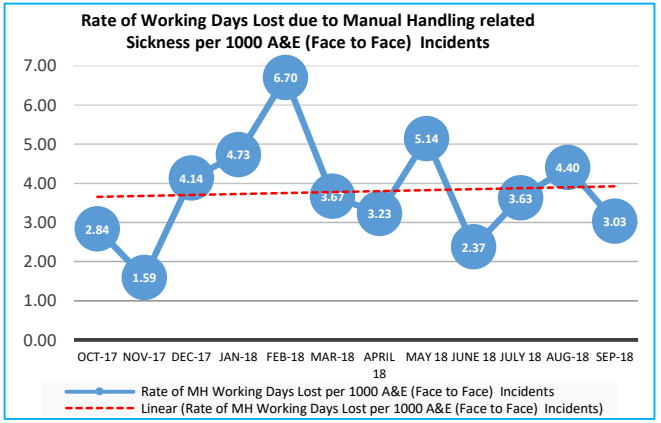
Reporting Time Lag

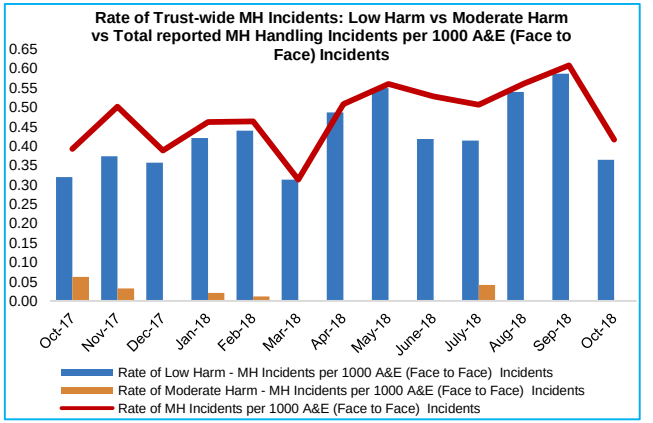


Owner: Julie Parham | Exec Lead: Dr Trisha Bain

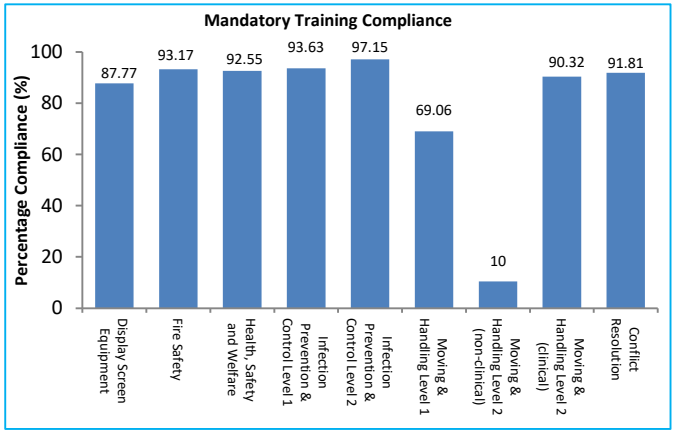
Manual Handling (MH) related Incident, Sickness and Severity Rates

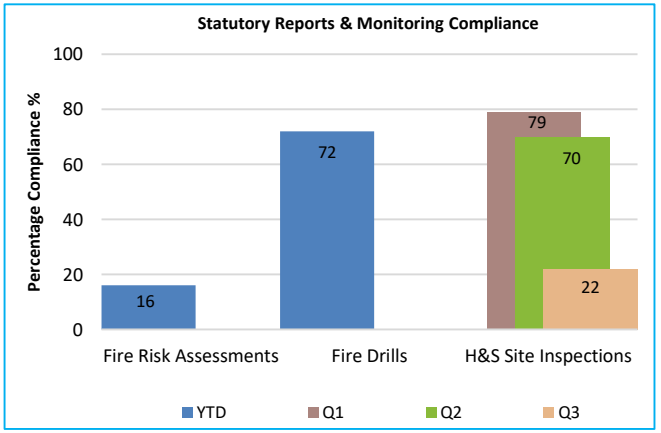






Mandatory & Statutory Compliance





Key Updates

Key Updates:

- The completion of the Mangar-Elk project has seen a reduction in the number of incidents relation to failure, availability and compatibility.
- There has been a reduction in the incidents reported involving Manger Elks, Track Chairs and Tail lifts as a direct result of new equipment being purchased by the Trust along with a more defined maintenance schedule. Monitoring of these incidents will continue for the coming months to ensure consistence.
- The Fire Risk Assessment Tender has closed, with an evaluation of the bid received was undertaken. A subsequent meeting with the company is due to take place during the November for clarification purposes. During the interim time period the Health & Safety Department has incorporated a review of the fire risk assessment action plans into the Site Specific Risk Assessment programme.

2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Clinical Ambulance Quality Indicators
- Clinical Audit Performance

Outstanding Characteristic: *Outcomes for people who use services are consistently better than expected when compared with other similar services.*

Trust-Wide Scorecard

Exec Lead: Dr. Fenella Wrigley

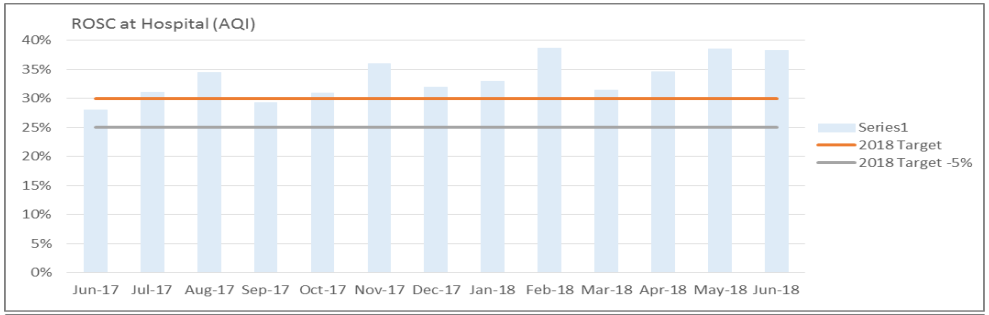
Measures	Target / Range	RAG	YTD 17/18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	0	39%	38%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	59%	70%					↔			LQ1b		
STEMI care bundle (AQI) (Reported every 4 months)		G	70%							↔			LQ2c		
Stroke Care Bundle (AQI) (Reported every 4 months)		G	97%	99%						↔			LQ3b		
Stroke on scene time (CARU continual audit)	00:30	R		30	30	30	31	31		↔					
Survival to Discharge (AQI)			10%	8%	11%					↑					
Survival to Discharge UTSTEIN (AQI)			38%	19%	34%					↑					
STEMI- On scene duration (CARU continual audit)				39	37	38	40	39		↑					
Call to Angiography - Mean (hh:mm)				8%	10%										
Stroke - Call to Arrival at Hospital - Mean (hh:mm)				5%	5%										
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	85%	85%	88%	75%	70%	84%		↑		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD										↔			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	98%	97%	98%	97%	97%	98%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%	97%		↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	R	92%	94%	94%	92%	94%	91%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	97%	97%	97%	97%	97%	97%		↓		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	96%		96%		95%			↓		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)		G		90%	90%	90%	91%	92%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	98%		98%		98%		↔			LQ12		

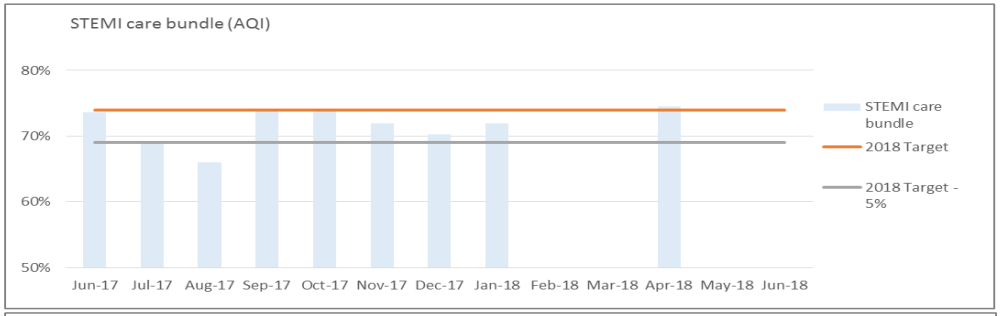
Assurance and concerns

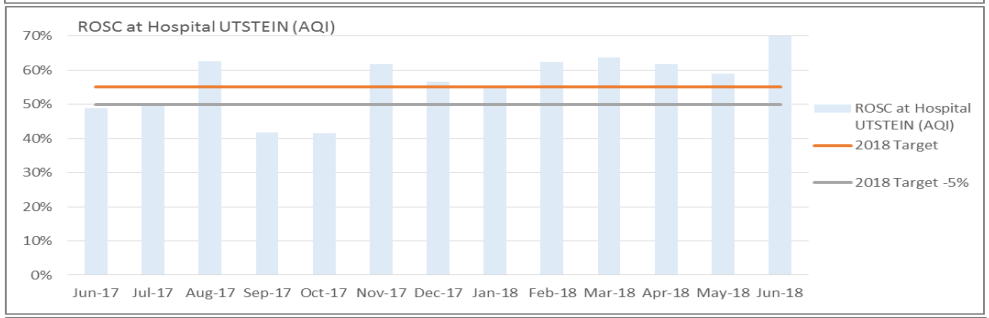
- LAS CPI completion in September increased to 84% after a sudden drop in completion in August, with the LAS achieving their highest completion rate in three months.
- The LAS continued to provide a high standard of care to patients under the Discharged at Scene, Cardiac Arrest, Glycaemic Emergencies and Severe Sepsis CPIs in September, as well as general documentation. The LAS can improve care to patients with an undiagnosed psychiatric problem further by recording appearance for more patients. Under the Elderly Falls CPI, there is great variance across the Service regarding the standard of care delivered.
- 429 members of staff (11% of all LAS frontline clinicians) received a face-to-face feedback session in September.
- Vacancies and process changes in IM&T have resulted in no development work on the CPI database since August.

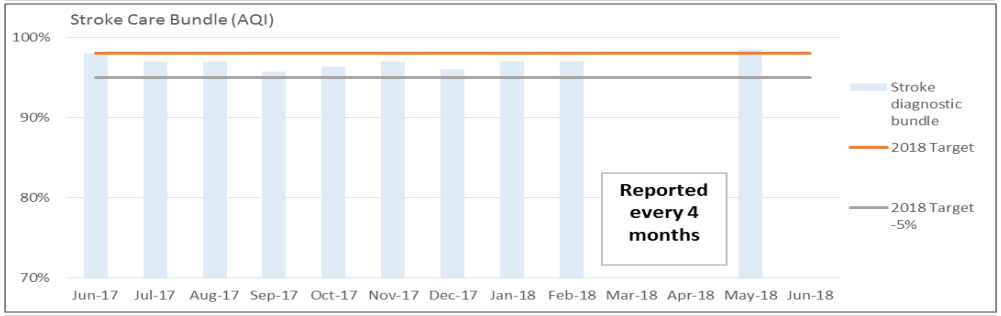
Clinical AQIs

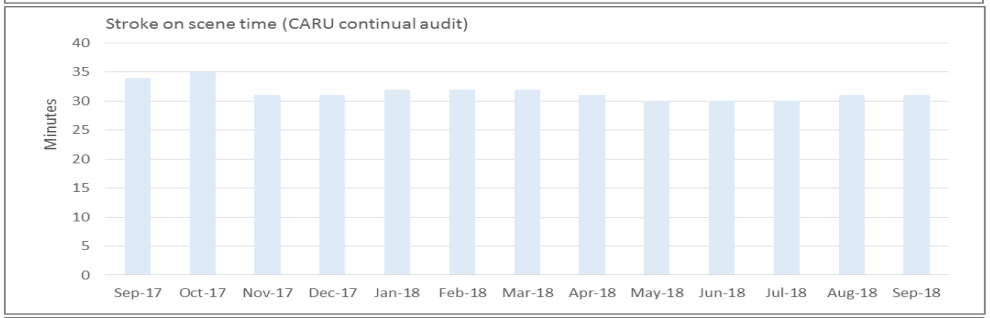
Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley

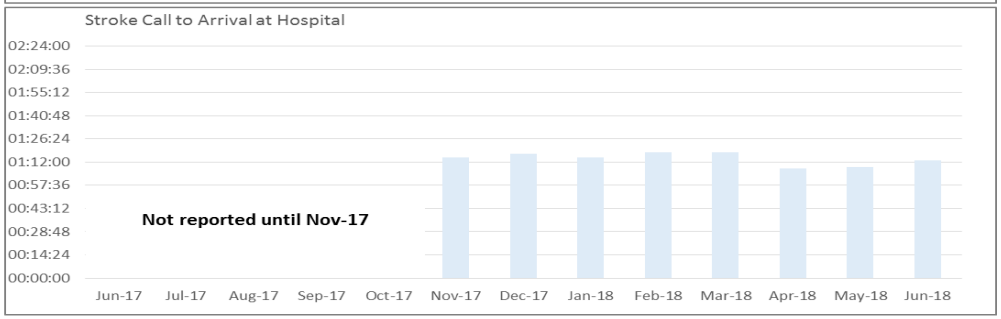


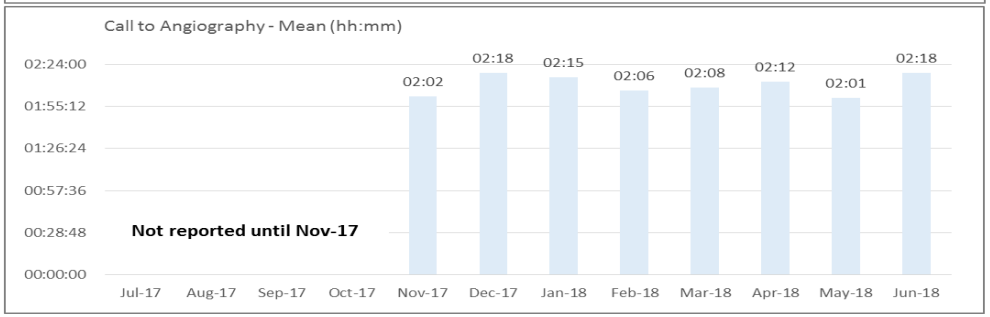






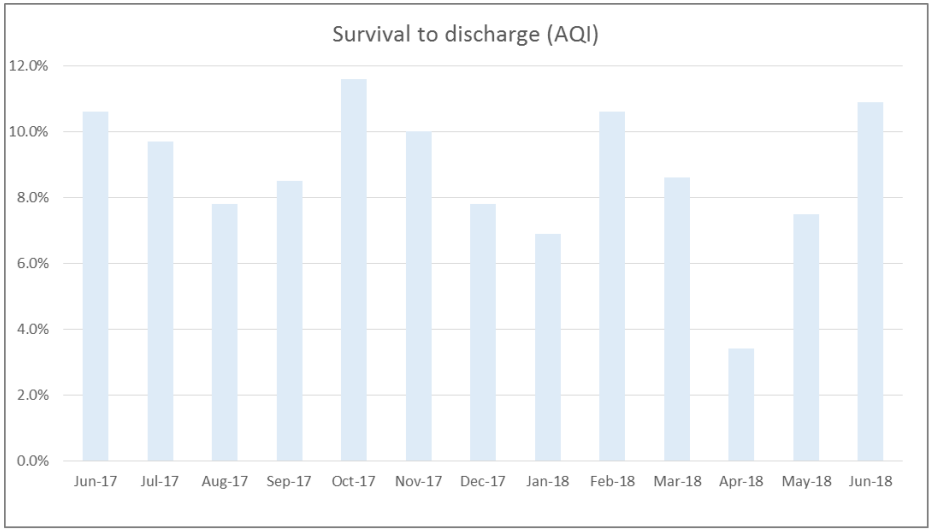


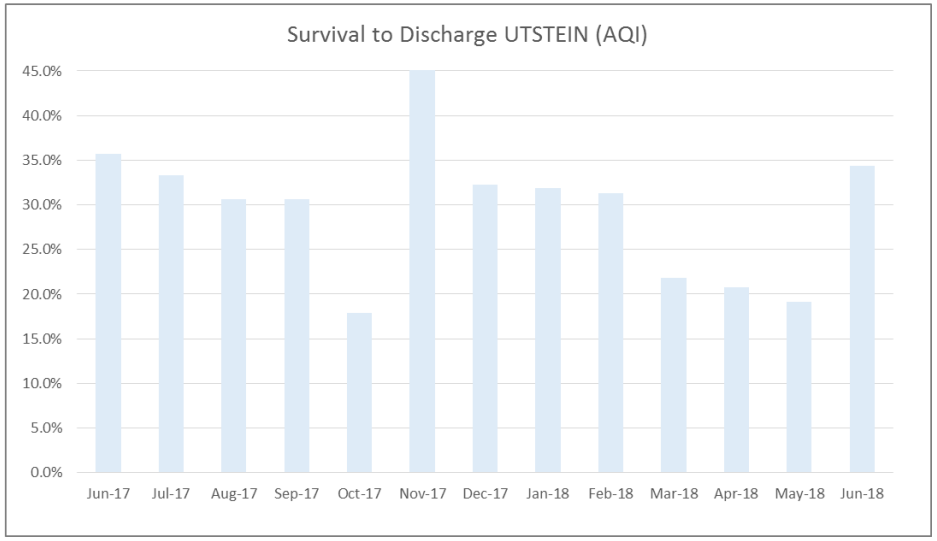




Clinical AQIs

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





AQI: Narrative

In June, ROSC on arrival at hospital for both the overall and Utstein comparator group was above average at 38% and 70%. Similarly the survival to hospital discharge figures for both groups were higher than average at 11% and 34%. Defibrillator downloads decreased by 8% to 14% (from a high of 22% last month).

The mean call to angiography time for STEMI patients in June was 2 hours and 18 minutes, with a 90th centile of 2 hours and 58 minutes, which is higher than previous months. This mean is above the national average of 2 hours and 11 minutes but the 90th centile is below the national average of 3 hours and 5 minutes. The STEMI care bundle has moved to reporting one month every quarter with the next submission due to be reported in December based on July data. The average on-scene time decreased by 1 minutes to 39 minutes in September.

In June, the mean and 90th centile for call to hospital for stroke patients was 1 hour and 3 minutes and 1 hour and 13 minutes respectively, which remains in line with the national average. The stroke diagnostic bundle has moved to reporting one month every quarter with the next submission due to be reported in January based on August data. The average on-scene time has maintained at 31 minutes in September.

A new AQI reporting a care bundle for adult sepsis patients with a National Early Warning Score of 7 and above was reported this month (based on June data). The care bundle measures: observations, fluid and oxygen administration and the provision of a pre-alert. The LAS provided the care bundle to 85% of patients, compared to a national average of 68%.

AQI: Actions

CARU have worked with colleagues in the Medical Directorate and IM&T to continue to develop the process by which defibrillator downloads can occur at station. It is hoped that the process will be streamlined in the coming months to allow for a greater volume of downloads.

* The time lag for these measures is reflective of the time taken to receipt all the information required from NHS England

Clinical Audit Performance

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

Clinical Audit: Actions

As a result of our Continuous Re-contact Clinical Audit, in October:

- 44 crews were recommended for feedback (12 positive & 32 constructive)
- Two Clinical Advisors were recommended for constructive feedback
- Eight Datix forms were completed:
- Five were reviewed by SIG (no SIs):
    - One unexpected death where the LAS acted appropriately. The NETS crew were sent a thank you letter for their CPR attempts
    - One cardiac arrest on re-contact where the LAS acted appropriately. This case was flagged to CCG to review actions of the STARRS team following initial referral by LAS
    - One patient with ACS on re-contact where the LAS acted appropriately. However, this case will be included in Insight Magazine for learning
    - One patient who was FAST+ on re-contact which prompted discussion around whether guidance on Idiopathic Thrombocytopenia Purpura (patients who bleed easily) was issued to the CHUB and clinical staff (as it had not in this case). This will now require organisational review and bulletins to be circulated regarding management of patients with ITP
    - A further cardiac arrest on re-contact where the LAS acted appropriately
- Three incidents have been referred for local investigation:
    - One where the HCP admission protocol was not followed
    - One patient who was discharged on scene following completion of a small PRF only
    - One patient with a NEWS score who was discharged with advice only. A case reflection was undertaken by the crew

Clinical Audit: CPI actions and Projects

In September, CPI training was delivered to 5 paramedics on restricted duties, 4 Emergency Responder Team Leaders and 1 Team Coordinator.

CPI auditors placed 8 datix reports and contacted EBS to discuss the potential for 5 retrospective safegaurding referrals.

In October, CARU published the an End of Life Care Clinical Audit designed and undertaken by a Paramedic in her own time. CARU facilitated this clinical audit and shared the findings with the the Medical Directorate, End of Life Care Working Group and End of Life Care Pioneer Services Team for discussion regarding any necessary actions. The findings will be shared with the Clinical Audit and Research Steering Group at the next meeting to discuss whether this should be considered as part of the clinical audit work plan in the future.

Research Update

Rachael

Did you want to add in here the issue surrounding the Data Protection Register and MPDS Maternity?

3. Caring

We must ensure that the service involves and treats people with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Mental Health
- Maternity
- End of Life
- People and Public Engagement

Outstanding Characteristic: *People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.*

Trust-Wide Scorecard

Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Aug-18	Sep-18	Oct-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Mental Health related calls as percentage of all calls			8%	8.5%	8.0%	8.1%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.2%	2.0%	2.2%	↑				
Mental Health related Incidents as percentage of all calls			5%	5.8%	5.2%	5.3%	↑				
Mental Health related HCP Incidents as percentage of all calls			0%	0.38%	0.35%	0.40%	↑				
Total incidents coded as Mental Health			59366	8902	7999	8515	↑				
Mental Health calls closed with Hear and Treat			2520	327	373	340	↓				
Mental Health incidents closed with See and Treat			21130	3234	2890	3159	↑				
Total MH Incidents conveyed as a %			64%	63.7%	63.9%	62.8%	↓				
Mental Health Patients conveyed to an ED			56%	55.1%	55.0%	54.1%	↓				
Mental Health Patients conveyed to an alternative care pathway (Including other)			4%	4.2%	4.5%	4.4%	↓				
Birth Imminent Incidents			1159	183	161	184	↑				
Conveyance rate of birth imminent			92%	95.1%	89.0%	93.0%	↑				
Head out/head visible Incidents			151	29	25	16	↓				
Conveyance rate of Head out/head visible incidents			79%	75.9%	80.0%	69.0%	↓				
Haemorrhage after 24 weeks Incidents			1472	208	207	210	↑				
Conveyance Rate of Haemorrhage after 24 weeks Incidents			93%	90.4%	95.2%	91.0%	↓				

Mental Health

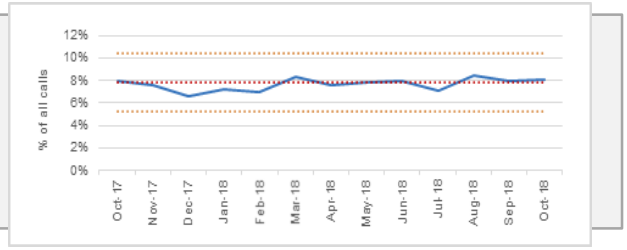
Owner: Carly Lynch | Exec Lead: Dr Trisha Bain

Calls and incidents related to mental health issues often require us to respond differently to other types of patient – ensuring we are able to respond both effectively and with respect is vital for these patients and this is something we are developing through our Pioneering Services Programme (see section 6 of this report)

Trend Analysis

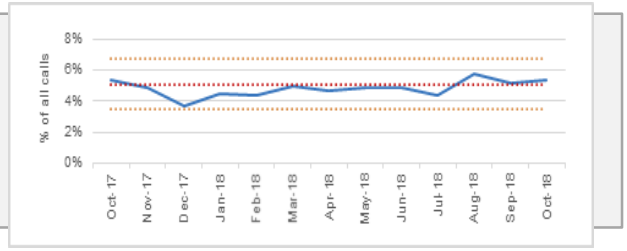
MH as % of all calls

Latest Month: **7.1%**



MH related incidents

Latest Month: **4.4%**



MH Incident Response

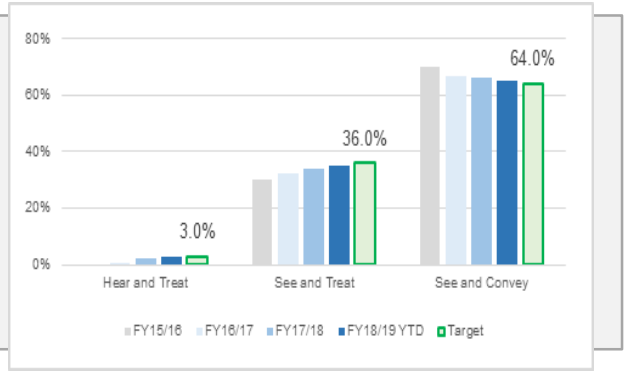


CHART KEY
- Monthly value
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Data Source:

Highlights:

The Mental Health Team met with Prince Charles during his visit to HQ and spoke to him about the Mental Health Joint Response Car

The Mental Health Joint Response Car launches on 26/11; we have recruited three paramedics and the team will spend 5 days training together before the car is launched.

We continue to offer training around the organisation on topics such as the Mental Capacity Act and the EOC CSR.

ACTIONS: We continue to engage with a group of Experts by Experience around co-production.

Exceptions (Improvement Required):

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: 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

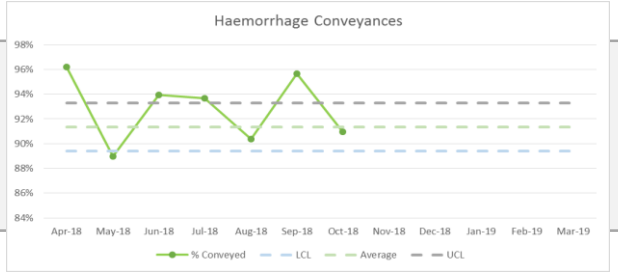
Maternity

Owner: Amanda Mansfield | Exec Lead: Dr Trisha Bain

Effectively handling the needs mothers who require emergency assistance during the birth of their children are some of our most challenging incidents and ones that require us to demonstrate compassion, kindness, dignity and respect for all involved. We are developing our response to maternity incidents through our Pioneering Services Programme (see section 6 of this report)

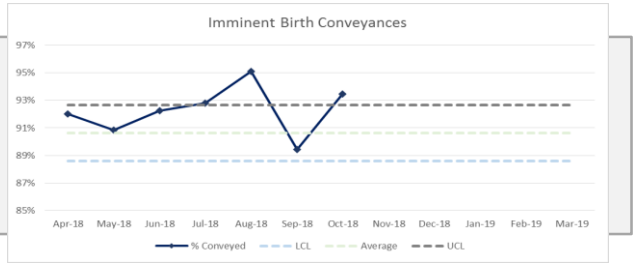
Haemorrhage conveyance

Latest Month: **6%**



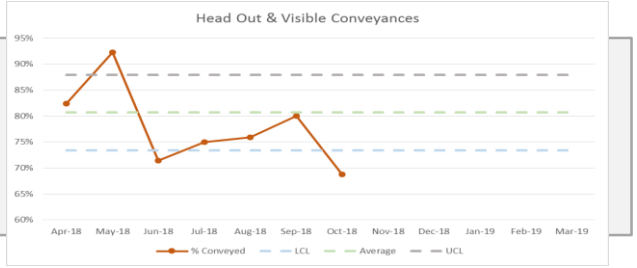
Imminent birth conveyance

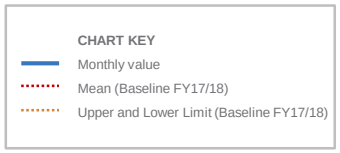
Latest Month: **7%**



Head out and visible conveyance

Latest Month: **18%**





Data Source:

Highlights

- Implementation of new response profile for Health Care Professional (HCP) requests for maternity emergencies
- 2 Joint Maternity Multidisciplinary Training Events (Westminster/Croydon) with representatives from local Maternity Units

Exceptions (Improvement Required):

- Roll out of Joint Maternity Training – Pan London Engagement Event planned for December – Chief Executive to provide video-message
- Datix Maternity Reports to be developed and shared across each station to improve awareness of maternity triggers
- Monitoring of the new HCP

ACTION: Annual plan to be drafted following December event

Outstanding

- Outstanding Obstetric Emergency audit

ACTION: New audit officer identified

Agreement of new maternity Datix reports to be agreed December-18

100% of maternity related incidents to receive specialist review

People and Public Engagement

Owner: Margaret Luce | Exec Lead: Dr Trisha Bain

The work we do through attending public engagement events supports the development of our reputation with patients and members of the public as well as the long term future development of our organisation through raising awareness of career opportunities available as part of the London Ambulance Service.

Public Engagement Events

In October we held 64 events across London covering the following types of activity:

- School visits
- Knife crime e.g. Pupil Referral Unit visits and Your Life, You Choose
- Careers events
- Junior Citizen Schemes
- Brownies, guides, cubs and rainbows
- LFB open day, safety day and careers day
- MPS community event
- Road safety (Safe Drive Stay Alive / Biker Down)
- Youth Ambassador Scheme event
- Restart a Heart Day
- Pensioners' group

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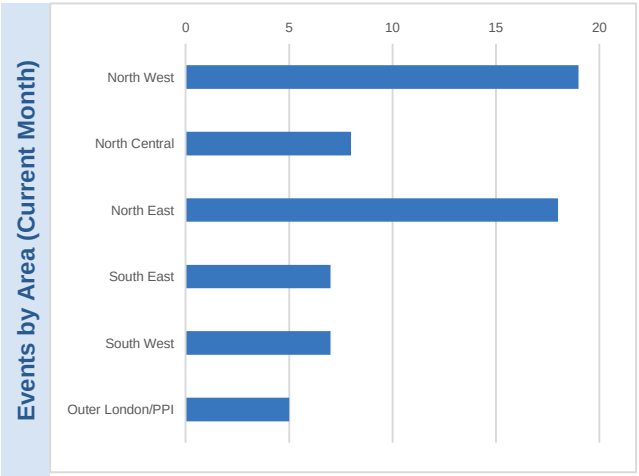
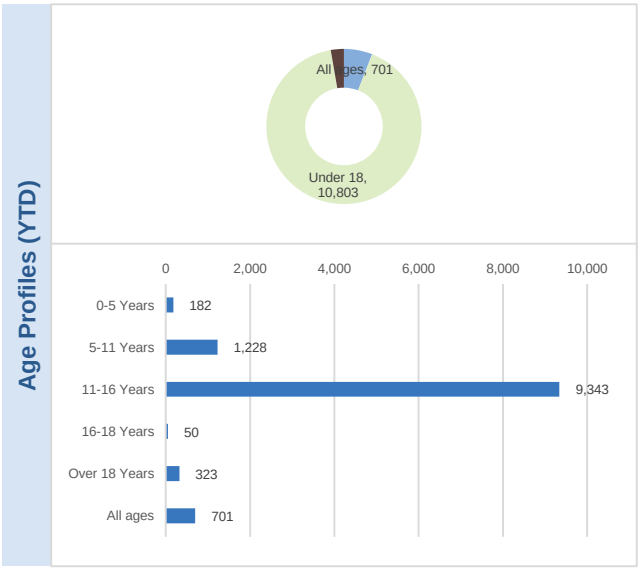


Public Engagement Activities

Supplementary information	
No. of public engagement events: year to date (April – October 2018)	356
Approximate audience numbers (October 2018)	11,827
Approximate audience numbers: year to date (April – October 2018)	54,147
Public engagement: no. of hours (October 2018)	263
No. of staff on LAS Public Education Facebook group	747
No. of staff on contact list	1,349



Public Engagement Highlights

- Ruth Lewis, PPI & Public Education Co-ordinator, attended a primary school in Camden. The feedback from teacher who organised the visit said: **"The children absolutely loved the visit. You had such a calm and lovely manner with the children and I feel they learnt a lot. They loved putting on your equipment and the little toys went down very well as a memory of your visit. Hopefully we'll have some budding paramedics in the making!"**

- Graham Fox, an EAC from Romford, attended a school in his area. Afterwards, the school said: **"Graham was absolutely fantastic. He spoke to the children, and they listened well. He allowed them to try on his coats and hard hat and they were totally enthralled by that. We even had children pretending to take temperatures and listen to our hearts!! He would definitely be someone I would ask to come back to have another talk as he was fantastic with the kids and very involved!"**

- Emma Purslow (Public Education Officer) leads on a joint project called Your Life, You Choose, aiming at reducing knife crime. Feedback from the students who attended an event in October included:
  - **"It has changed my life, now I know that a knife can change everything."**
  - **"It made me think about making the right choice."**
  - **"I will now do good stuff so I won't end up in prison."**
  - **"I will watch who I hang out with."**

4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Frequent Callers
- Complaints

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*

Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Aug-18	Sep-18	Oct-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			4	4	4	4	↓				
Number of Frequent Caller calls			19414	5918	6115	6162	↑				
Total Frequent Callers			4228	629	631	588	↓				
Number of Public Engagement Events			0	21	33	64	↑				
Number of service re-design projects involving patients/public				5	5	5					
CMC records viewed			2209	426	0	0	↔				
Rate of Complaints per 1,000 Incidents			1.0	1.1	1.1	0.9	↓				
Complaints Response (35 working day breach) YTD			229	32	19	26	↑				
Complaints Acknowledged within 3 working days			100%	100%	100%	100%	↔				

Frequent Callers

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

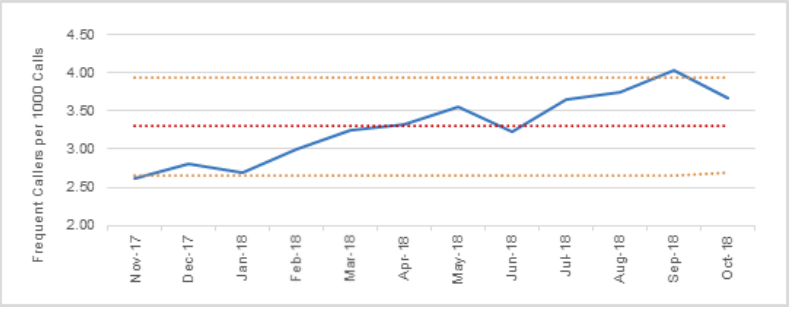
Responding effectively to frequent callers is a significant challenge and one that requires support from our various partners. We have a dedicated Frequent Caller Team working alongside a number of 'High Intensity User' initiatives across London, all aiming to better support these patients and ensure they seek help from the most appropriate service.

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 Rate

Latest Month: **3.85**



Calls from Frequent Callers as a proportion of total calls to LAS = 3.85 for October 2018. The rate continues to be above the average from FY17/18.

CHART KEY
Monthly value
Mean (Baseline FY17/18)
Upper and Lower Limit (Baseline FY17/18)

Data Source:

Frequent Caller Team (FCT) October 18 updates:

Last month the Frequent Caller Management Database (FCMD) identified 606 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.

FCT are undertaking a systems review. They are reviewing DATIX and the Frequent Caller Management Database to allow for better reporting.

Frequent Caller Team (FCT) challenges:

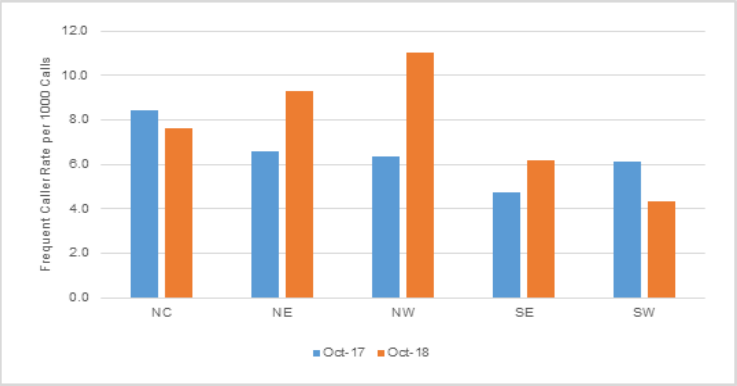
The use of Coordinate My Care (CMC) with external partners and ensuring care plans are accessed continued to be an ongoing challenge. A Task & Finish group is still in progress re. the management and review of 'care plans', including Patient Specific Protocols, and A&E plans.

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

The data in the table on the right shows the number of Frequent Caller calls by CCG.

This table also highlights the top 5 patients from the current month.

Year on Year Comparison by Sector



Data Source:

Further validation work required to ensure that frequent caller rate metrics are consistently reported across sectors and overall for the Trust

The case study on the next page explores the case of the most frequent caller in the last month

Sector	CCG	Patients	Oct-18	Calls last quarter	Calls last 12 months	
NE	CITY AND HACKNEY CCG	34	461	1162	3597	
NC	BARNET CCG	32	234	776	2349	
NC	HARINGEY CCG	29	305	684	2180	
NC	ISLINGTON CCG	25	284	846	2155	
NW	EALING CCG	25	270	886	2588	
SE	GREENWICH CCG	25	161	841	2115	
NE	NEWHAM CCG	24	162	483	1815	
NC	ENFIELD CCG	23	248	714	2378	
SE	LAMBETH CCG	23	260	783	1961	
NW	CENTRAL LONDON (WESTMINSTER) CCG	22	232	765	2011	
NW	HAMMERSMITH AND FULHAM CCG	22	264	636	1931	
NW	WEST LONDON CCG	22	131	620	3161	
SW	CROYDON CCG	22	240	740	1994	
NW	HOUNSLOW CCG	21	410	874	3131	
NC	CAMDEN CCG	20	148	412	1281	
SE	SOUTHWARK CCG	20	190	529	1472	
SW	WANDSWORTH CCG	20	126	530	1754	
NW	HILLINGDON CCG	19	257	716	1759	
NW	BRENT CCG	18	129	373	1060	
NE	BARKING AND DAGENHAM CCG	17	221	445	1070	
NE	REDBRIDGE CCG	17	116	422	1168	
SE	LEWISHAM CCG	16	232	536	1451	
NE	HAVERING CCG	13	216	585	2391	
NE	TOWER HAMLETS CCG	13	114	285	991	
SW	MERTON CCG	13	128	412	913	
NE	WALTHAM FOREST CCG	12	194	472	1297	
SW	RICHMOND CCG	12	107	346	1310	
SE	BROMLEY CCG	11	63	239	550	
SW	SUTTON CCG	11	69	229	610	
NW	HARROW CCG	9	76	262	766	
SE	BEXLEY CCG	9	87	264	635	
SW	KINGSTON CCG	7	27	101	258	
	Top 5					
NW	HOUNSLOW CCG	65 (f)	195	255	1742	Diabetic problems, chest pain, learning disability.
SE	LAMBETH CCG	64(f)	131	210	677	Anxiety, learning disability
NE	WALTHAM FOREST CCG	59 (m)	107	211	491	Breathing problems, paranoid schizophrenia, COPD,
NE	HAVERING CCG	77 (m)	107	142	172	Breathing problems, COPD.
NC	HARINGEY CCG	64 (f)	80	109	225	Bipolar disorder, Cancer, Intoxication.

Data Source:

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

CASE STUDY – MS H

Presenting Situation

- 65 year old female with learning disabilities, unmanaged type 2 diabetes, social isolation, depression and complex behavioural issues.
- Lives alone in extra care accommodation, with 24/7 support staff on site.
- Identified as a frequent caller in 2015, LAS continue to work with local health and social care partners.
- 12 month total = 1,742 calls, costing £19,750.19.
- Chief complaints: varies from chest pain, abdominal pain, diabetic problems, or an 'unknown' diagnosis.
- Individual Dispatch Protocol (IDP) flag in place, asking for carers to verify if an ambulance is required.
- Patient Specific Protocol (PSP) clinical/behaviour management plan is flagged on the LAS system.
- Experienced marital domestic abuse some years earlier, resulting in children being removed from her care. Patient has complex family relationships with her adult children (and their partners), which trigger regular safeguarding concerns. Patient is vulnerable to exploitation by family members.
- Patient has been physically aggressive to health professionals trying to monitor her diabetes.
- Patient mostly calls late at night from her room via mobile phone. Initially, majority of calls were with chest pain, now more with diabetic problems. Carers lack confidence in cancelling calls.
- Patient's calls can spike further during family crises or safeguarding concerns being raised.

Intervention

- Regular meetings with local health and social care professionals. Meetings involving patient result in patient becoming very distressed and not engaging.
- Arranged basic awareness training for care staff, delivered by a senior paramedic, to increase confidence in responding to patient's health concerns/calls to LAS, providing basic first aid awareness in relation to patient's specific needs, and helping staff understand when calls may be appropriate to be cancelled.
- Care staff are now more confident in responding to patient's calling behaviour, and more regularly cancel ambulances if not deemed appropriate.
- During June-August 2018, the patient's mobile phone was broken and there were no calls. Patient did not request ambulances via care staff during this period, indicating a clear behavioural element to the calls.
- Work continues to be attempted to try to modify patient's behaviour. E.g. increasing patient's activities during the day; focus on bedtime routines & sleep patterns; and reducing caffeine intake at night, to try to reduce call activity at night. Patient often will not engage in activities arranged with support workers.

Outcome

Though no significant drop in call rate, almost all calls are now cancelled and units are rarely dispatched, as carers feel more confident to cancel ambulances – this is helped by patient calling less with chest pain and more with less urgent complaints. Significant reduction in resources. During October 2018 = 195 calls. Of these, 193 calls cancelled; 2 calls resulted in a response from an ambulance, with 1 conveyance to hospital. The case continues to be regularly reviewed. Weekly call data is shared with the Local Authority Chair of the MDT meetings, to inform their local monitoring. Patient is requesting a move to smaller accommodation– FCT have emphasised patient requires 24/7 access to support staff, otherwise inappropriate use of emergency resources will increase.

Challenges / Areas for Development

- Effectively escalating LAS' concerns to Local Authority/CCG for a prompt response.
- Regularly reviewing behaviour management plans with local services, in particular for patients with Learning Disabilities
- Changes in allocated care coordinator, psychologist, GP and support workers can have a negative impact on any multi-agency plan being effectively followed.
- Limited local resources means no continuous psychology input with patient is available.

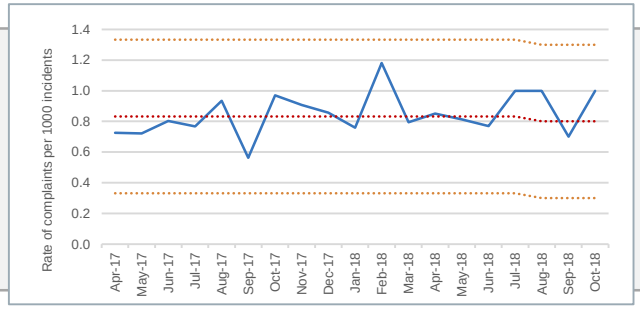
Complaints

Owner: Gary Bassett | Exec Lead: Dr Trisha Bain

Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

Rate of Complaints

Latest Month: **1.1**

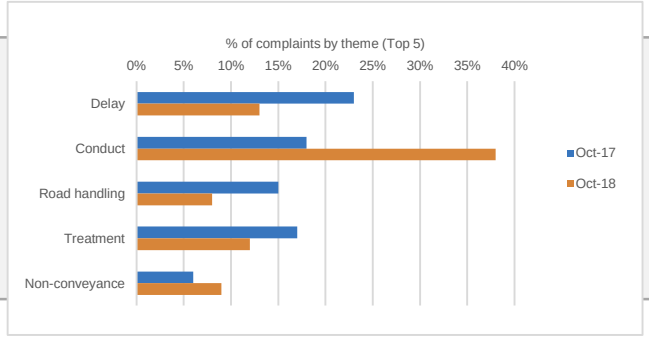


In October we received 89 complaints, in line with the average per month (83). We anticipate a trajectory of 1000+ complaints for 2018/19.

Enquiries to the department currently average 368 per month. The complexity of a number of these PALS enquiries meant that 112 were unable to be concluded within 24 hours.

There was a record number of requests from Solicitors for patient records = 172

Categorisation

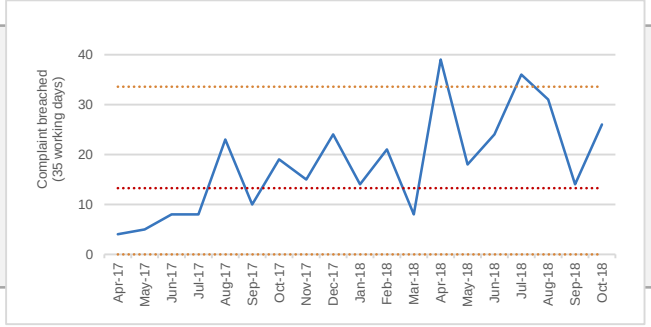


The percentage of complaints regarding **conduct and behaviour** continue to increase and now outweigh those pertaining to delayed response. During October there were 34 in this category against 12 delay complaints. This was the highest number of such complaints for 5 years.

The other category that has increased over the year is non-conveyance. This includes referrals to NHS 111, arranging a taxi call management issues or the patient unhappy with being left at home

Responding to complaints

Latest Month: **26**



There were **26 complaints that breached the 35 day response target** in October – this represents an annual average of 34% out of time.

- Of these, 18 complaints are now closed (as at 09/11/18), 8 remain open.
- We received 20 Health Partner Alerts during October - there have been 128 such enquiries in 2018/19

CHART KEY
Monthly value
Mean (Baseline FY17/18)
Upper and Lower Limit (Baseline FY17/18)

Data Source:

Owner: Gary Bassett | Exec Lead: Dr Trisha Bain

Case examples

Example one - Complaint alleging that the 999 call was under-triaged and that the call handler failed to take into account that the patient may have been suffering from sepsis

The Quality Assurance evaluation confirms that the 999 call was largely determined at the appropriate level of priority, given that the triage system we use considers a patient's presenting signs and symptoms at that time. Unfortunately even though possible sepsis was mentioned, the call handler did not record this. Whilst call handlers are obliged to apply the triage questioning protocol based on the patient's symptoms, they should record suspected sepsis where this information is offered and can highlight this to a clinician based in the Emergency Operations Centre. This does not however mean that the priority would have been changed, as they would depend on the outcome of a further assessment, itself dependent on capacity within the Clinical Hub to call back before an ambulance was arranged. The complaint was partially upheld.

Example two – Complaint from patient's daughter that her mother was not conveyed to hospital despite later being found to have several broken ribs..

From a clinical perspective, we were largely satisfied that the crew conducted an appropriate examination. Injuries that result in the kind of bruising the patient experienced will usually have localised pain. However, despite there being no obvious fractures and whilst staff have no authority to compel a patient with capacity to attend hospital, given the patient's history of blood cancer and that she had been feeling faint, it would have been best practice for the crew to encourage her to attend hospital for an x-ray and further assessment, enlisting the help of the family to do so. We would also expect the crew to have carried out a chest examination given that a raised respiratory rate can be attributed to a chest injury. We recommended that the crew meet with a Clinical Team Leader to review their care management with particular reference to the clinical issues indicated. The complaint was partially upheld.

Actions and Learning

Assurance through the Parliamentary Health Service Ombudsman

- The Ombudsman looks at whether the person affected has been put back into a position where they would have been, had there not been a negative impact on them.
- If that is not possible, for example, where the injustice has been caused by distress or unnecessary pain, the Ombudsman may suggest a financial remedy is made to the complainant.
- To that effect, the Ombudsman has introduced six different levels of injustice ranging from zero to £10,000 plus
- There will likely be a financial impact on the Trust who are now obliged to consider financial remedy

Health Partner Alerts from midwives

- We have received a number of alerts from midwives who had requested an immediate response because of complications to a mother, an unborn baby or newborn baby. The maximum HCP call was a Category 2
- As a result of these concerns, we worked with the Consultant Midwife and midwives who are now being provided with a maternity complications communication card to ensure their patient receives a Category 1 response where the criteria is met.

Improving throughput of responding to complaints and PALS management

- We are working with local managers to improve complaint throughput by timely preparation of crew accounts using Datix as a monitoring facility.
- We are participating in a local project regarding the management of lost property. We have also added a 'lost property' form to the Trust's website

Audit of Department by Grant Thornton

- The auditors were with the department for the whole month whilst they worked with the team to monitor our methodology and complaint management practices
- It is anticipated that their report will be available within the next few weeks

Learning From Deaths, Inquests and Claims

Owner: Laura O'Donoghue | Exec Lead: Trisha Bain

Inquests

Latest Month: **1.1**

	2017-18				2018-19			
	Jul-17	Aug-17	Sep-17	Oct-17	Jul-18	Aug-18	Sep-18	Oct-18
Total Prevent Future Deaths in Month	0	0	1	0	1	0	0	0
Total Inquests where LAS asked to give evidence - In month	9	10	6	4	6	2	8	8
Total Inquests where LAS asked to give evidence - Year to date	23	33	39	43	22	24	32	40

No PFD reports were issued against the Trust this month. However, a request was made by a Coroner on 29 October for evidence to be provided to him in relation to further training of Emergency Medical Dispatchers within 28 days.

Claims

The NHS Resolution Quarterly Report, Q2 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 information set out in the attached chart.

Table 1:

No. of Claims	Total Claim	Total Damages Reserve	Total Claimant Costs Reserve	Total Defence Costs Reserve	Total Outstanding Estimate	Total Payments
44	£88,083,135	£78,547,472	£7,551,298	£1,984,365	£78,075,473	£10,007,661

Table 2:

No of claims	Total Claim	Damages Reserve	Claimant Costs Reserve	Defence Costs Reserve	Outstanding Estimate	NHSLA Funded Payments	Total Payments
55	£2,500,519	£1,626,334	£675,185	£199,000	£2,206,957	£258,902	£293,562

- 5 Clinical Claims were reported to NHSR in October, these included claims for delay in responding to Claimants, alleged failure to provide a pre-alert, concerns around hospital handover and a potential claim requesting a stay whilst the Claimant investigates potential allegations.
- 2 Employers' Liability Claims were reported to NHSR in October concerning a members of staff slipping on liquid and sustaining an electric shock.
- NHSR closed 7 claims in October, damages were paid in 3 of the cases, the remaining 4 cases were closed without any payment of damages.

Data Source: Datix

5. Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*

Learning from our actions

Exec Lead: Dr Trisha Bain

By regularly reviewing the success of actions taken to improve Quality and by taking forward the lessons learnt from each intervention we make we can seek to make better decisions in the future. In this section we take each domain in turn and examine the actions we have taken over the previous quarter and whether they are having the anticipated impact.

4. Responsive

Frequent Callers

Complaints

Headline – One borough working project

Issue Identified

The London Ambulance Service receives multiple calls from patients with complex care needs. The Frequent Caller Team use various methods to try to reduce or stop the calls. They also work with external agencies to formulate care plans. With 600+ patients identified each month, the Team struggles to initiate intensive work with all frequent callers.

Agreed Actions

It was agreed that for one month, one of the officers would review one CCG and work only on patients living in this CCG. Bexley CCG was chosen. For the month of May 2018 there were 22 callers identified. All calls were reviewed. All patients GPs were contacted, requests for meetings were pursued, as was liaison with social services, Health Care Professionals and other relevant projects.

Impact of Actions

The immediate effect was not apparent, but over some weeks the calls started to reduce. Five months later the call rate had reduced across the whole CCG. For October 2018, there were 9 frequent callers with only three of these patients having a negative impact on resources.

Lessons Learnt

Intensive working with one borough/CCG can have a longer term positive impact, helping develop more effective, trusting working relationships with GPs and other local services. However, other external projects had also begun in Bexley during this time and may have also impacted on the reduced call rates.

Quality Priorities

Exec Lead: Trisha Bain

Quarterly Priorities (Latest report as at 10-Sep-18)

SAFE

- 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.
- 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.
- The **secure drug rooms project** is progressing well for those where it was a agreed that new drug rooms will be built.
- Actions to increase the number of **defibrillators** are progressing well

EFFECTIVE

- The implementation plan for **clinical training** is on track.
- New **clinical quality indicators** have been agreed and are included in the monthly CEO performance pack for review.
- 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 November 2018.
- Sector **roster reviews** are underway with regularly feedback being received from sectors on implementation.

CARING

- Work continues to address the **frequent callers** and a KPI to reduce the number of calls has been set.
- 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.
- **Two whole time practice development midwives** have been recruited and implementation of a training programme is underway.

RESPONSIVE

- Review of **operational model** - a paper went to Board which included an action plan which was approved.
- To improve our **response to complaints** a process mapping exercise has been undertaken and an action in place.

WELL LED

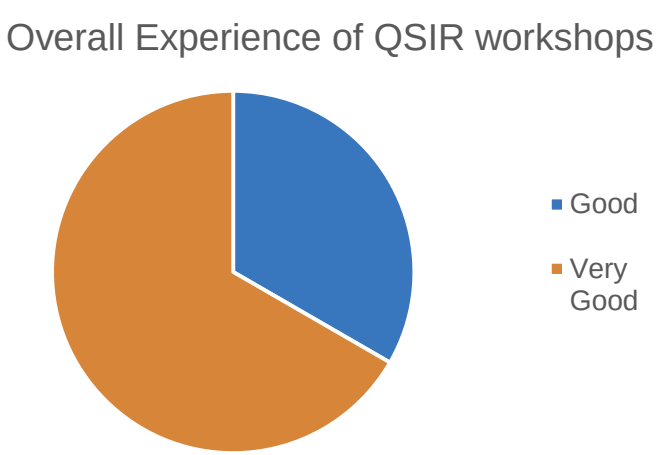
- **Statutory and mandatory training** is on course with trajectories established at station level in place.
- **Leadership programme** has been written and the first cohort undertaken the training this month.
- The progress on **P&OD strategy** is regularly discussed at the people and culture committee.

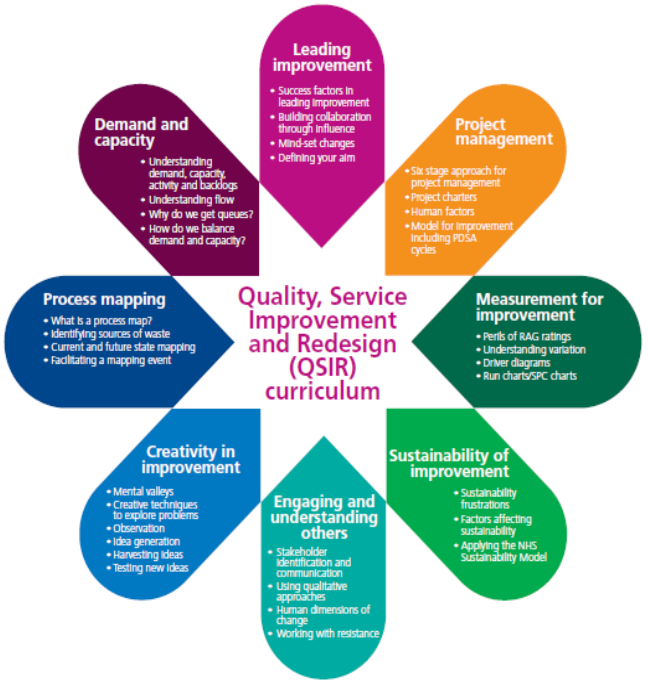
Data Source:

Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

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.
The Trust 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 first cohort is approaching the last training day which will take place in November. This has been extremely successful with positive feedback being received following each training day. The details of this are detailed below. The second cohort has been identified and training dates are currently being agreed with the two current trainers. There are further QSIR practitioners who will undertake the assessment and attend the faculty to become accredited trainers to support this programme going forward.





Comments from participants:

"I liked the opportunity for sharing experiences"

"I enjoyed engaging with other colleagues and the knowledge of the trainers"

"Fun, interactive, with a variety of learning tools"

Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

Below details the HealthAssure Programme of work for 2018/19. The overall aim is to have CQCAssure fully implemented by the end of the financial year. Once this has been achieved the other modules (NICE, Audit, policy and CAS Alerts) on the system will be implemented.

The Corporate alignment is underway and both Safe and Well-led KLOEs have been completed but work continues to populate the remaining KLOEs. It is anticipated that this will be done by the end of Quarter 3.

The first HealthAssure User Group was held in October, the aim of this group is to talk about the system and ensure that it is maintained and streamlined for end users. It was also to reintroduce the system to the new Locality Group Station (LGM) Managers following the Operational Restructure. This meeting talked about the requirements and timeframes in which the safe and Well led KLOEs need to be reviewed. Leads were provided with a deadline of the 3rd December 2018 to populate the system with narrative and evidence for the Safe and Well Led domains, with an aspirational target of mid-January 2019 for the remaining domains to be populated. This has been stretched to March 2019 to accommodate winter pressures, though population and quality assurance of content will continue during this time and will be supported by the central team and the QGAMS.

The HealthAssure User Group will be developed to share learning and good practice from across the different group stations/sectors. It will also be the forum to share and action any themes and trends that are found from the Peer Reviews which are conducted quarterly.

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

Explanation of the assessments above:

1. The assessments above are primarily to provide an overview of systems population as opposed to a robust CQC self-assessment rating.
2. This is because the system has not been fully populated as yet, and the ratings below are high level self-assessments by an area against the fundamental standards, which need quality assuring as described above. It is worth noting that a current self-assessment rating of “Requires Improvement” may mean evidence simply needs to be sourced to support the achievement of the standard. Equally a rating of “Good” may need quality assuring to ensure the supporting evidence is accurate.
3. Where there is a grey box / box states “Not Assessed”, this can mean that either no work has been undertaken for this domain by the group station / corporate area, or that population has commenced but not yet been completed.
4. Continued review of the status of the evidence will be available and reported on until full compliance is achieved.

Owner: Helen Woolford | Exec Lead: Dr Trisha Bain

We have conducted six very successful peer reviews on all sectors throughout July, August, September and October. A plan is being produced to ensure that all areas included some support areas (e.g. Fleet workshops) are included on the peer review plan for the coming year. We did initially book all sectors to have a peer review in July but due to the Operational Re-structure we have postponed 4 reviews.

The following sites were reviewed:

EOC-Waterloo	Westminster Station
Camden Station	Barnehurst Station
Homerton station	Wimbledon Station

These Peer Reviews have mainly focused on the following domains in particular to look at some of these must do / should do actions, and how they are being implemented:

Safe: People in our care are protected from abuse and avoidable harm

Well-led: Our leadership, management and governance assure the delivery of high-quality person centred care, supports learning and innovation and promotes an open and fair culture.

Effective: Our care, treatment and support achieve good outcomes for our patients and service users and we promote a good quality of life based on the best available evidence.

Domain	Theme identified	Actions
Safe	Medicines management: The new drug rooms are making a real difference to the management of drugs in LAS. There is varying room temperatures and there is a trust stance needed as to what the drug room temperature should be and what to do should this should fail Incidents and Risks: Staff on the front line do not always know what their local incident and risks are, despite this information being available on newsletters etc.	1. Trust pharmacist to be informed and come up with a Trust standards and issue this to those stations with new drug rooms. 2. Work with other departments to include incident and risk information when providing patient outcomes newsletters to staff. 3. Continue to look at ways of increasing and sharing learning across the organisation.
Well Led	Complaints: Staff on the front line do not always know what their local complaints trends are but most are aware that behaviour and Attitude is a Trust –wide issue.	1. Work with other departments to include incident and risk information when providing patient outcomes newsletters to staff. 2. Continue to look at ways of increasing and sharing learning across the organisation
Effective	None identified	

6. Clinical and Quality Risks

To run an efficient organisation we need to manage the important and unique risks we face as an ambulance service.

This section summarises the **most significant clinical and quality risks** that we are actively managing as part of the Quality Directorate risk register.

6. Clinical and Quality Risks

Clinical and Quality Risks Summary

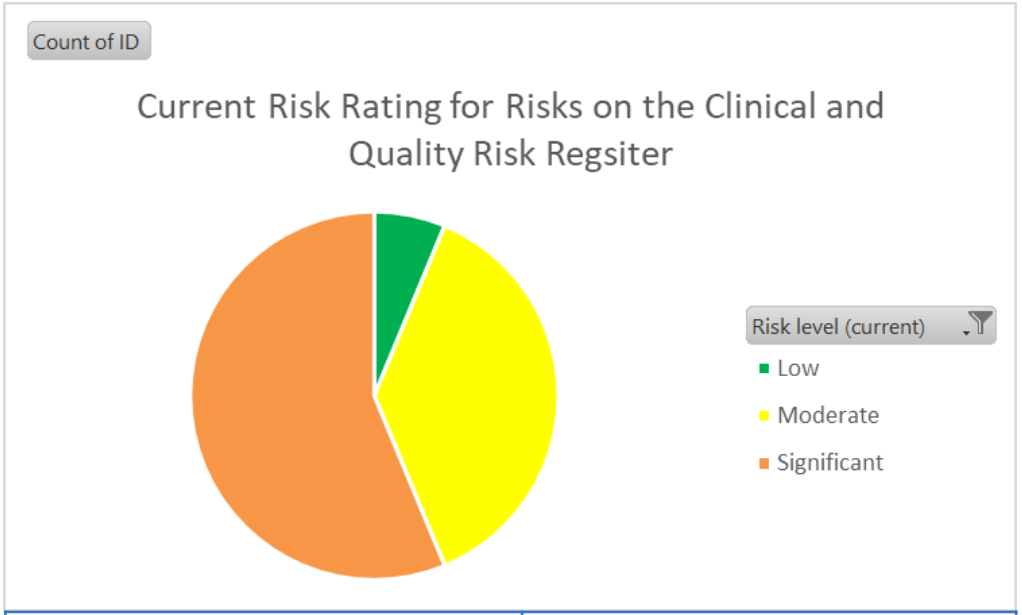
Exec Lead: Dr Trisha Bain & Dr Fenella Wrigley

There are currently 48 overall risks on the clinical and Quality Risk Register, this is all risks from all departments within the Medical and Quality Directorates. Of these 48 risks there are 13 that have a current risk grading of 12 or above. The highest risk (ID 677) Risk of musculo-skeletal injuries to frontline staff which was scored as a 15 has been reviewed and downgraded in the last month at the Health & Safety Committee to a score of 12 as there has been a reduction in the number of incidents with harm.

Below provides a high level overview of all risks on the clinical and quality risk register. The needs to be a review of all these risks and also new teams within the teams needs to ensure that their risks are on the risk register as required.

The new Risk Manager has recently started in the Trust and will be reviewing our current process and will be working with the Quality Intelligence and Risk team to look at where improvements can be made particularly to improve the system and increase training and Risk Management Knowledge.

Clinical and Quality Risks Overview



Risk Level	Count
Low	3
Moderate	18
Significant	27
Total	48

ID: 677 Most Significant Clinical and Quality Risk

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.

Previous Rating: 15 Current Rating: 12 Target Rating: 9

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

Updates since the last review

An audit was completed in regards to the CSR 1:2018 practical training. All Manger Elks now in situ within vehicles - there has been a reduction in the number of incidents related to failure, compatibility and availability. Therefore risk downgraded.

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 manual handling 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.

London Ambulance Service NHS
NHS Trust

Report to:	Trust Board			
Date of meeting:	27 November 2018			
Report Title:	Health and Safety Action Plan			
Agenda item:	Additional report circulated for information and assurance only			
Report Author(s):	Julie Parham, Interim Head of Health and Safety			
Presented by:	Julie Parham, Interim Head of Health and Safety			
History:	Presented to Executive Committee			
Status:	☒	**Assurance**	☐	**Discussion**
	☐	**Decision**	☐	**Information**

Background / Purpose:

The purpose of this report is to highlight key items of discussion from the Corporate Health and Safety Committee meeting held on 25 October 2018, as well as to provide an update on the current status of actions recommended in the Health and Safety Independent Review Report, in order to provide assurance/highlight any issues that might impact the successful implementation of the recommended actions. The report is supported by the following documents:

Appendix 1: Updates on actions 'In Progress and on schedule and behind schedule'
Appendix 2: Health and Safety Scorecard – providing an overview of the Trust's health and safety performance from Q1 & Q2 (2018/19).

Recommendation(s):

The Trust Board is asked to note the reports and issues escalated.

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

Links to Datix risk 677 – relating to the Manual Handling Incidents. Risk Rating: 12

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	☐

Health and Safety Update

Introduction & Background

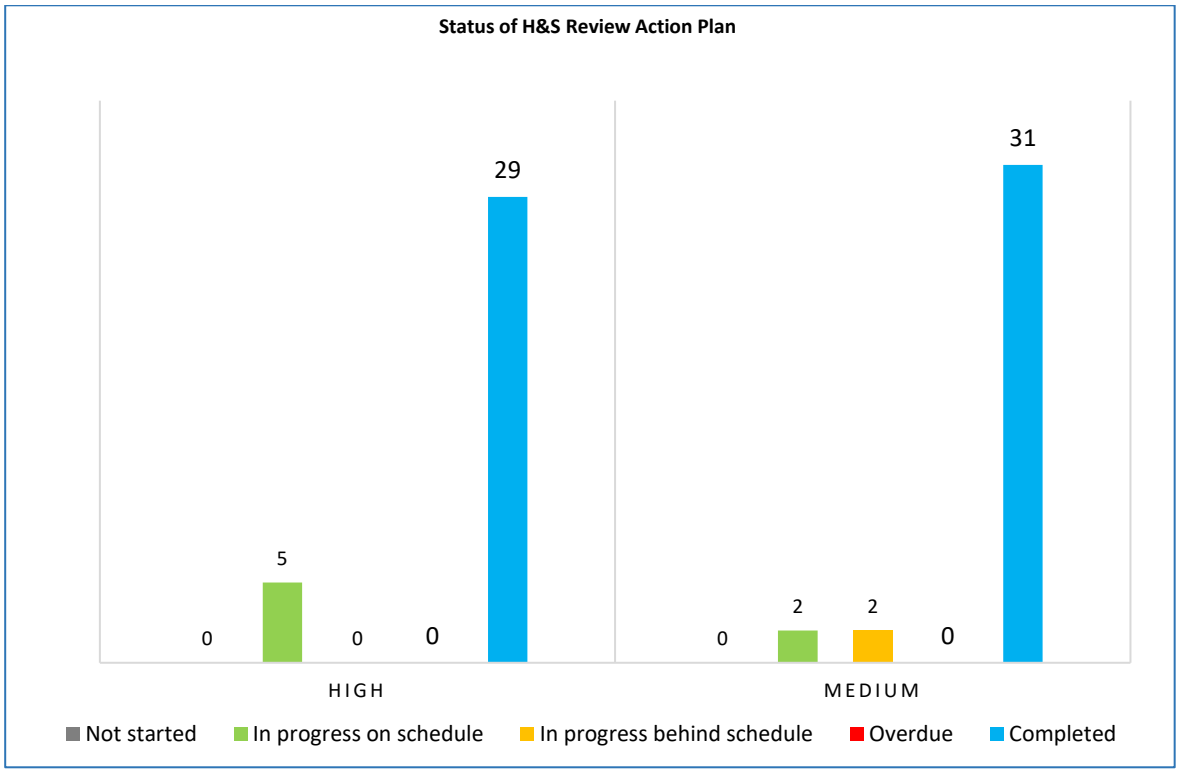
1. Two (2) independent audits were completed in 2017/18 to assess the Trust's arrangements for health and safety. The objective of the audits were to assess the level of the Trust's compliance with health and safety legislation/statutory requirements. The report from the audits identified key areas of risk and areas of improvement, and recommended key actions that need to be completed to improve compliance.

2. This report aims to provide an update on the current status of open actions (yet to be completed) recommended in the Health and Safety audit reports, and to provide assurance/highlight issues that might impact on the successful implementation of the recommended actions.

Highlight of actions recommended

3. A total of 59 actions (categorised as high/medium priority) were recommended following the audit conducted in June 2017. 10 additional actions were recommended following the March 2018 audit and have been added to the action plan. This brings the total number of actions to 69.

4. A total of 60 actions have been completed, 9 actions are in progress and currently underway. A breakdown of the current status of the actions is provided below:



Updates on the H&S Review Action Plan

5. **Closed/Completed Actions:** An overview of the actions that were closed/completed since the September 2018 report is provided below:

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
2.1	Update Health & Safety Policy document in line with good practice and clearly define responsibilities for Directors, HS&S team, Heads of departments and managers.	High	Julie Parham	Trisha Bain	The draft trust-wide Corporate Health and Safety Policy has been written and sent out for consultation. The policy was tabled at the April 2018 Corporate H&S Committee meeting for approval however it was agreed that further discussion was required before the policy can be approved. Policy approval was reviewed at the July Corporate H&S Committee meeting – Chief Quality Officer confirmed that the policy had been reviewed and approved by the committee, subject to the inclusion of the comments by the Head of Legal Services. Comments received from legal services on 05/09/2018 and these have been incorporated forwarded to the PMAG with EQIA for approval and publication.	Jun-17	31-07-2018	Completed
17	HART: Develop and implement appropriate system to assess staff health conditions to ensure that they are able to continue to work safely.	Med	Marc Rainey	Paul Woodrow	The Resilience and Capability Survey being developed for this year's NARU survey will be broken down as follows: 1. Individual - The individual report will allow each member of HART to obtain a basic summary of their results. The reports will also provide any guidance to support continuous enhancements to their health and well-being. 2. Team - The team reports will provide an aggregated view of the team's health on various key factors. It will also highlight any areas where the team needs to focus to help strengthen its approach. 3. Unit - The Unit reports will not only provide an aggregated view of the entire Unit, it will also help managers to compare teams and roles and take targeted action so it can have the most beneficial impact. 4. National - The national report will provide NARU with an aggregated view of the data across all Units. This will allow a greater understanding of mental health issues and satisfaction at work for all staff. Work on an initial psychological assessment has not yet been progressed nationally.	Mar-18	31-12-2018	Completed
16	HART: Ensure SOPS and risk assessments not only reflect changes in NARU standards but also	Med	Marc Rainey	Paul [illegible]	All national SOPs are assessed for compliance against LAS policies before implementation. Risk assessments to be reviewed with Safety and Risk.	Mar-18	31-10-2018	Completed

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
	consider any changes in LAS policies, including format for risk assessments.							
8	Undertake review of bariatric provision across the Trust – with aim of reducing manual handling risks to staff.	High	Richard Harpin	Pauline Cramer	Capability development as well as vehicle and equipment design scoping project for the delivery of the Bariatric Service commenced in August/September 2018 with a view of agreeing vehicle and equipment design to enable the placement of orders during the next financial year. Pioneering services remit and they will be assessing work to look at training and education.	Jun-17	30-09-2018	Completed
15	Confirm from occupational health that there is a process in place for monitoring and addressing any gaps relation to staff immunisation.	High	Nicola Bullen	Patricia Grealish	The staff immunisation programme is ongoing. 4000 staff have been identified as requiring further intervention. Targeted campaigns continue in South East due to measles outbreaks in that area, as well as North West. A full programme has been prepared. However we do have some challenges currently with PAM meeting the demand of this project and an approach has been made to the Medical Director/ PAM to see whether Paramedics could support with this program with the necessary permissions to expedite the completion. We await an update on the number of staff fully immune versus those that still require a nurse intervention. Monitoring of the monthly reports by people and culture committee issues in relation to current contract being escalated to Chief Executive to Chief Ex's discussion.	Mar-18	30-09-2018	Completed
18	HART: Work with Zeal Solutions as well as P&OD Directorate to implement appropriate process to ensure psychological fitness for work and good mental health of staff, from recruitment.	Med	Marc Rainey	Paul Woodrow	Staff on application are not assessed for psychological fitness. This issue has been closed as there are no ongoing discussions around implementation of physical and psychological fitness of staff for work Trust wide..	Mar-18	31-08-2018	Completed

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
3.14	Define and communicate requirements for PPE maintenance and replacement. This should include head protection, fall protection and stab vests.	High	Julie Parham	Trisha Bain	Policy has been agreed at October Corporate H&S Committee with minor changes and these have been incorporated and will be forwarded to the PMAG with EQIA for approval and publication.	Jun-17	31-07-2018	Completed

Updates on Health and Safety Compliance

Manual Handling:

6. Practical Moving and Handling Training was delivered to staff through the CSR 1:2018, a total of 3607 staff has attended the training and the Trust's compliance rate is currently at 90.5%. There has been a noticeable increase in the use of manual handling equipment and reference to this equipment from staff which is positive.

7. The Manual Handling Competency Assessment which has been incorporated into the annual Occupational Workplace Review (OWR) went live in September.

8. A programme of training on how to undertake the manual handling (OWR) assessment and Incident investigation for CTL/M's is being delivered during 2018/2019

9. There has been a reduction in the incidents reported involving Manger Elks, Track Chairs and Tail lifts as a direct result of new equipment being purchased by the Trust along with a more defined maintenance schedule. Monitoring of these incidents will continue for the coming months to ensure consistence.

Management of Health and Safety Risks:

10. The timeframe compliance of reporting RIDDOR incidents (<15 days) to the HSE across the Trust during Q2 was 77%.

11. Trust wide compliance for the completion of fire drills is currently 68%.

12. The Fire Risk Assessment Tender has closed, with an evaluation of the bid received was undertaken. A subsequent meeting with the company is due to take place during the 1st week of November for clarification purposes. During the interim time period the Health & Safety Department has incorporated a review of the fire risk assessment action plans into the Site Specific Risk Assessment programme.

Training:

13. The Trust's health and safety mandatory training compliance rate in September 2018 was 79.75 %

Conclusion

14. Progress is being made to implement the health and safety systems that are required to improve the Trust's compliance with health and safety legislation. The outstanding actions are being monitored on a regular basis to ensure that updates can be provided to ELT and the Corporate Health and Safety Committee.

15. An overview of actions in progress is given in Appendix 1

16. An overview of the Trust's health and safety performance September 2018 is provided in the Health and Safety Scorecard at Appendix 2.

Dr Patricia Bain
Chief Quality Officer

APPENDIX 1 - Updates on actions 'In Progress and on schedule & behind schedule'

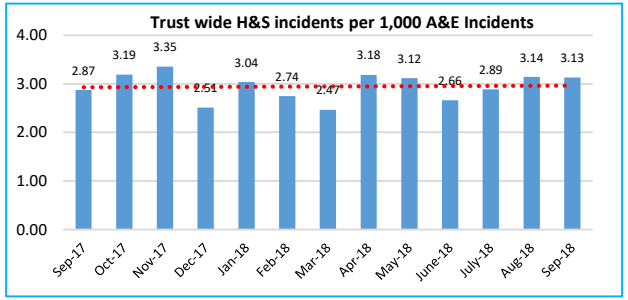
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
1.10	Complete and implement assessments for facilities i.e. site specific risk assessments. This should consider traffic flows and location of equipment such as pressure gauges.	High	Julie Parham	Trisha Bain	Process and templates for completing site specific risk assessments have been developed. The risk assessment template form will be made into LA form and available on the Pulse. The completion date for this action has been extended to Q4 2018/19 to allow the H&S Team undertake the assessment of all sites across the Trust.	Jun-17	31-03-2019	In progress on schedule
1.2	Ensure human factors including fatigue, alcohol, drugs, night-working and stress are considered in the risk assessment process	High	Patricia Grealish	Gill Heuchan	Head of Healthy Workplace is now leading the review of the stress management policy with support from the H&S Team.	Jun-17	30-09-2018	In progress on schedule

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
3.15	Implement monitoring regime to verify effectiveness of training provided to staff.	High	Peter McKenna	Paul Woodrow	A manual handling audit template has been drafted by the Health & Safety department to be used for conducting manual handling competency assessments following the delivery of practical manual handling training to staff. The competency assessment has been incorporated into the OWR process from September 2018. H&SS Team will be providing training to CTLs during 2018/19. Qualitative feedback from staff following training sessions is collected and reviewed by the P&OD Department.	Jun-17	31-10-2018	In progress on schedule
3.3	Ensure systems are implemented to monitor staff competence after training and to ensure that training requirements are achieved and maintained.	High	Peter McKenna	Paul Woodrow	A manual handling audit template has been drafted by the Health & Safety department to be used for conducting manual handling competency assessments following the delivery of practical manual handling training to staff. The competency assessment has been incorporated into the OWR process from September 2018. H&SS Team will be providing training to CTLs during 2018/19. Qualitative feedback from staff following training sessions is collected and reviewed by the P&OD Department.	Jun-17	31-10-2018	In progress on schedule

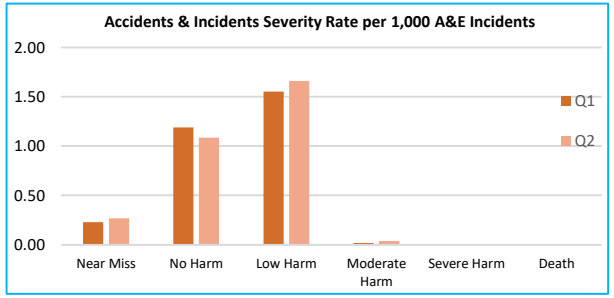
Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
3.6	Develop system for and maintain clear records associated with training in use of equipment	High	Tina Ivanov	Fenella Wrigley	CES have performed initial scoping of student management systems and is continuing to work with IT and Procurement in relation to an identified system that has the potential to be used for recording equipment training. Further scoping has identified the need for corporate support. Meetings with suppliers are ongoing as well as modelling around LAS requirements. Subject to full scoping and appropriate approval, the aim is to procure a system within Q3 of the 2018/19 financial year. In view of the likelihood for a bespoke system and multi-faceted buy-in required, the estimated time scale is now 31st December 2018. The associated risk on the risk register is risk 675 “Management of the student journey”.	Jun-17	31-12-2018	In progress on schedule
3.9	Provide guidance and training to staff on how to effectively use Datix	Med	Helen Woolford	Trisha Bain	The training package has been developed. The PO&D team to be approached for assistance in turning this into an e-learning package. The plan is to launch in Q3 2018/19.	Jun-17	31/12/2018	In progress on schedule
4.8	Ensure that local station managers have access to statutory checks regarding facilities. These are the people who are directing staff to work in the premises and must be assured they are in good condition and are aware of their responsibilities.	Med	Steve Dawson	Benita Mehra	Estates still have further works to do regarding communications and a central repository of information may not be possible at any time in the near future due to the various contractors and the disparate systems they operate. Records management will be considered as part of the department's planned Asset Management system implementation (this financial year).	Jun-17	31/03/2019	In progress on schedule

Ref	Improvement	Priority	Action Lead	Executive Lead	Action Updates	Date Assigned	Estimated Timescale	Action Status
2.8	Define process for managing fire risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Julie Parham	Trisha Bain	The Fire Risk Assessment Tender has closed, with an evaluation of the bid received was undertaken. A subsequent meeting with the company is due to take place during the 1st week of November for clarification purposes. During the interim time period the Health & Safety Department has incorporated a review of the fire risk assessment action plans into the Site Specific Risk Assessment programme.	Jun-17	31-07-2018	In progress behind schedule
2.7	Define process for managing legionella risk assessments that addresses communication, remedial actions and provision of assurance.	Med	Steve Dawson	Benita Mehra	Legionella risk assessments are completed and up to date. The H&S administrator will work with Estates to develop shared drive to hold records that can be accessed by stations. Assurance to be provide through Site Based Risk Assessment checks and quarterly system audits by H&S Team.	Jun-17	31-12-2018	In progress behind schedule

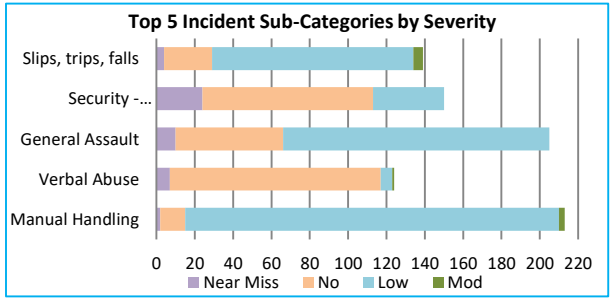
Health & Safety Scorecard – (September 2018)



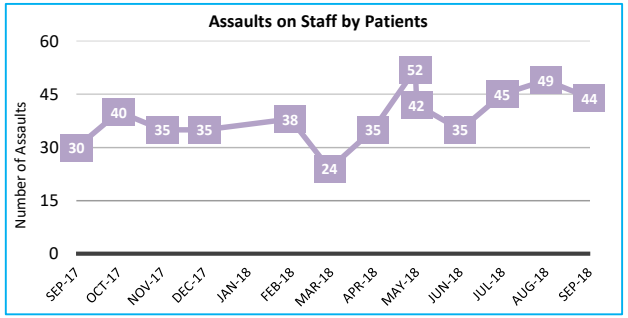
Total of 1678 H&S incidents have been reported across the Trust during 2018/19. 283 H&S incidents were reported in Sept-2018, these incidents account for 40% of all the incidents reported across the Trust in Sep-2018.

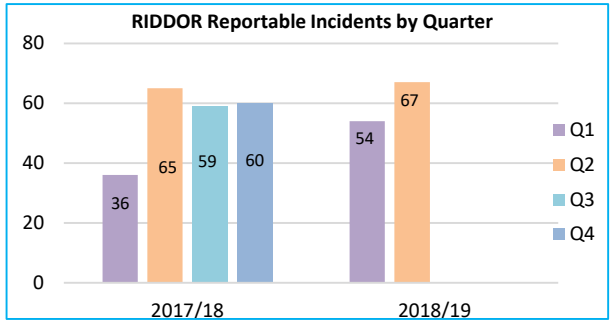


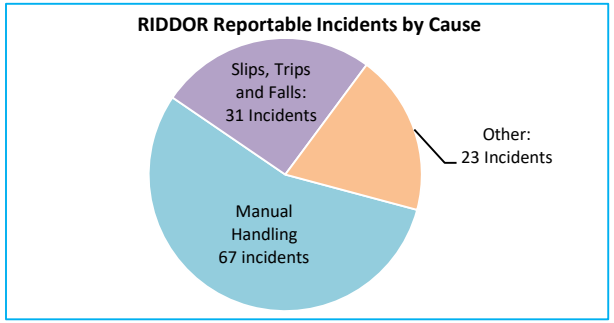
893 (53%) of the H&S related incidents reported during 2018/19 resulted in low harm. 15 (1.0%) incidents resulted in Moderate harm. 770 (46%) of the incidents were reported as 'No Harm/Near misses'.

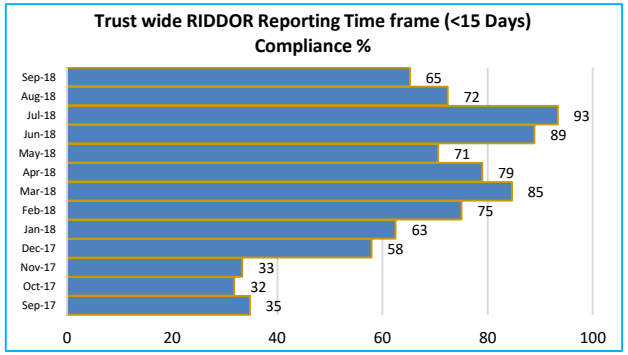


Manual Handling – lifting patients (MH), General Assault and Security (violence, aggression & verbal abuse), incidents account for the highest number of incidents reported during September 2018.

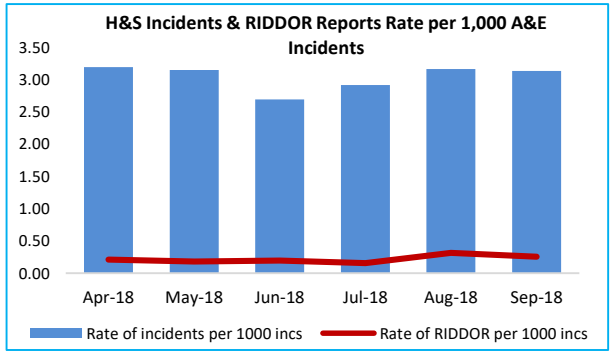




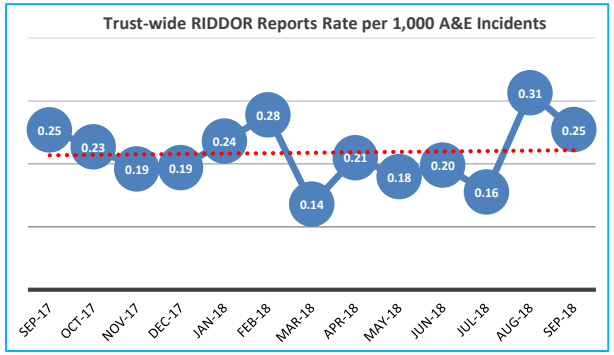




121 RIDDOR incidents were reported to the HSE in 2018/19. 23 RIDDOR incidents were reported in September 2018.
The Trust wide RIDDOR reporting Compliance in September 2018 was **65%.**
8 out of the 23 RIDDOR incidents were reported out of time in Sept-2018**.**

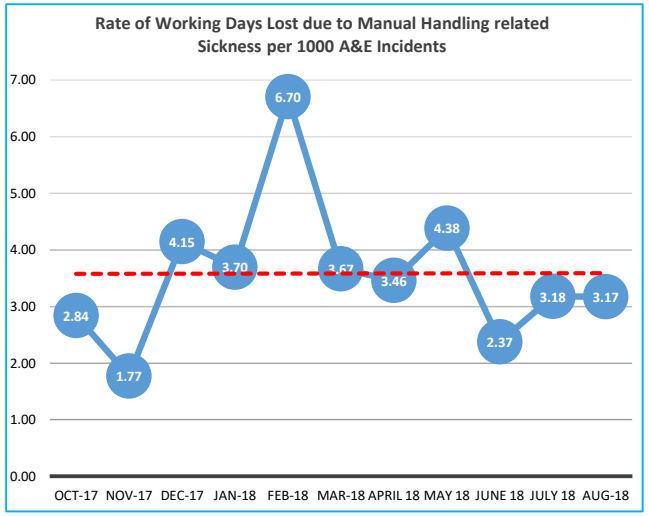


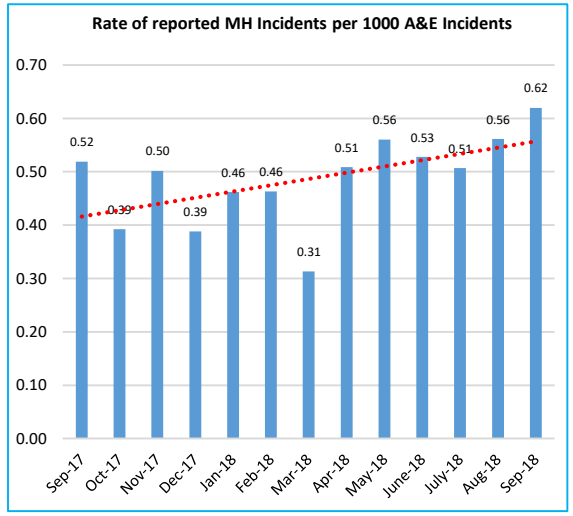
The above table highlights the YTD rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust.
There is no benchmark/comparable data was received from any of the other ambulance Trusts during September 2018.

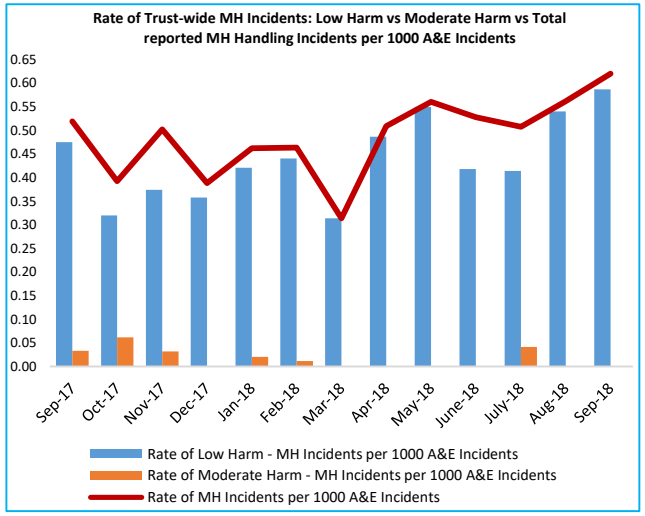


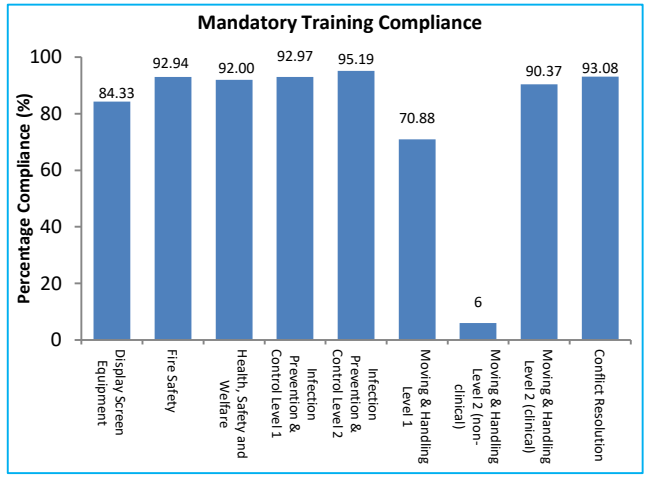
The above table highlights the rate of RIDDOR incidents per 1000 A&E incidents attended by the Trust up to September 2018.

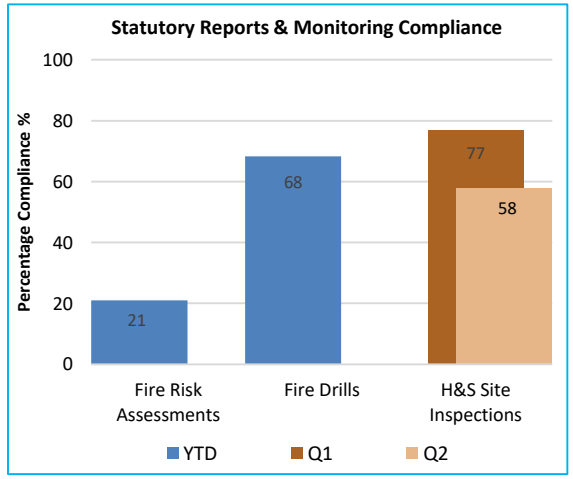
Health & Safety Scorecard – (September 2018)











There has been a increase in reporting of MH incidents since April-2018 when we introduced the Programme of practical training, although overall there has been a reduction in the level of harm with an increase of no harm reports being completed.

There was a slight decrease in the number of assault on staff by patient related incidents in Sep-2018. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

Key Updates:

1.The Practical MH Training was delivered to staff through the CSR 1:2018, a total of 3607 staff attended the training and the Trust's compliance rate is currently at 90.4%. There has been a noticeable increase in the use of manual handling equipment and reference to this equipment from staff which is positive.

2.The Manual Handling Competency Assessment which has been incorporated into the annual Occupational Workplace Review (OWR) went live in September.

3.A programme of training on how to undertake the manual handling (OWR) assessment and accident investigation for CTL/M's will be delivered during Q3-2018.

4.The tender process for the Trust's fire risk assessment contract is due to close on 18th Oct-2018.

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	Aug	Sep		
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	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.