



MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 26 MARCH 2019 AT 10:00-15:00, ROOM G02, GROUND FLOOR, LONDON FIRE BRIGADE HEADQUARTERS, 169 UNION STREET, LONDON SE1 0LL

Agenda: Public session

Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
10.00	1.	TB/18/143 Oral	Welcome and apologies To welcome attendees and note any apologies received.	HL	
10.05	2.	TB/18/144 Oral	Declarations of interest To request and record any notifications of declarations of interest in relation to today's agenda.	All	
	3.	TB/18/145 Attachment	Minutes of the meeting held in public on 29 January 2019 To approve the minutes of the meeting held on 29 January 2019.	HL	Decision
	4.	TB/18/146 Attachment	Matters arising To review the action schedule arising from previous meetings.	HL	Information
10.15	5.	TB/18/147 Attachment	Report from the Chair To receive a report from the Chair.	HL	Information
10.25	6.	TB/18/148 Attachment	Report from Chief Executive To receive a report from the Chief Executive (CEO).	GE	Information
10.35	7.	TB/18/149 Attachment	Collaborative working with SCAS and other ambulance trusts To receive a report on the collaborative work being undertaken with other ambulance trusts	LB	Information
STRATEGY & PLANNING					
10.50	8.	TB/18/150 Attachment	Digital Strategy To approve a Digital Strategy, reflecting the Trust-wide Strategy approved by the Board in April 2018	RF	Decision
11.05	9.	TB/18/151 Attachment	Business Planning 2019/20 i) Draft Business Plan 2019/20	LB	Decision

Timing	Item	Ref.		Owner	Status
			ii) Business Plan NHSI Operational Narrative 2019/20		Assurance Decision Discussion Information
QUALITY, PERFORMANCE AND ASSURANCE					
11.20	10.	TB/18/152	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		Assurance
		Attachment	(i) Logistics and Infrastructure Committee meeting on 05 February 2019	TdP	
		Attachment	(ii) Audit Committee meeting on 11 February 2019	JJ	
		Attachment	(iii) Finance and Investment Committee meeting on 12 March 2019	FC	
		To follow	(iv) People and Culture Committee meeting on 13 March 2019	JM	
		To follow	(v) Quality Assurance Committee meeting on 19 March 2019	MS	
12.05	11.	TB/18/153 Attachment	Integrated Quality & Performance Report To receive the integrated quality & performance report.	LB	Assurance
12.25	12.	TB/18/154 Attachment	Board Assurance Framework and Corporate Risk Register To receive the Board Assurance Framework and the Corporate Risk Register	PH	Assurance
12.40	13.	TB/18/155 Attachment	Serious Incident Management To note declared and closed Serious Incidents.	TB	Assurance
12.55	14.	TB/18/156 Attachment	Approach to Annual Reports & Accounts To approve the proposed outline content of the 2018/19 Annual Report and Accounts.	PH, LB	Decision
13.05	15.	TB/18/157 Attachment	Gender Pay Gap Report To receive information about the difference between the average earnings of men and women across the Trust, expressed relative to men's earnings	PG	Information
GOVERNANCE					
13.20	16.	TB/18/158 Attachment	Report of the Trust Secretary To approve the membership and Terms of Reference of Board Assurance Committees in 2019/20	PH	Decision
13.30	17.	TB/18/159	Trust Board Forward Planner	PH	Information

Timing	Item	Ref.		Owner	Status
					Assurance Decision Discussion Information
		Attachment	To receive the Trust Board forward planner.		
13.35	18.	TB/18/160 Attachment	Staff Story		
13.55	19.	TB/18/161 Oral	Questions from members of the public	HL	Information
14.05	20.	TB/18/162 Oral	Any other business	HL	Information
14.10	21.	TB/18/163 Oral	Review of the meeting To consider: <ul style="list-style-type: none"> - Behaviours at the meeting. - Standard of papers submitted for Board consideration. - Standard of debate / challenge. 	HL	Information
14.30	22.	TB/18/164 Oral	Meeting close The meeting of the Trust Board in public closes.	HL	
	<p>Date of next meeting: The date of the next Trust Board meeting in public is on Thursday 23 May 2019 at a venue to be confirmed.</p>				
<p>Additional reports, circulated for information only:</p> <p>TB/18/165 Quality Report</p>					



TRUST BOARD: Public meeting – Tuesday 29 January 2019

DRAFT Minutes of the public meeting of the Board held on 29 January 2019 at 10.00am in the Burfoot Court Room, Ground Floor, Counting House, Guy's Hospital, Great Maze Pond, London SE1 9RT

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
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
John Jones	JJ	Non-Executive Director
Amit Khutti	AK	Associate Non-Executive Director
Robert McFarland	RM	Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Theo de Pencier	TdP	Non-Executive Director
Paul Woodrow	PW	Director of Operations
Fenella Wrigley	FW	Medical Director
Apologies		
Jessica Cecil	JC	Associate Non-Executive Director
In attendance		
Katy Crichton	KC	Freedom to Speak Up Guardian (for item 14)
Ross Fullerton	RF	Chief Information Officer
Philippa Harding	PH	Director of Corporate Governance
Patricia Grealish	PG	Director of People and Culture
Benita Mehra	BM	Director of Strategic Assets and Property
Rita Phul	RP	Corporate Secretary

1. Welcome and apologies (TB/18/121)

1.1. The Chair welcomed all to the meeting. The Board noted that it would be Bob McFarland's last meeting as a Non-Executive Director at the Trust and the Chair thanked him for his contribution.

2. Declarations of interest (TB/18/122)

2.1. There were no declarations of interest.

3. Minutes of the meeting held in public on 27 November 2018 (TB/18/123)

- 3.1. The minutes of the Trust Board meeting held in public on 27 November 2018 were approved as a true and fair record of that meeting.

4. Matters arising (TB/18/124)

- 4.1. The action log was reviewed by Board members. It was noted that all actions except one had been completed; the Board considered the one open action, ref: TB/18/106 and noted that the UPS upgrade work was on track and meetings were being undertaken during the course of the week. Paul Woodrow (PW) provided an update confirming that the upgrade would commence from Sunday 3 February 2019 and be completed within five working days. Contingency plans were in place in the event of unforeseen issues.

5. Report from the Chair (TB/18/125)

- 5.1. The report from the Chair was noted and taken as read. The Chair offered congratulations to Paul Woodrow, Director of Operations, who had been awarded an OBE in the New Year Honours in recognition of a long and distinguished career of outstanding achievements in patient care. Congratulations were also offered to Pauline Cranmer, Deputy Director of Operations who had received the Queen's Ambulance Medal and Jayne Mee, Non-Executive Director, who had been admitted as a Member of the Order of St John.
- 5.2. Board members received an update on the NHS Long Term Plan and the Chair confirmed that the Trust was broadly aligned to the strategy.
- 5.3. The Chair highlighted a visit to the North East Sector on 11 December 2018 and noted that the issue raised in a Staff Story in November with regard to relief rosters and carrying heavy kits were being addressed. The Board noted new roster patterns were in place and travel arrangements for staff working between 12am-4am were being piloted to allow for staff to be conveyed back to their group station at the end of shifts.
- 5.4. The Board was informed of the restructure within the Operations directorate which would also assist with re-profiling rosters; it was noted that all 18 Location Group Managers and now been appointed and were progressing through the Leadership Programme.
- 5.5. Board members considered the value of being kept informed of restructures within the Trust and it was noted that details of senior appointments should be circulated to the Trust Board on appointment.

6. Report from the Chief Executive (TB/18/126)

- 6.1. Garrett Emmerson (GE) presented his report on progress and key issues, events and activities for the months of December and January.
- 6.2. The error on the National Ambulance Services Balance Scorecard at section 5. was noted, and that C4 90th Centile (03:00:00) for December 2018 (02:52:36) should be green and not red.

- 6.3. The Board observed that the Trust's South East London 111 (SEL) call answering performance in December had seen a slight improvement from the previous month. The Clinical Assessment Service (CAS) had been fully functional since December 2018 and all pathways were now open allowing clinical resolution for a significant number of patents. A reduction in hospital handovers was noted, achieved through joint working with staff and leaders across organisations.
- 6.4. Members of the Board noted that SEL would mobilise into a 24 hour service from 26 February 2019, applying lessons learnt from the mobilisation of the North East London 111/IUC Service (NEL). The Board appreciated that there had been some challenges with staff capacity in NEL and that predicting demand and variations within the integrated urgent care was complex due to the newness of the service.
- 6.5. The Board was advised of the appointment of a new Head of Partnerships who would lead on the Trust's partnerships and engagement function, including the management of Stakeholder Engagement Management. The post would commence from February 2019, aligning sustainability and transformation partnership (STP) strategic movement, establishing strong relationships with stakeholders, and addressing the Trust's capability to progress in parallel with STPs. Board members acknowledged that there would be greater involvement with the Non-Executive Directors and that this would be communicated in future briefings at the Trust Board.
- 6.6. An update was provided to Board members on the flu vaccine uptake and that the programme had been relaunched this week with a clinic at the Trust's headquarters. The Board received assurance that it was anticipated 65% of vaccinations would be achieved, providing the Trust with 75% of CQUIN funding.
- 6.7. The Board noted the report of the Chief Executive.

7. Carter Report – LAS Formal Response (TB/18/127)

- 7.1. Lorraine Bewes (LB) provided background to the Carter Report, which the Trust welcomed. The Board observed that benchmarks for establishing productivity and efficiency within the organisation would be presented to the Trust Board at its meeting in March. The Board's approval was sought regarding the second part of the Carter Report, a formal response from the London Ambulance Service NHS Trust (LAS), which stated that the Trust fully accept the Carter recommendations, and intended to align these with the LAS business planning process.
- 7.2. The Board was made aware that the detailed comparison of costs had been discussed at the Finance and Investment Committee (FIC) and other Board Assurance Committees.
- 7.3. The Board considered the nine recommendations that the Trust would undertake and agreed that evidence should be identified for each recommendation.

ACTION: Lorraine Bewes (LB) to redraft the formal response to incorporate the Trust's evidential actions against the nine recommendations.

RESOLVED:

- 7.4. The Board resolved to pass delegated authority to GE and LB to sign off and submit the formal LAS response to the Carter Report.

8. Health and Safety Strategy Action Plan Refresh (TB/18/128)

- 8.1. Trisha Bain (TB) presented the Health and Safety Action Plan Refresh, explaining that the focus for 2019/20 year would be the Trust staff. The Board's approval was sought to commence with the Health and Safety Strategy as set out in the Plan, to be led by the Trust's newly appointed Health and Safety lead.
- 8.2. It was noted that the 5 year period on 1.3 of the Action Plan should state 2019-2023 and was incorrectly stated within the report.
- 8.3. The Board discussed Health and Safety across the organisation and acknowledged that there was a need to embed a cultural change within LAS. Union representation noted that there had been good work regarding health and safety in the past year and there had been a reduction of sickness and incidents relating to equipment.

RESOLVED:

- 8.4. The Board resolved to approve the Health and Safety Strategy Action Plan Refresh.

9. Trust Board Assurance Committee Reports (TB/18/129)

(i) People and Culture Committee meeting on 10 January 2019 (TB/18/129(i))

- 9.1 Patricia Grealish (PG) presented the report to the Board highlighting the implication of the slowing down of the Health and Care Professions Council (HCPC) registration process. It was noted that the delays in HCPC registration were causing significant on-boarding challenges to the Trust and that the People and Culture Committee had advised that senior intervention was needed. The Board was made aware that Garrett Emerson (GE) would be writing to the Chief Executive of HCPC to progress the issue, which it was understood was a concern for ambulance trusts nationally.
- 9.2 The Board received an update regarding the Rethink training review implementation plan. Members observed that a programme manager was to be confirmed to progress the review and that assurance was being sought to ensure planned outcomes were being funded.
- 9.3 Board members considered the staff survey results, noting the Trust's 65% completion rate and that 34% of responses were significantly better compared to the previous year. Staff satisfaction responses would be received at the end of February.
- 9.4 Key decisions for the Trust were noted by the Board including the Drugs and Alcohol review and the Disclosure and Barring Service (DBS), which would provide a report to Board Assurance Committees in March 2019 to confirm the checking process and

advice on recommendations based on research undertaken to benchmark against other trusts.

- 9.5 The Board considered the risks, noting that BAF Risk 47 relating to staffing levels at Bow and Waterloo Emergency Operation Centre had been mitigated and should be de-escalated from the BAF. The corporate risk relating to the Trust's occupational health provider (PAM) continued to be monitored and PAM had received formal communication from the Trust in relation to their contingency plan. Agency spend had been addressed and there was a clear action plan to ensure the agreed ceiling would not be breached.

(ii) Finance and Investment Committee (TB/18/129(ii))

- 9.6 Fergus Case (FC) addressed the Board and recommended that the achievement of the Trust's control total remain a BAF risk. The Board noted that December incident activity had been reported as the highest on record at the Trust and was being investigated to understand the increase of activity. Members noted that the impact of the over performance had led to £3m of the £4m control total being realised.
- 9.7 The Board was advised of a dispute registered with the Commissioners regarding funding of the Ambulance Response Programme (ARP). The Board was assured that the dispute was necessitated to demonstrate the requirement for additional funding to allow the Trust to achieve ARP. It was noted that further evidence would be submitted to the Commissioners in support of the dispute. The Chair advised that Miles Scott, the Chief Executive at Maidstone and Tunbridge Wells NHS Trust could support the Trust regarding the ARP issue.
- 9.8 The change in personnel amongst the Trust's Commissioners was discussed by the Board and noted that this had exacerbated the issue, but that the Trust continued to plan to reduce its deficit and align its strategy to the Carter principles.

(iii) Quality and Assurance Committee (TB/18/129(iii))

- 9.9 Bob McFarland (BM) provided the Quality Assurance Committee's report to the Board, noting that the successful launch of the 111/Integrated Urgent Care Service in North East London had placed demands and costs on the Trust beyond those predicted and lessons learnt should be applied to future initiatives.
- 9.10 Outstanding issues relating to the operation of WiFi at Deptford and the 3-year DBS recheck were noted. An update was provided by Ross Fullerton (RF) and the Board noted that a new contract with British Telecom (BT) was in place and the Deptford station would be prioritised in upgrades. The date of the BT roll out was to be confirmed and would be communicated to the Chair on 31 January 2019.

ACTION: RF to inform the Chair of the Trust the date of the BT roll out.

- 9.11 Board members discussed Pioneer Mental Health Early services, noting that results of the pilot were positive and well received by rotational staff and patients, and with 80% of the patients treated without conveyance.
- 9.12 The Board noted that the baseline Care Quality Commission (CQC) inspection would be undertaken next week and additional things to acknowledge included the need for the Trust to strengthen its operational procedures.

10. Integrated Quality and Performance Report (TB/18/130)

- 10.1 The Board noted that this was the second time the newly developed Integrated Quality and Performance Report (IPR) had been presented. LB outlined key points with regard to each scorecard; there had been a very strong performance on the patient category and good performance with Return of Spontaneous Circulation (ROSC), and the Trust continued to remain within the top three trusts nationally. Focus was required for the People category in the area of sickness which continued to be above average and more work was required in the Partnership category with regard to call answering and Integrated Urgent Care services.
- 10.2 Board members received assurance on the outcome of the early winter planning and preparations for New Year's Eve. It was noted that there had been a 43% increase in activity in Central London this year and the Conference Room at LAS headquarters had operated as an overspill area. Members acknowledged the excellent trust wide co-operation with the teams, resulting in a successful operation across New Year's Eve.
- 10.3 Recruitment and retention was discussed by the Board and PG confirmed that work was underway with BME recruitment to ensure retention as well as recruitment. PG highlighted that opportunities in the integrated urgent care centres had allowed for an increase in BME and disabled staff because of the different environment. It was noted that the IPR indicated an increase in turnover and the Board needed to be sighted on the reasons for the increase.

ACTION: PG to investigate and report to the Board the reasons behind the increase in turnover as indicated in the IPR.

- 10.4 Board members considered the deliverables and whether a trajectory was required to link the initiatives to delivery outcome. In response to the Board seeking assurance with regard to actions being undertaken, the Board noted that reporting was undertaken through Datix, the Quality Assurance Committee and a recently introduced Serious Incident Assurance group. Actions were signed off by the owners of the action alongside their leads.

ACTION: The Board sought further assurance to ensure actions were being completed and it was confirmed that the Quality Assurance Committee would provide feedback to the Board.

11. Board Assurance Framework and Corporate Risk Register (TB/18/131)

- 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 that BAF risk 47 would be de-escalated from the BAF following the receipt of sufficient evidence to support this. BAF risk 51, pertaining to procurement, would be de-escalated following discussions at the Logistics and Infrastructure Committee in October. However the risks associated with the disruption of EU exit continued and the risk regarding EU exit would therefore remain as a BAF risk. The Board agreed to support the de-escalation of BAF risk 50, following

successful implementation of the UPS upgrade, and that the risk should remain on the Corporate Risk Register for a further two months to provide assurance whilst follow up tests were completed after implementation.

- 11.3. PH advised Board members that the next risk assessment meetings would review horizon scanning and these would be presented to the Trust Board.
- 11.4. Board members observed the Corporate Risk relating to Microsoft Licensing and PH provided assurance that the risk had been inappropriately articulated and that the risk had been financial and not IM&T related. The Microsoft Licensing risk would be re-articulated and the Board noted that negotiations were underway with contractors to address the financial risk.
- 11.5. The Board considered the Risk Appetite Statement and expressed concern that the Financial/VFM was not clear.

ACTION: PH to redraft the Financial/VFM Risk Appetite Statement and circulate to the Trust Board.

- 11.6. The Risk Appetite Statement was approved subject to the redrafting of the Financial/VFM statement and confirmation that this would be presented to the Board on a more frequent cycle.

12. Serious Incident Management (TB/18/132)

- 12.1 Trisha Bain, (TB) provided an overview of the incidents reported and declared to Commissioners. The Board noted that more training was required for staff to address serious incidents and that Quality, Governance and Assurance Managers would take more responsibility to manage serious incidents.

13. Annual EPRR Assurance Assessment (TB/18/133)

- 13.1 The Board received a report providing some background on the Emergency Preparedness, Resilience and Response (EPRR), the process which the NHS England use in order to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event. The Board noted the Trust's submission of its annual self-assessment to NHS England covering 220 standards. The Board was advised that the Trust received formal confirmation on 24 December 2018 of substantial compliance of the EPRR under the 2018 process.
- 13.2 Board members appreciated there had been five amber ratings out of the 220 standards, and that these related to work in 111 services - full integration of services, and robustness for business continuity planning.
- 13.3 The Board observed a further assurance process resulting from a visit from the National Ambulance Resilience Unit (NARU) on 16 November 2018 which had resulted in a positive outcome.
- 13.4 Board members noted that an action plan had been developed and would be agreed with NHS England to address the standards rated as amber as well as the four actions identified as outstanding by NARU. All actions were due to be completed by 31 March

and it was noted that an update would be presented to the Trust Board at its meeting in March.

14. Quarterly Freedom to Speak Up Report (TB/18/134)

- 14.1 Katy Crichton (KC), the Freedom to Speak Up (FTSU) Guardian explained her role to the Board and that she had become a full time FTSU guardian since December 2018, joining only two other ambulance services who also had a full time FTSU Guardian (South East Cambridgeshire Ambulance Service NHS Foundation Trust (SECamb) and South Central Ambulance Service NHS Foundation Trust (SCAS)). The Board noted that the Trust also now had 20 FTSU advocates in place from across the service who had volunteered to undertake the role.
- 14.1 The Board noted the significant figures of FTSU cases, observing an increase from Q2 of 16 cases to 42 cases in Q3. Board members reflected that previously only 40% of LAS staff were aware of the FTSU guardian, and that this had now increased to 89%. The Board was made aware that future Board meetings would receive KPI metrics but that due to the newness of the data, these were not yet available.
- 14.2 KC thanked the Board for their support and GE in turn paid tribute to KC for her commitment alongside the work of the supporting Executive and Non-Executive leads (Philippa Harding and Fergus Cass respectively). The Board considered the significant uptake in issues being raised, allowing the Trust an opportunity to improve the experience of staff. KC informed the Board that staff reporting experiences through the FTSU route were now referring other colleagues, which was an indication of the positive response of how matters had been addressed, without detriment to the instigator of the issue.
- 14.3 The Board discussed the length of time for a FTSU issue to be investigated and closed and PH confirmed it was on a case by case basis.

ACTION: KC's future reporting to provide indication of length of time of open FTSU issues.

15. London Health Care Record Exemplar (TB/18/135)

- 15.1 Lorraine Bewes (LB) provided an outline of the London Health Care Record Exemplar (LHCRE) and the Trust's ambition to become the lead provider and host for the LHCRE. The Board's approval was sought to progress the proposal.
- 15.2 The Board acknowledged the desire to deliver joined up patient health care records across England and noted the national capital funding of up to £7.5m to deliver the concept.
- 15.3 Board members sought assurance that due diligence had been conducted and risks had been mitigated, particularly strategic risks. The Board was assured that the initial outcome would be for the Trust to become a bank, for which due diligence had been conducted. The next phase would be to progress to a wider role, and the due diligence for that element had yet to be undertaken.
- 15.4 Further clarity was sought by the Board in relation to governance arrangements and more understanding with regards to the benefits realisation.

ACTION: LB to redraft the paper to clearly identify that the Trust would host the LHCRE as a bank facility and to conduct further due diligence and seek Board assurance if the Trust intended to pursue further progression with LHCRE.

RESOLVED:

15.5 The Board resolved to delegate authority to the Chair of the Trust and the Chair of the Audit Committee to review the redrafted outline case regarding LHCRE and to approve it.

16. Trust Board Forward Planner (TB/18/136)

16.1 The Board considered the proposed revised dates for Trust Board meetings and a mixed response from Board members was noted in consideration of the impact of other Board assurance meetings as well as prior commitments of non-executive directors outside the Trust.

16.2 Following discussion of the proposed dates the Board agreed that Trust Board dates should remain as they are for 2019 and the new schedule of dates should commence from January 2020. The schedule of meeting dates for 2020 should be circulated to Board members and diarised next week.

Action: PH to circulate the revised schedule of Trust Board meeting dates for 2020 to the Board.

Action: PH to provide A3 hard copies of the forward plan to future Board meetings.

17. Patient Story (TB/18/137)

17.1 The proposed video of the patient story was unable to be viewed due to technical issues at the meeting venue.

17.2 The Board received an oral update of the patient story which related to a sufferer of Ehlers Danlos Syndrom – a rare condition that impacted connective tissue and resulted in extreme pain for the sufferer.

17.3 Board members discussed the importance in such cases, to listening to the patient and responding appropriately according to the wishes of the patient. The Board noted the patient's reluctance to visit a hospital due to the pain suffered and considered this against the nervousness of visiting ambulance crews who were required to administer very high doses of pain killer to assist the patient, who had become resistant to standard doses over the years.

17.4 It was agreed that the patient should be written to and acknowledged that the Board had heard her story. It was also agreed that the patient should receive confirmation of what steps the Trust would undertake in the future to assist with her condition.

Action: PW/FW to advise the best options for the patient.

Action: PH to circulate the video of the patient story to Board members.

18. Questions from members of the public (TB/18/138)

- 18.1 The Chair addressed questions from the public:
- 18.2 LAS Patients' Forum: Complaints Charter. The Chair confirmed that more work would be undertaken to publicise the Charter and it is now linked to the Complaints Letter.
- 18.3 LAS Patients' Forum: Safeguarding Referrals – Controls and Feedback from the London Ambulance Service NHS Trust. The Chair confirmed that the Safeguard Referrals were supported.
- 18.4 LAS Patients' Forum: Effective Partnership and STP. The Chair confirmed that a new member of staff would be joining the Trust in February and would be the lead in progressing the LAS strategy and aligning it with the STP.
- 18.5 LAS Patients' Forum: Have London STPs signed up to the LAS Strategy. The Chair referred to the above response.
- 18.6 LAS Patients' Forum: Modus Operandi new patients. The Chair confirmed that this would be addressed by the Patient Strategy which would be presented to the March Trust Board.

19. Any Other Business (TB/18/139)

- 19.1 There was no other business.

20. Review of the meeting (TB/18/140)

- 20.1 Board members confirmed that there was a good standard of reports and an appropriate challenge and debate exercised by the Board, particularly with regard to the LHCRE proposal.
- 20.2 Board members commented positively on the presentation to the Board of the Health and Safety Strategy Action Plan and providing Board members the opportunity to offer feedback and input.

21. Meeting Close (TB/18/141)

The meeting closed at 14.00. The next Trust Board meeting in public will take place on 26 March 2019 – time and venue to be confirmed.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	STATUS	Comments / updates <i>(i.e. why action is not resolved / completed)</i>
					On track	
					1 month late	
					Over 1 month late	
					CLOSED	
TB/18/106	Additional assurance relating to the UPS upgrade work to be provided to the Logistics and Infrastructure Committee.	Benita Mehra	27/11/18	29/01/18	CLOSED	This was discussed at the LIC meeting on 5 February 2019.
TB/18/127	Lorraine Bewes (LB) to redraft the formal response to incorporate the Trusts evidential actions against the nine recommendations from the Carter Report.	Lorraine Bewes	29/01/18	26/03/19		Update sought
TB/18/129(iii)	RF to inform the Chair of the Trust the date of the BT roll out.	Ross Fullerton	29/01/18	26/03/19		Update sought
TB/18/130	PG to investigate and report to the Board the reasons behind the increase in turnover as indicated in the IPR.	Patricia Grealish	29/01/18	30/07/19	On track	An initial report was presented to the PCC in March
TB/18/130	The Board sought further assurance to ensure actions were being completed and it was confirmed that the Quality Assurance Committee would provide feedback to the Board.	Trisha Bain	29/01/18	26/03/19	CLOSED	The QAC has been provided with further information about the Serious Incident Learning and Action Group
TB/18/131	PH to redraft the Financial/VFM Risk Appetite Statement and circulate to the Trust Board.	Philippa Harding	29/01/18	26/03/19	CLOSED	See risk appetite statement as set out in BAF report
TB/18/134	KC's future reporting to provide indication of length of time of open FTSU issues.	Katy Crichton	29/01/18	23/05/19	On track	To be presented to the Board in May
TB/18/135	LB to redraft the paper to clearly identify that the Trust would host the LHCRE as a bank facility and to conduct further due diligence and seek Board assurance if the Trust intended to pursue further progression with LHCRE.	Lorraine Bewes	29/01/18	26/03/19		Update sought
TB/18/136	PH to circulate the revised schedule of Trust Board meeting dates for 2020 to the Board by w/c 4 February 2019.	Philippa Harding	29/01/18	26/02/19	CLOSED	See report of the Trust Secretary
TB/18/136	PH to provide A3 hard copies of the forward plan to future Board meetings.	Philippa Harding	29/01/18	26/03/19	CLOSED	To be tabled at the meeting.
TB/18/137	Patient Story, Ehlers Danlos Syndrom - PW/FW to advise the best options for the patient.	Paul Woodrow/Fenella Wrigley	29/01/18	26/02/19	CLOSED	Circulated via separate email
TB/18/137	PH to circulate the video of the patient story to Board members.	Philippa Harding	29/01/18	26/02/19	CLOSED	Circulated via separate email



Report to:	Trust Board		
Date of meeting:	26 March 2019		
Report title:	Report of the Chair		
Agenda item:	05		
Report Author(s):	Heather Lawrence, Chair		
Presented by:	Heather Lawrence, Chair		
History:	N/A		
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>
Performance	<input checked="" type="checkbox"/>
Financial	<input checked="" type="checkbox"/>
Workforce	<input checked="" type="checkbox"/>
Governance and Well-led	<input checked="" type="checkbox"/>
Reputation	<input checked="" type="checkbox"/>
Other	<input checked="" type="checkbox"/>
This report supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

Report from the Chair

Non-Executive Director Appointments

1. I am delighted to formally welcome two new Non-Executive Directors to the Board:
Dr Mark Spenser, a GP by background, brings strong credentials working across London on a variety of initiatives. His past work in clinical leadership and at a strategic level for NHS England will support him in his role with us. In 2018 Mark was appointed to the role of Vice Chair of the London Clinical Senate.

Professor Karim Brohi, a Trauma surgeon and clinical academic who brings a track record of London wide leadership around major trauma. Currently working as the Clinical Director, Pre Hospital Care at Bart's Health NHS Trust and Director, London Major Trauma System at NHS England.

Women's Breakfast

2. On the 31 January 2019 I attended the Women's Breakfast event hosted by the Equalities team. The event was well attended by both uniform and non-uniform staff from across the trust. It is planned that this will become a regular bi monthly event and the next meeting will be hosted by NHS Confederation. The attitudes of some of our male staff means that women in the service are unlikely to seek promotion and the experiences they shared are sadly reflected in the staff survey.

Mayor of London Sadiq Khan

3. On the 14 March 2019, together with the Chief Executive I attended a meeting with the Mayor at City Hall. The following items were on the agenda for discussion:
 - Appointment of the London Ambulance Service NHS Trust Chair
 - 999/111/Integrated Urgent Care
 - Vehicle/Fleet Renewal Progress
 - NHS 10 Year Plan
 - Stakeholder Engagement
 - Brexit Preparedness
4. The meeting was very positive with the Mayor expressing gratitude for the service our staff offer to Londoners. He commented that the LAS is now recognised as an engaged organisation by stakeholders.

Ambulance Leadership Forum 2019

5. The annual forum hosted by the Association of Ambulance Chief Executives took place on the 19th and 20th March 2019 and was attended by both members of our executive and staff.
6. I am pleased to advise that Lena Shennan a Clinical Education Tutor received the award for outstanding service as a Mentor or Tutor/Educator within the ambulance service at the Gala Dinner and I am sure the Board will join me in offering our warm congratulations for this achievement.

Lena Samuels Chair South Central Ambulance Service NHS Trust (SCAS)

7. I met with Lena Samuels the Chair of SCAS to discuss her new role as Chair of AACE Chairman's group and the joint work that the Chief Executive Officer's and their executive teams are undertaking. We agreed that our respective Executive Teams now need to develop programmes of work with tangible benefits as set out in the Carter report.

NHS Improvement and NHS England

8. In December 2018 NHS England announced a new joint senior leadership team — the NHS Executive Group.
9. As part of [closer working arrangements between the two organisations](#), a new combined management group with NHS England, chaired by the two chief executives. Under the new structure, the seven integrated regional teams will play a major leadership role in the geographies they manage, making decisions on how best to assure and support performance in their region, as well as supporting local system transformation. The Regional Director role, appointed by the NHS Commissioning Board Authority, are currently accountable to both CEOs.
10. The corporate teams will provide specialist support and expertise to the regional teams, as well as taking a national lead on their areas.
11. The NHS Executive Group held its first meeting in January 2019, with the new national and regional directors expected to formally lead their integrated directorates by April 2019.
12. Subsequent to this there have been two further developments:
 - The announcement of a single CEO between NHSE and NHSI, Simon Stevens and a new CCO role to be appointed to.
 - A consultation on legislative change to formally merge NHSI and NHSE. We will be briefed further at our April meeting.

Deloitte Dinner

13. Together with Theo de Pencier I attended a Deloitte sponsored dinner at which Baroness Harding was the guest speaker. Her focus was on the newly announced change in leadership as set out above and her focus on the workforce and culture. As part of the consultation on this Patricia Grealish will share the Trust response with the People and Culture Committee. Baroness Harding also spoke of the Kark review which is looking at the governance of boards and part of this will be a newly formed group who will examine the accreditation for boards and managers alike.

South West London STP/ICS

14. I attended a Provider Chair and Lay Members Workshop on 11 March at which the following areas were covered:
 - Exploring the governance arrangement and considered where Non-Executive board members should fit in.
 - We received a presentation from Matthew Kershaw who is now CEO at Croydon Health Services and until recently a Fellow at the Kings Fund. He shared with us his research into how ICS' are being developed across the country and two key findings which are:

- None have progressed to a legal entity preferring a system collaborative approach
 - There is an increasing role for Health Partnership Boards in each locality
- The Chairman of Croydon Health, Mike Bell shared an understanding of our statutory organisations. Key to this is agreeing common definitions:
- Integrated Care Systems Sub Region – in population > 1m such as South West London
 - Integrated Care Partnership – Place eg: borough – population c 250 – 500k
 - Care Neighbourhood – recognisable locally – population c 50k

15. This is extremely important to the LAS as the STP CEO seemed to be of the view that Place is where the LAS will be commissioned. This has significant implications for our strategy and as a consequence I have asked that we spend time on this at our next board briefing meeting with external speakers including Cheryl Coppell, Lay Chair of the STP and whom I am meeting on the 2nd April.

Visit to New Malden and Wimbledon Ambulance Stations

16. I was hosted by Paul Cook ADO and met with the Locality Group Manager Rochelle McIntyre and Team Leader Jack Wakelin who were both alert to the issues that need addressing particularly the staff survey and conveyance rates. We visited St George's Hospital and met with ambulance crews. I have asked Andrew Matthews, Paramedic be invited to attend the Board for us to hear how he is using Coordinate my Care (CMC) enabling him and his partner to reduce their conveyance rates. He has made a staff video to share the benefits of CMC. The visit was enjoyable and impressive to see staff leading changes that are necessary to make us more efficient, provide appropriate care to patients and in engaging with the front line.

Heather Lawrence OBE Chairman



Report to:	Trust Board			
Date of meeting:	26 March 2019			
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:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
<p>The Chief Executive's report gives an overview of progress and key events within the Service since the last time the Board convened.</p> <p>The report is structured in sections, covering key areas of focus of the Trust and Board.</p>				
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	<input checked="" type="checkbox"/>			
Performance	<input checked="" type="checkbox"/>			
Financial	<input checked="" type="checkbox"/>			
Workforce	<input checked="" type="checkbox"/>			
Governance and Well-led	<input checked="" type="checkbox"/>			
Reputation	<input checked="" type="checkbox"/>			
Other	<input checked="" type="checkbox"/>			
This paper supports the achievement of the following Business Plan Work streams:				
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>			
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>			
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>			
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>			

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. As can be seen from the table below, the Trust continued to achieve the national key standard for Category 1 life-threatening calls during the months of January and February for both the mean and 90th centile performance, with the year to date cumulative performance remaining within the 7 and 15 minute targets. The Trust continued to experience increased levels of demand during the months of January and February with face to face incidents increasing by 3.3% in January, and 5.1% in February, when compared to the same period last year. Against the predicted monthly contract value, face to face incidents in January finished 4.2% (an increase of 4,067 more incidents) and 3.7% (an increase of 3,246) in February above the predicted forecast. The proportion of face to face Category 1 incidents continues to surpass NHS England's 8% baseline with the proportion increasing to 12.4% in January and 12.7% in February.
3. The increase in demand has impacted on the delivery of meeting the national standard measures for Category 2 and Category 3 incidents in January and February, whilst achieving the Category 4 90th centile measure in January but failing to attain this in February. The Category 2 mean year to date performance remains outside the 18 minute target by 1 minute 22 seconds while the 90th centile remains within the 40 minute target by 16 seconds.
4. Despite these additional challenges, the Trust reached its Category 1 life-threatening patients faster than the previous January (the mean performance by 46 seconds and the 90th centile by 1 minute and 16 seconds). The Trust did, however, fall short of achieving the Category 2 mean target in January (21 mins 36 seconds) and in February (22 mins 21 seconds) and for the Category 2 90th centile in January (46 mins 9 seconds) and February (46 mins 58 seconds). The Trust was also above its Category 3 90th centiles in January and February and the Category 4 90th centile in February. The Trust did, however, see a significant improvement in the Category 4 90th centile performance decreasing from 3 hours 32 minutes last January to 2 hours 51 minutes this January, an improvement of approximately 40 minutes. For the month of February, the Trust performed better across all categories when compared to the previous February with the exception of Category 3 90th centile performance. At the time of preparing this report, all national performance standards for March are being met.
5. In terms of call handling, in January, 88% of calls were answered within 5 seconds and with a mean call answering of 6 seconds. For the month of February, calls answered within 5 seconds or less decreased to 82.4%, with the mean recorded at 11 seconds. The year to date call answering position is 86.3% with a mean of 8 seconds.
6. When benchmarked across 13 key metrics included in the National Ambulance Services Balanced Scorecard, we continue to be one of the highest performing Ambulance Services (the Trust is ranked third nationally in the latest national scorecard). The Trust is frequently best in class for the Category 1 mean and 90th centile measures.

	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
January 2019	00:06:20	00:10:30	00:21:36	00:46:09	02:41:50	02:51:25
February 2019	00:06:36	00:10:59	00:22:21	00:46:58	02:53:15	03:24:43
Year to Date (2018/19)	00:06:29	00:10:47	00:19:22	00:39:44	02:11:03	03:05:45

7. As part of the business planning process for 2019/20, senior operational leads are currently developing the project initiation documents (PIDs) for a variety of operational efficiencies which will help to support and improve 999 performance in the coming months. These efficiencies include, but are not limited to, improving attendance, reducing out of service, improving pre and post- handover times and reducing conveyance to emergency departments.
8. As the Board are aware, the Trust committed to undertake a pan-London roster review as soon as possible after the Ambulance Response Programme (ARP) was implemented in November 2017. The aim of the review was to better meet the organisation's resourcing requirements and enhance the working lives of our staff through improved rosters. As part of the roster review, 16 operational groups were established and four working party events were held between July and December 2018 when the new rosters were agreed. The new LAS rosters will go live over a five week period which starts on 25 February and concludes at the end of March. A project group is working in parallel with the roster review to develop new processes and policies for our staff who are not on core rosters and are known as relief staff. The intention of this work is to improve the work/life balance of these staff members while ensuring that we meet the requirements of our patients in the post-ARP period.

111 Operations

9. As can be seen from the table below, South East London 111 (SEL) call answering performance in February remained almost the same as the previous month returning 76.20% within the SLA of 60 seconds. This remains below the national target of 95%. SEL was the best performing service in London for calls answered in 60 seconds which had a London average of 70.04%. The number of calls abandoned by patients in the month of February was recorded at 3.2%, well below the national target of 5% and was the best performing service in London for call abandonment. SEL referrals to 999 remained within the 10% national standard returning 8.93% for the month. This compares to the London average of 9.9%.
10. The mobilisation of the SEL Integrated Urgent Care (IUC) took place on 26 February. The Trust received praise from SEL commissioners and NHS England for the smooth mobilisation of the IUC and work is now focused on consolidating the operation of two IUCs.
11. North East London 111 (NEL) call answering performance returned 65.3% in February while calls abandoned after more than 30 seconds returned 6.10%. An executive-led improvement programme is currently underway to improve these performance standards as quickly as possible.

12. The NEL clinical assessment service (CAS) has been fully functional since 18 December. Since implementation there has been a positive impact on those patients calling 111 who have had an advanced clinical assessment made and their care completed without onward referral which significantly improves the quality of care provided over a standard 111 service and releasing pressure on the wider healthcare system. The Trust continues to work to identify which patients benefit most from being managed via the CAS.
13. NEL referrals to 999 were 7.11% in February, a decrease from 7.85% on the previous month. NEL was again the top performing provider in London in respect of this national standard, further indicating the benefits of a CAS. NEL was also the top performing London provider in terms of the percentage of calls referred to emergency departments.
14. I continue to hold weekly meetings with the 111 SEL and NEL teams to review the operational delivery and mobilisation of the full IUC services. Also telephone conferences have continued with the commissioners to provide oversight of the delivery of 111 services as well as providing assurance of our resilience.

Location	Month	Total Calls Offered (Inc Balanced calls)	SLA calls in 60s (Target 95%)	Abandonment rate	Calls to Ambulance
SEL	Jan-19	38471	76.3%	2.9%	9.43%
	Feb-19	35884	76.2%	3.2%	8.93%
NEL	Jan-19	55271	69.3%	5.0%	7.85%
	Feb-19	50123	65.3%	6.1%	7.11%

Finance & Performance

15. As reported elsewhere on the agenda the Trust is £0.7m ahead of plan at the end of January. Income to the end of January was £4.9m higher than planned. Incident activity, which increased during Q2 due to the prolonged hot weather throughout July and August remained high in Q3. Call levels remain high. Pay expenditure was £6.5m lower than plan to the end of January due to frontline vacancies partially offset by private ambulance (PAS) and agency usage. The executive team continues to focus on recruitment and retention to reduce reliance on overtime and PAS whilst maintaining safe and effective rosters. The Trust has delivered savings of £9.9m to the end of January and work continues across the organisation to ensure the full £12.3m is delivered in 2018/19. The Trust forecast is to exceed its £1.6m control total deficit by £1.9m ensuring access to additional £4.0m Provider Sustainability Funding (PSF) from NHS Improvement.
16. Following the successful testing, implementation and deployment of the logic for in call upgrades, re-categorisation and duplicate calls the Business Intelligence (BI) team is now working with Trust commissioners to backdate and develop a newly agreed Minimum Data Set (MDS). The team met with their counterparts to discuss the

structure and content of the new MDS, incorporating and agreeing any additional criteria, which will be available from May 2019.

17. The BI team have also been working closely with the Association of Ambulance Chief Executives (AACE) to provide the data required for the Signal from Noise (SfN) national benchmarking tool. The team recently carried out a deep dive to understand the growth in Category 1 face-to-face incidents, as the LAS is a known outlier nationally. The findings evidence that the main driver for the growth in C1 proportion is an increase in “breathing problems” across the capital; further investigation is ongoing.
18. The Performance Directorate have recently made offers to two successful applicants: - one for the Senior Business Intelligence Analyst (secondment post) and the other for a Data Scientist. To continue supporting our recruitment drive within the Directorate, an advert has also gone out for a Senior Data Scientist. Efforts are ongoing across Business Intelligence, Forecasting & Planning, and Data Quality Assurance to fill all outstanding vacancies.
19. In order to understand where there may be efficiencies in sharing knowledge and collaboration between Trusts, the LAS Forecasting & Planning team are leading the national ambulance service predictive analytics network. The group, including representatives from 8 of the UK Trusts, met for a second time in February to share best practice methodologies and discuss ways to overcome common challenges. The teams from LAS and SCAS held a separate workshop to delve deeper into the modelling approaches conducted at both Trusts. This allows successful techniques and analytical findings to be shared, improving efficiency, increasing the accuracy of predictions, and reducing duplication of efforts across the sector.
20. The LAS and King’s College London’s Centre for Urban Science & Progress (CUSP) held a four-day collaborative “data dive” from 18th - 21st March 2019. This event saw students from New York, Warwick and London come together to delve into LAS data, generating insight, uncovering new relationships, and developing predictive models. At the end of the event, the students presented their findings to the Trust, and following a successful funding application, a researcher from KCL will help the LAS implement any useful modelling or analytics into their business as usual processes to enable continued utilisation of the students’ efforts.

IM&T

21. All service levels were achieved in January and February for the processing of patient records, requests for access to call recordings and marking addresses with care plans. Final reductions in agency staffing were achieved with all regular staff data processing now on permanent or fixed term employment contracts.
22. All IT services were resilient throughout the operationally busy months of January and February, however an external power failure at the EOC training facility at Southwark Bridge Road required significant technical works to remediate and minimise impact on busy EOC training schedules.
23. The IM&T Essentials capital plan has been tracking behind trajectory over the last 4 months. Delivery plans are in place to complete the majority of planned works this financial year. For example, upgraded WiFi has been commissioned at Deptford Stores and WiFi site surveys are planned to complete at all sites in March; visitor WiFi access is now more reliable at all sites and network security has been improved.
24. A substantial milestone was the go-live of South-East London 111 integrated urgent care. The implementation of new infrastructure, clinical systems and workflow with

providers across South-East London were successful. Telephony continues to be delivered on the legacy CISCO system and will migrate to a new Avaya system once call handlers have all been trained.

25. A large focus for the IM&T Directorate was preparing for and support the technology, telephony and infrastructure works required to deliver the Bow electrical maintenance project. The project was technically complex – many teams required relocation to new sites, additional resilience was designed and introduced to mitigate the risks of reliance on Waterloo for up to 5 days and the controlled shut down and startup of all systems hosted in Bow. This included the creation of a new remote business continuity location with 999 telephony and voice recording, IT systems and Airwave radio setup.
26. In advance of the electrical maintenance work IM&T completed 2 enabling projects that replaced the connection of our systems to the Internet. These changes future-proof our connectivity to other services and introduce greater protection to cyber-attack. Following introduction of the new cyber controls some user services faced temporary minor disruption due to new firewalls blocking unauthorised traffic. This is a positive improvement and demonstrates that only authorised traffic is permitted between LAS systems and the Internet.
27. Testing completed successfully of the new 999 telephony system which will replace the existing system which is unsupported after June 2019. EOC training of the new phones is underway with anticipated go-live of the new system in April 2019. The new system brings flexibility to the operations of the 999 control rooms, ensures we have access to support from our supplier and brings our 111 and 999 systems onto the same shared telephony capability.
28. Finally, the Aadastra clinical system used in 111 was deployed into the 999 Clinical Hub. Our configuration of Aadastra provides clinicians with access to detailed patient records, access to direct booking into various local services such as out of hours GP clinics and includes the ability to generate an electronic prescription and send it directly to a pharmacy. Once fully embedded this system will help to improve Hear and Treat rates in 999 and improve the performance of both 111 and 999 services by allowing us to manage resources more effectively across 999 and 111. This is a key enabler of the Trust's vision for integrated clinical assessment and triage (iCAT London) as set out in the Trust strategy.

Strategy & Communications

29. We continue the process of refreshing all of our 'enabling strategies' and writing new ones for areas of our organisation where they do not currently exist. At today's meeting, Trust Board is considering the Digital strategy which has been developed in conjunction with staff, stakeholders, service users and patient representative groups.
30. On 7th February, we held a Mental Health 'Whose Shoes' service development workshop. This workshop, following on from the highly successful Maternity Whose Shoes workshop we held in May 2018, was structured to focus on how service users experience our mental health service and where improvements could be made. The workshop was energetic and provided a number of ideas which are being taken forward as part of our mental health service improvement work. There was a great deal of interest generated in the workshop with a number of mental health professionals getting in touch over social media looking to learn from the work that we are doing.
31. We were pleased to receive 100% of the Q3 STP engagement CQUIN award, which is reflective of the close and positive working relationships that we have with our STP partners in each of our five sectors. This CQUIN has been agreed locally by our ADOs

and their STP colleagues and identify key priorities that they are working together to deliver. Some of the common themes are:

- Increasing usage of non-Emergency Department pathways
- Working together to reduce lengthy hospital handovers
- Providing additional data and intelligence to help STPs make informed decisions about their services
- Working with STPs and our local teams on demand management initiatives

32. The Collaborative Contact and Response (CCR) Project is ongoing and the programme continues with data collation, workshops and mapping exercises. The LAS have actively contributed to this by assisting with data collation, arranging and facilitating workshops with both senior managers and frontline staff in conjunction with the MPS CCR Team. The target date for the completion of the High Level Design (HLD) and strategic outline business case was 25th February. Thereafter, it will be shared across all three emergency services with a robust communications plan in place to ensure all relevant stakeholders are informed of progress.

33. Several work streams are ongoing under the people banner of collaboration these include the following areas:

- Cadets and apprenticeships
- OHD provision
- Well-being and staff welfare
- Recruitment and shared learning
- Recruitment of BAME and females
- Potential use of LFB assessment centre in Hammersmith

34. A joint LAS & LFB branded vehicle has been provided by the LFB for use by our interoperability paramedic embedded within the LFB. This will allow the officer to respond, facilitate training and feedback to colleagues at the LFB.

35. The trust engaged in a number of media communications during the early part of the year which included:

- “Saving hundreds of people’s lives every day” in the Emergency Service Times focussing on the different control room roles
- BBC’s Inside Out programme with Central and North West London NHS Trust featuring the Camden Rapid Response Admission Avoidance Service
- Teach the Beat campaign launched to the media at the Greenwich Leisure Ltd venue at Olympic Park featuring our Training Officers visiting organisations to provide volunteers training in lifesaving skills. Chris Hartley- Sharpe, Head of First Responders was interviewed live on LBC Radio
- We invited 10-year-old Rihanna Malcolm-Moore to visit Waterloo HQ after she made an exceptional 999 call when her mum collapsed at home. I presented her with a certificate and she met the EMD who answered her call. The story was covered by the Evening Standard.
- The Evening Standard also covered a story on our Brexit preparations, following a paper and discussions at the last Trust Board meeting. The Standard covered the release of a CQC report into an inspection of the Service in November. This related to an incident involving a staff member who responded to 999 calls without having completed his training.

36. We have continued to send out our weekly winter stakeholder bulletin which is read by over 500 stakeholders in the NHS. We also produced a monthly stakeholder newsletter which was distributed to over 300 external stakeholders and saw an engagement rate of 38 per cent. We have been working with stakeholder engagement managers across the Service to produce a quarterly newsletter for the 1,000 GPs across London.
37. We attended a Transport for London roundtable discussion event around the impact the introduction of 20mph speed limits and speed bumps will have on the delivery of our service.
38. It was pleasing to see that over 150 nominations were received involving some 500 members of our staff for our annual VIP awards taking place in May. Our panels are now busy reviewing the submissions and preparations continue in advance of the awards night. The evening is always a great way to celebrate the hard work and commitment of colleagues right across the Service and I am very pleased that so many people continue to engage with it.
39. I continue to regularly deliver my CEO video updates to keep everyone informed about news and activities across the Service and, in February 2019, I held a clinically focused Facebook Live session along with our Medical Director. The session received some good feedback and I intend to continue to hold further sessions, along with other members of our executive team. The next one planned is with our Chief Information Officer to address any IM&T matters arising with our staff.

Quality Improvement

40. Following the 'Whose Shoes' event, as reported within the communications section, commissioners in North East sector have contacted the Mental Health (MH) nurse and Chief Quality Officer (CQO) to support the commissioning of an additional 3 mental health nurses to pilot the approach in this sector. A meeting is being arranged to finalise the arrangements, this will also work in conjunction with the pilot that we are hoping to take forward in the South Sector with the support of the Mental Health trusts in that area.
41. In addition the Capgemini project is concluding and together with the MPS we are looking to develop a single mental health hub to support system wide signposting of patients in mental health crisis to the most appropriate care. Again the arrangements have yet to be finalised.
42. An assessment against the current quality plans has been undertaken to identify our CQC status against all quality domains. The work identified that the organisation is currently maintaining its position as good overall with evidence of systems and processes being embedded. Following agreement of the business plans and the quality priorities, refreshed 'Toward Outstanding' plans will be developed for corporate and sector teams. The plans will be implemented from April onwards with the aim of reaching an outstanding rating at the 2020 CQC inspection.
43. Recruitment to the Safeguarding team is now underway to take forward the Level 3 training programme for front line staff. Following agreement with national ambulance executives, the trust will work with other ambulance services to share our approach and support the delivery of a standardised programme. In addition to their safeguarding training roles the teams will also increase the number of audits undertaken related to safeguarding. One of the team will take responsibility for ensuring the training in relation to the Mental Capacity Act is taken forward to meet national guidelines the outcome of which will benefit patients who may not have the capacity to make the right decisions about their care.

44. A second cohort of staff have now completed the Quality Service Improvement and Redesign (QSIR) training course. A total of 55 staff have been trained, the directorate will now integrate those trained into sector quality teams to take forward the newly created quality plans. In addition the teams will support the delivery of projects and programmes across the organisation aligned to the quality priorities.
45. A number of mystery shopper activities have taken place across every station to assess current security measures. The outcome of the visits are currently being collated into a report and will be presented to the Quality Assurance Committee to provide assurance in relation to the actions taken. In my role as Chief Executive Officer I intend to launch the 'OK to Challenge' campaign to strengthen security across the Trust.
46. The new Head of Health and Safety attended the Board health and safety training on February 26th. Delivery of the implementation plan from the newly approved strategy will be his main objective alongside a 'Focus on Musculo-skeletal injuries' campaign to reduce incidents and sickness levels due to manual handling injuries.
47. The contract for the Fire Risk assessments has now been signed and a rolling programme of assessments agreed. All areas will have a completed assessment by the end of 2019, the health and safety team will be trained via this external team and take forward the assessments in 2020.
48. The Quality directorate held an away day during January, the outcome of the day was an agreement to develop a culture charter based on our vision and values. All members of the team will sign to show their commitment to the charter. This will be shared with other directorates.
49. The Chief Quality Officer (CQO) has been invited to be the ambulance service safeguarding representative on the National Safeguarding Steering Group. The inaugural meeting will take place within the next 2 months. The steering group will focus on providing train toolkits and the development of services to align with the 10 year plan.
50. The CQO has been asked to speak at the National Quality Conference in June in relation to systems and processes to support quality improvement and regulatory standards.
51. The CQO is meeting/communicating regularly with South Central Ambulance Service Director of Nursing to share best practice between respective teams. Areas of good practice that we are sharing include our QSIR training and QI approach, our Safeguarding Level 3 approach to meeting national recommendations, our risk management activities and pioneering services programme.
52. The Portfolio Management Board are now working with the finance teams to ensure that the agreed programmes within the business plans are resourced, monitored and reported to ensure successful delivery. A demand management process has been agreed and all project requests within the Trust are being assessed to agree those that will be taken forward in 2019-20. This will bring value for money by ensuring that the programmes will be delivered and the productivity and efficiencies savings realised.

Medical Directorate

53. The Medical Directorate continues to widen the profile of LAS, by presenting at the National Ambulance Leadership Forum data demonstrating incremental benefits of the UC APP programme, and further expanding our clinical network with a representative at the Health Innovation Network 'Managing Deterioration' events. We continue to be

represented in the Australian recruitment drive by the CES, who have successfully recruited into 201 posts

54. There is a further expansion of the Medical Directorate with recruitment for a managerial position in the APP UC programme being successful, and further approval for additional Urgent Care APP posts being approved. IPC are continuing to recruit into administrative posts and CES are advertising an Associate Tutor and further Driving Instructor roles
55. In recognition of the expansion of the Medical Directorate team size we have commenced a Directorate wide leadership and development programme which will look at communication in and between teams and into the wider organisation.
56. The February issue of 'Clinical Update' has been printed and disseminated to EOC and operations. The issue focused on pre-hospital tracheostomy and laryngectomy emergencies, the correct use of Adrenaline and Hydrocortisone, public use of defibrillators as well as relevant case studies and articles
57. There is significant focus on increasing capacity across the Clinical Education and Standards (CES) team in preparation for 2019/20 training plan. This is to accommodate the expected numbers for 19/20.
58. The Deputy Director of CES has been working closely with colleagues from IM&T and finance to close the two internal audit actions – removal of boxes of student records in with Data Protection Act currently stored in training centres – and purchasing a student management system to transition to electronic records.
59. The Head of Clinical Audit and Research has undertaken a review in line with the CQC inclusion of clinical research since September 2018.
60. Future CQC inspections will review clinical research under KLOE W8 and present it to the Quality Oversight Group. We are on target for completing the Infection Prevention 'All Station' audits with the last two stations being audited in Quarter 4. Further to this, for the Infection Prevention A&E Observational audits, the last 8 A&Es are either booked or completed for Quarter 4. Both audit deadlines are due at the year-end 31st March 2019.
61. Hand Hygiene wipes have been introduced on front line vehicles to enable staff to clean their hands in the absence of soap and water, ensuring that we are in line with Trust Policies on Infection Prevention. This coincides with a rise in our monthly compliance for Hand Hygiene, which has seen a 5.9% rise over the 90% target.
62. The Falls pioneer service paramedic training has been completed, which included one day alongside Non-Emergency Transport Service (NETS) partners. The service is expected to go live as planned on the 11/03/19.
63. We are in the final stages of our electronic patient care records (ePCR) procurement, and 3 providers have been shortlisted. We are on track for completion of the ePCR full business case by the end of March, which will be developed in conjunction with Channel 3 (consultants).
64. The Summary Care Record application (SCRa) which would enable staff to access patient details on scene - has significantly progressed. We are working towards a trial for April, involving around 80 members of staff. There is continued work around the registration authority (smartcard) structure and process to support this.
65. The iPad asset management process has been worked on as part of the connecting clinicians programme. The purpose is to ensure all clinical staff have access to an

iPad. We currently have 75 new starters who are without iPads, and this is being addressed currently.

66. The original ambition was that staff joining the organisation would receive the iPads from leaving members of staff. The original project had to be rushed to meet the CQUIN and some of the BAU processes were not yet robustly implemented.
67. Consequently there was a delay in new staff obtaining an iPad due to broken iPads are delayed being fixed, stolen iPads being replaced, leaving members of staff failing to return iPads to Union Street in a timely manner and non-clinical staff being allocated iPads out of the clinical stock, all causing a deficit.
68. To resolve this issue in the short-term the purchase of 80 iPads is going through. The team will also review the data to determine how many leavers and new starters are affected by this, and how many iPads are broken or stolen. An 'asset management' software has already been purchased, and once uploaded with this data will help reduced the numbers of missing iPads. As a continuation plan, the team are also reviewing the 'end to end' process of distribution of the iPads, to ensure more robust measure are put in place.

People and Culture

69. Our business case for the 19/20 ESR programme has been finalised and funded within the business plan. This covers a 12 month period for quarter 4 18/19 to quarter 1 19/20. The programme will include streamlining and automating information flows between a number of Trust systems (e.g. GRS and ESR); record and track agency staff and staff assets and introduce an employee relations system which will transform the way in which employee relations cases are recorded and reported.
70. In addition the programme will deliver four key elements covering Manager Self Service, Employee Relations Case Management, Recruitment e-Form, and online appraisal.
71. Control of spending within the directorates Agency Cap has been a major focus of work with colleagues across the organisation in conjunction with our Finance team. Significant focus has continued in ensuring corporate functions control agency costs within their respective ceilings; in addition we have been working with the 111 teams to ensure managed services have been implemented; competitive rates are established for GPs and a clear recruitment plan is built to meet the needs of the service.
72. The final push on flu vaccination to the end of February 2019, has resulted in a 67.95% uptake in the vaccine, compared to 56.9% in 17/18. This has been the result of significant effort across the organisation and with support from other NHS organisations to supply vaccine when our stocks dried up.

Trust Total

	Staff	Uptake	Declined	Offered
Clinical	4208	2662 (63.26%)	648 (15.40%)	3310 (78.66%)
Non-Clinical	1309	658 (50.27%)	167 (12.76%)	825 (63.03%)
Total	5517	3320 (60.18%)	815 (14.77%)	4135 (74.95%)

CQUIN Totals

	Staff	Uptake	Declined	Offered
Operational staff	3735	2503 (67.01%)	422 (11.30%)	2925 (78.31%)
EOC staff	536	399 (74.44%)	93 (17.35%)	492 (91.79%)
Total	4271	2902 (67.95%)	515 (12.06%)	3417 (80.00%)

These numbers only include staff that are included in CQUIN totals, not all Ops / EOC staff.

73. The Drug and Alcohol Task and Finish group has now been established. We will be working in partnership with colleagues and Trade Unions across the Trust to develop an updated policy that addresses the current climate of recreational drugs and protects and informs both employees and the Trust. The policy will aim to be preventative, informative and supportive as well as hold those to account who abuse substances – either drugs or alcohol.
74. At the end of February 2019, we completed our recruitment campaign in Australia having sent two teams to recruit graduate paramedics. Our successful campaign has led to building renewed ties to universities in Sydney and Melbourne and will focus our attention on supporting their applications through the UK HCPC registration process which can be lengthy. I have engaged directly with the HCPC Chief Executive, Marc Seal, to ensure he is aware of the need to deliver a smooth registration process for incoming international paramedics in support of the profession in the UK. We have appointed an International Support Officer who will work with operations to help international paramedics settle into their roles in the UK.
75. We have completed a review of our on-boarding processes with a presentation by the team on 1 March 2019. The review covered the candidate journey from attraction through, assessment, selection, training and assignment into operations with key findings highlighting opportunities to improve our processes and collaboration to enhance the candidate journey. Following this presentation, we are putting together a plan to deliver on quick wins as well as setting out longer term objectives that will require us to consider different ways of working and different employment models.
76. The final phase of our DBS rechecking programmes has started with the final 1800 checks to be completed by September 2019. We have had an encouraging response to-date with over 300 online applications completed within the first two weeks. An options paper for future iterative checks has been prepared and will be presented to the March People and Culture Committee.
77. The Reverse Mentoring programme, a programme to support employee engagement, cultural evolution and, continuous improvement has extended leadership and executive committee members being mentored by colleagues from across the service. The programme completed its integration event on 27 February and plans are underway for a 'closing' event on 11 June to celebrate the successes and achievements of the programme. This innovative programme, facilitated by The Performance Coach, is rare in NHS organisations and has been extremely positively received by participants. We have recently received confirmation of funding from Health Education England for a second cohort and will plan this into activities for 19/20.
78. The third cohort of Visible Leaders will commence on 11 March and will include our newly appointed Sector Clinical Leads and Incident Delivery Manager.
79. Our first women's breakfast took place on 31 January 2019 and was well attended by both corporate and operational colleagues. The discussions, joined by our Chair

Heather Lawrence, were wide ranging across topical gender issues and will inform the shape of the programme across the remainder of the year. The group will meet every other month and the next meetings is planned for 28 March 2019 and will be hosted by NHS Confederation at their offices in Victoria.

80. The Workforce Race Equality Standard Action Plan is now well underway and the Trust has achieved its target of 15% BME representation in the overall workforce by 31 March 2019. Monitoring of progress is through the quarterly WRES Action Plan group which I chair. We were represented on Friday 8 March for International Women's Day at a march in central London for Emergency Services.
81. The Workforce Disability Equality Standard (WDES) has now been launched by NHS England and sets ten specific measures that will enable the Trust to compare the experiences of our disabled non-disabled employees. The first WDES data will be submitted in August 2019 to NHS England and the Trust will develop an action plan based on analysis of the data in a similar way to that of the WRES Action Plan which has been co-produced.
82. The People & Culture team are engaging with our trade unions, managers and staff to refresh the existing Managing Attendance Policy.
83. We are working hard to re-set the emphasis of our policy and guidance to focus on fitness and wellbeing with the importance of our managers' role in supporting their teams in their overall wellbeing central to this. This will support our approach to encouraging our staff to be proactive about their own wellbeing and ensuring that immediate line managers manage sickness absence on a day to day basis to avoid escalation and remove any punitive language.
84. Our People and Culture Business Partners continue to support a significant programme of restructure and change in Corporate Services directorates. As well as existing programmes in EOC, Finance & Performance, Operations and Fleet; it is anticipated that Business Partner support will shortly be required in other teams within Strategic Assets & Property, and Quality & Governance.
85. In support of our positive culture work we are engaged in discussions with NHSi and senior academic, Duncan Lewis, on the implementation of our organisation-wide Cultural Review. It is intended that the Review supplement our methods to understand how the Trust acts on concerns associated with dignity at work, freedom to speak up and employee grievances.
86. We are now well underway with our project to introduce our Employee Relations casework tracker which is planned to launch on 1 May. This tracker will be established on our existing framework with Selenity which hosts our expenses system.
87. Work is progressing with our Trade Union colleagues to review and update our Partnership Agreement. This Agreement sets the framework for positive engagement and partnership working with our recognised trade unions within the Trust, currently Unison and GMB.
88. As part of the recommendations from our recruitment audit focused on 111/IUC we will be running refresher training on the Transfer of Undertakings Regulations (TUPE) supported by our legal advisers, Beachcroft. This training will be targeted at our people and culture teams and managers within our commercial and IUC teams.

Assets & Property

89. The Uninterruptable Power Supply project at Bow was successfully delivered for the first week of February, as planned. A third party decant facility was put together and

manned by the operations team in the event there was a power compromise at HQ. Once the work was completed the reintroduction of systems that had not been powered down were reinstated. Within the project, time had been allowed for the reintroduction of these systems to allow for any unplanned failures. The planned return to Bow was on plan and the operational teams encountered minimal disruption. A significant number of people from operations including business resilience, IMT and their multiple technical leads, Fleet and Property, led the project to a successful conclusion.

90. The Fleet team have been reviewing working practices in line with the modernisation of the fleet profile and work has started with a standard stores layout and stock holding, this approach has been rolled out at Fulham with the balance of workshops due to be undertaken and concluded by June. Upgrades to the Civica Tranman software have also been procured to introduce and ensure greater functionality and better control of our stock usage, alongside this the Civica Tranman fixed asset software will now support stock purchasing and stock management.
91. Phase 2 Waterloo headquarters is on programme and is due to complete by April 2019, designs for the first and second floor are now being developed to follow on from the completion of the third floor refurbishment and will bring the People & Culture teams into one location. Currently the Finance team are decluttering their existing space as they will be moving to Union Street following the completion of the third floor and this move will only take place after year end accounts have been submitted.
92. The LSU building works have been concluded in preparation of the roll out of the bags programme. Communication and implementation plans have now been agreed with operations and logistics for the roll out of the ALS bags which will commence from the end of March, and conclude in September, this soft roll out has been derived to ensure there is little or no impact to business as usual.

Garrett Emmerson
Chief Executive Officer



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Collaborative working with SCAS and other ambulance trusts			
Agenda item:	07			
Report Author(s):	Graeme Dunn, Knox Financial Ltd Lorraine Bewes, Director of Finance and Performance Charles Porter, South Central Ambulance Service NHS Foundation Trust			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Previously presented to Executive Committee meeting on 13/03/19 (ref: ExCo/18/370)			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
This paper sets out the collaboration work completed thus far between the London Ambulance Service NHS Trust (LAS) and South Central Ambulance Service NHS Foundation Trust (SCAS), potential collaboration opportunity areas, and next steps to be undertaken to begin to realise those opportunities.				
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	<input type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>

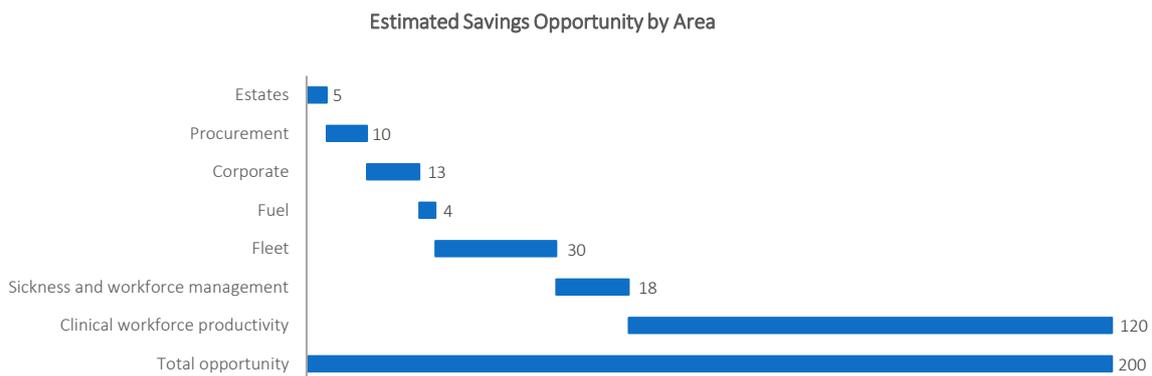
Other	<input type="checkbox"/>
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input type="checkbox"/>
Partners are supported to deliver change in London	<input type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>



LAS and SCAS Collaboration Update

Strategic Context

1. The recent Lord Carter review into Operational Productivity and Performance in English NHS Ambulance Trusts suggests “trusts should focus on moving to a common infrastructure and operating model supported by new ways of working such as the alliance formed in the North”.
2. The Carter Review indicated that if all 10 English Ambulance Trusts implemented the practices of the best, the scope for greater productivity is around £200 million by 2021 which would be driven across the areas outlined in the graph below.



3. Although there are differences in terms of geography, volume of calls and financial turnover, both Trusts are similar in terms of the services they provide and therefore opportunities to collaborate are thought to be identifiable and have the scope to be adapted and applied to both services.

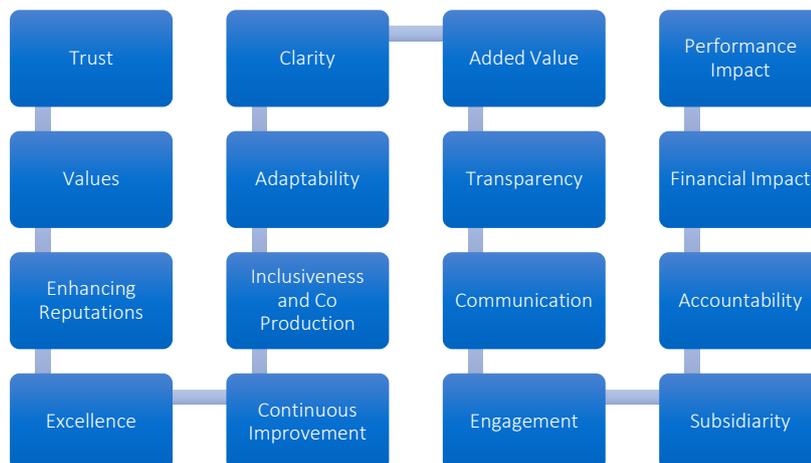
Progress Update

4. The London Ambulance Service NHS Trust (LAS) and South Central Ambulance Service NHS Foundation Trust (SCAS) have formed an alliance in order to identify and assess opportunities to improve services, expand capacity, achieve efficiencies, increase value for money and lead the digitisation of healthcare provision in the urgent and emergency care service area.
5. The alliance has been formed in response to recent outputs from the Lord Carter Report into Operational Ambulance Productivity and Performance, and the NHSI Corporate Benchmarking exercise.

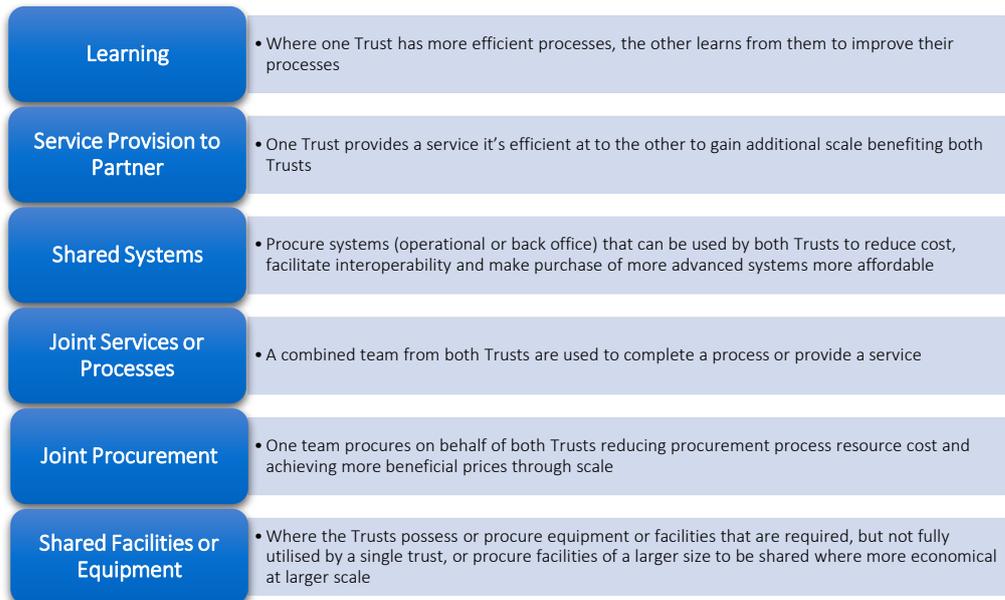
6. The Trusts have begun conducting collaboration efforts by holding two joint executive team meetings where overviews of the two Trusts' positions have been discussed and challenges faced identified, thus allowing Trust Directors to identify areas where collaboration will likely yield benefits.
7. These meetings have also allowed the development of Joint Collaboration Principles to guide collaboration which are outlined below.

Collaboration Principles and Approaches

8. SCAS and LAS have agreed to formally work together and collaborate over an undefined period, in part as a response to the outcomes of the Lord Carter review into productivity in the ambulance service.
9. The Boards and Senior Management Teams of the two organisations will share expertise and best practice, and collaborate with a view to identifying opportunities that will reduce costs, accelerate operational/clinical/financial improvements and performance, and maintain/improve the quality of services being provided to patients across the SCAS and LAS footprints.
10. The principles outlined to guide the collaboration include trust, inclusiveness, transparency, excellence and continuous improvement amongst others.



11. Collaboration benefits are expected to be achieved through a number of generic approaches as noted below.



12. Any collaboration opportunity areas identified will be considered by the Executive Teams (and Boards where appropriate) of the respective organisations in terms of their implementation or otherwise, noting that each statutory Board has responsibility for taking decisions impacting on their organisation and patients.

Work in Progress

13. Several financial and operational data gathering exercises have been conducted recently (including those by NHS Improvement) and the input to and output from these exercises along with other information gathered from respective management teams has been used to perform a broad analysis exercise. This exercise has compared costs, structures, systems and performance between the Trusts in order to identify a significant number of potential areas where collaboration may result in improvements being realised.
14. Many teams across the two Trusts have also engaged on a direct level following the joint board meetings. Guided by their Directors, Senior Teams have engaged with their counterparts in a number of areas to commence identifying differences in structures, costs, systems, processes and approaches.
15. This level of engagement will allow identification of areas where each Trust can learn from the other to improve performance, and continuation of these close professional links in future is expected to yield significant benefits for both Trusts.
16. Detailed collaboration work is commencing in IM&T, Human Resources and Forecasting & Planning, along with the day to day collaboration that is becoming more common in other areas such as Fleet, Logistics, Medical and Quality.

Collaboration Opportunities

17. Collaboration efforts are expected to be focused on functions and services where changes can be made that will have the greatest impact on the efficiency of the largest area of both Trusts – Frontline Operations. Changes in these areas may be small, but their impact overall is likely to be more significant. Potential collaboration areas which may have moderate to high impacts on efficiency are noted in the table below along with high level assessments of timescales involved.

18. In order to validate the initial assessments, further in-depth analysis and due diligence exercises will be needed to confirm the viability of these opportunities, timescales and likely financial and efficiency benefits.

2019-20 or Longer Term	Area	Potential Collaboration Opportunity	Type of Collaboration	Potential for Financial or Efficiency Benefits	Likely Lead Time	Potential Time Scale for Delivery
2019-20	111	111 Forecasting and Data Reporting	Joint Procurement / Shared Systems / Shared Expertise and Resources	Low - Medium	3-6 Months	6-12 Months
2019-20	Digital	Electronic Patient Care Record System	Learning / Shared Processes	Medium - High	6-12 Months	1 year Plus
2019-20	Frontline Operations	Forecasting and Planning (Anaplan)	Learning / Joint Procurement / Shared Expertise	Low - Medium	3-6 Months	6-12 Months
2019-20	EOC	EOC Resources and Processes	Learning / Shared Resources / Shared Expertise	Low – Medium	3-6 Months	6-12 Months
2019-20	Human Resources and Payroll	Occupational Health	Joint Services / Joint Procurement	Low - Medium	Under 3 months	3-6 Months
2019-20	Human Resources and Payroll	Joint Recruitment and Assessment Programmes	Joint Processes	Low - Medium	3-6 Months	6-12 Months
2019-20	Human Resources and Payroll	Improved Health at Work	Shared Resources and Programmes	Medium - High	6-12 Months	1 Year Plus
2019-20	Legal	Legal Processes and Advisory Services	Learning / Shared Resources or Processes / Joint Procurement	Low - Medium	3-6 Months	6-12 Months
2019-20	Procurement	Procurement Processes	Learning / Shared Resources / Joint Procurement	Medium - High	6-12 Months	1 Year Plus
Longer Term	111 / Digital	111 Telephony and Software	Shared Systems / Joint Procurement / Shared Expertise or Resources	Low - Medium	1 Year Plus	1 Year Plus
Longer Term	Clinical Education	Joint Paramedic Apprenticeship Programmes	Joint Services	Low - Medium	1 Year Plus	1 Year Plus
Longer Term	Clinical Education	Frontline Training Mix	Learning	Medium	1 Year Plus	1 Year Plus
Longer Term	Digital	Dispatch Systems	Learning / Shared Expertise / Joint Procurement	Medium - High	1 year Plus	1 year Plus
Longer Term	Digital	Telephony Systems	Learning	Medium	1 Year Plus	1 Year Plus
Longer Term	Fleet	Fleet Procurement	Joint Procurement	Medium	6-12 Months	1 Year Plus

Longer Term	Fleet	Fleet Managed Service	Learning / Service Provision to Partner	Medium - High	1 Year Plus	1 Year Plus
Longer Term	Frontline Operations	Operational Model Alignment	Learning	Very High	1 Year Plus	1 Year Plus
Longer Term	EOC	Operational Model Alignment	Learning	Medium	6-12 Months	1 Year Plus
Longer Term	EOC	Triage System Alignment	Learning / Joint Procurement / Shared Systems	Low – Medium	1 Year Plus	1 Year Plus
Longer Term	Logistics	Vehicle Preparation/Make Ready	Joint Services or Processes / Joint Procurement / Shared Facilities	Medium	6-12 Months	1 Year Plus
Longer Term	Property	Maintenance Approach	Learning / Joint Services / Joint Procurement	Low - Medium	1 Year Plus	1 Year Plus
Longer Term	Property	Licensed Standby Points	Learning	Medium	1 Year Plus	1 Year Plus

Key Conclusions

19. The LAS and SCAS are similar in terms of their operational structure, both providing 999 and 111/Integrated Urgent Care (IUC) services and have a willingness to collaborate where possible in order to improve operational productivity and increase value generated from services provided.
20. The collaboration work completed to date has shown a number of areas where collaboration can be beneficial, and a high level of engagement and enthusiasm amongst Trust Managers.
21. Given its potential to add value, improve services and improve efficiency, the Trusts intend to continue their collaboration work to ensure these benefits are realised.

Next Steps

22. In order to continue to progress collaboration efforts with a view to realising benefits, the Trusts intend to:
 - Agree to continue scoping potential areas for collaboration efforts;
 - Refresh benchmarking and comparison information to confirm validity of potential collaboration opportunities;
 - Agree focus areas for a joint 2019-20 efficiency programme; and
 - Develop and agree a longer term joint efficiency programme for potential collaboration items with a longer time horizon.



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Digital Strategy			
Agenda item:	08			
Report Author(s):	Vic Wynn, Head of IM&T Strategy Security and Architecture			
Presented by:	Ross Fullerton, Chief Information Officer			
History:	IM&T SMT and ExCo			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>	Information

Background / Purpose:

The London Ambulance Service NHS Trust Digital Strategy has been developed as a key enabler of the Trust Strategy. Whilst the document has some roots in the IM&T Strategy published in September 2017, the draft strategy submitted to the Board in November 2018 (ref: PTB/18/25) was a significant revision and took into account a number of new and emerging factors. Since this submission there has been some fresh thinking, particularly in light of the Carter Review and the initial work to understand variances between ambulance trusts. This is particularly evident in the consideration of the model of the Trust's computer aided dispatch (CAD) and digital office capabilities. This updated document is the final issue of the Trust's Digital, Data and Technology Strategy to the Trust Board, and takes into account Trust Board feedback from the first submission and this new information. We seek approval for adoption and implementation of the strategy.

Recommendation(s):

The Strategy is approved for adoption and implementation.

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

Links to BAF Risk 45 - A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

Please indicate which Board Assurance Framework (BAF) risk it relates to:

Clinical and Quality	<input type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>

Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

The London Ambulance Service NHS Trust

Digital Strategy

A digital, data and technology strategy
to enable a world class Ambulance Service
for a world class city.

Update February 2019

CIO's foreword



London is one of the world's leading digital cities. Londoners are tech savvy, using contactless payments millions of times a day to travel, eat and shop. Penetration of smart phones is amongst the highest in the world, mobile data coverage is ubiquitous and London's tech sector is one of the most advanced.

In 2018 the Mayor launched his vision to make London the smartest city in the world and the new NHS long term plan rightly identifies technology as a key enabler of improving the quality of care we provide as well as the efficiency in doing so.

At the heart of everyday life in London is the NHS and The London Ambulance Service is one of its most visible components. The London Ambulance Service is one of the largest and busiest ambulance services in the world, serving a growing population of 8.6m people in one of the most socially and culturally diverse cities on earth. Londoners rightly expect the best possible healthcare and we are at the frontline of urgent and emergency care provision all day, every day.

The public expects healthcare professionals have access to their health records, to capture what we do digitally and to share that information with their GP and other relevant healthcare providers. They expect us to be harnessing the best innovations that push forward the quality of care. They expect the best care, appropriate for their individual needs, as quickly as possible, no matter how they contact us. And they expect our services to be resilient and secure in the face of increased threat of cyber-attack.

We deliver care in a complex range of settings that provide unique challenges to digital transformation – from the vibrancy and energy of Notting Hill Carnival to the depths of London Underground with everything else in between, spread out across the 620 square miles of London. We receive nearly 2 million 999 calls each year – that is 15% of all 999 calls in England - as well as nearly 1 million calls to the two NHS111 services we operate in East London.

Our vision is to be a world-class ambulance service for a world-class city. As the only NHS provider Trust that operates across London, we are uniquely positioned to play a leading role in the digital transformation of urgent and emergency care across the capital. Yet the state of our digital services and basic IT, like much of the NHS, is far behind where it needs to be.

This strategy sets out how we will use digital services to:

- get the basics right to run a world class organisation
- improve the quality of care we provide
- address the patient's needs at the earliest possible point of contact
- treat more patients on the phone and online, avoiding unnecessary ambulance dispatch
- treat more patients on-scene, avoiding unnecessary conveyance to A&E
- improve the utilisation and performance of our assets.

This strategy is rightly ambitious. The pace of change and investment in technology across healthcare is accelerating at a tremendous rate. We will proudly harness that change and play our role to deliver improvements in urgent and emergency care across London.

Ross Fullerton, Chief Information Officer

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1 Executive Summary

1.1 Digital transformation of a world class ambulance service

The LAS Five Year Strategy details how we will improve the way we provide care to the people who live, work and travel in London, with a vision of being a world-class ambulance service for a world-class city. The strategy identifies that to achieve this we need to be at the forefront of using technology and digital innovation. We not only want to use available technology, but want to lead the way in developing, piloting and utilising new technology.

Digital transformation and technological improvements are integral to each of the Trust's three strategic themes:

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

Our 999 and 111 contact centre staff will meet the needs of more patients at point of first contact. We will achieve this by providing our clinicians with access to patient records, expand the ability to book patients into appropriate care settings and send prescriptions directly to a local pharmacy. We will use our unique geographic footprint and system-wide data to optimise access to urgent and emergency care

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

Our ambulance crews will convey fewer patients to emergency departments and provide better quality care at home. We will achieve this by providing our clinicians with access to patient records, video triage support and digitising our patient care records

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

We will improve the efficiency, coordination and management of London's urgent and emergency care provision. We will achieve this by connecting the unique pan-London data that we manage with data from across the healthcare system to inform strategic planning decisions as well as day-to-day decisions for specific patients

Whilst our focus is on transformation based upon the Trust's strategic themes, we also need to get the basics right. We need to be efficient, effective and agile in our corporate environment to deliver the transformation needed across the organisation. This need stimulates the inclusion of a fourth complimentary theme.

4. Sustainable and Effective Corporate Functions

We will improve our core technical infrastructure, modernising our corporate systems, developing our exploitation of data, and innovating to improve our information flows and working practices and transform the internal running of our organisation.

1.2 The LAS's digital challenge

When compared to other Ambulance and NHS Trusts, digital maturity across the LAS is low and legacy technical complexity is high.

We rely on manual or paper-based processes to manage a variety of processes from patient records to staff training and development. We don't routinely have access to patient data that is available in other NHS care settings and we don't use data to efficiently plan the maintenance of our fleet. The systems we do have in place are rarely connected in a way that delivers reliable intelligence to inform better decision making.

Whilst there is a continuous programme to maintain and update systems, this has been done in the main with a traditional in-house refresh or renewal approach. As a result the Trust continues to directly manage a number of outdated legacy systems designed to suit the needs of the past. The combined web of systems is overly complex and does not provide the modern capabilities you would expect “out of the box” from modern systems.

From the Carter report it is evident that compared to other Ambulance Trusts this approach has led us to maintain systems that are inflexible and are costly to manage, secure and refresh. This is very apparent in the EOC environment and with standard “office” services provided to staff.

This strategy proposes significant step-changes in the way solutions are delivered. In particular there is a key decision to be made by the Trust on whether LAS should continue to invest in enhancing the existing core CommandPoint CAD system (only used by the LAS in the UK) or make an alternative investment to procure and implement a more standard and modern CAD, already in use elsewhere in the UK. In the corporate arena there are also decisions to be made such as whether we continue to manage our own Microsoft Office and e-mail environments or move to services managed and secured by others such as the NHS Digital managed NHS Mail service; as 80% of other Trusts do.

Strategically we need to move our focus away from directly developing and managing tailored technology systems in preference to using standard solutions already in use elsewhere. This will enable us to concentrate on ensuring our core digital services, intelligence and interoperability delivers continued stability and digitally enabled transformation for the benefit of our patients, people and the public.

The Trust will need to make some bold decisions to better balance modernisation, value and agility against traditional desires of ownership, tailoring and control.

1.3 Achieving our ambition

Achieving our ambition requires substantial changes to how the trust operates clinically, operationally and corporately. We have identified seven pillars to underpin our digital strategy.

1. Digitise the patient journey

Implementing electronic patient records, transforming our operations centres, and enabling electronic referrals and handovers

2. Connect clinicians and clinical data

Ensuring our people are fully connected, wherever they are, with access to the clinical applications and patient information that they need

3. Interoperate across London

Connecting with other care providers across London and nationally, integrating our systems to provide access to patient records, service availability, automated bookings and referrals, and linking our data with that of partners across London to provide a complete picture of the patient journey and outcomes. We are uniquely positioned to play a leading role in the integration of London’s health and care records.

4. Leverage external technology services

Accelerating delivery by aligning with national and regional initiatives, standards and services which can help us, and partnering with suppliers to deliver changes and commodity technical services.

5. Sustain and modernise our core services and infrastructure

Continuing to operate, secure, and modernise our infrastructure to support resilient ambulance and 111 operations, including implementation of recommendations from recent reviews such as the Carter review.

6. Build an advanced data and analytics capability

Transforming to a data-driven organisation by better managing, linking, and exploiting the valuable data which we hold or have access to as a pan-London organisation

7. Transform the employee experience

Increased remote working and use of modern and innovative tools, modernising our internal business systems to support more efficient ways of working and the wellbeing of our staff.

1.4 How we will deliver

We will establish a set of programmes to deliver the outcomes in this strategy and continue delivery of the Connecting Clinicians¹ programme.

Our high level deliverables are:

By 2020:

- All ambulance crews can access detailed patient records
- 999 & 111 contact centre clinicians can access detailed patient records
- Electronic patient care records captured for patient attendances
- Automated transfer of care to appropriate providers
- Establish analytics platform
- Corporate systems moved to cloud-based services such as Office 365_and NHSMail
- New control room systems implemented to replace Airwave ICCS
- Deploy national mobilisation application in vehicles
- Achieve Cyber Essentials Plus

By 2022:

- Implement a replacement computer aided dispatch (CAD) system
- Achieve ISO27001 for Information Security Management
- Implement Emergency Service Network in full
- Implement a replacement computer aided dispatch (CAD) system
- Fully integrate analytics platform with all data sources
- Introduce voice automation in call handling and major incidents
- Implement video capability for 111 and 999 patient

To achieve these deliverables requires a step change in capability and leadership across the Trust. The transformation described in this document is far-reaching and requires comprehensive business change: it will require process re-engineering, patient engagement, staff and system co-production, commercial acumen and clinical leadership.

¹ Connecting Clinicians delivers electronic patient care records (ePCR) and our role in London's Health & Care Records programme

1.4.1 Governance & Control

Oversight and scrutiny of delivery will be by the Logistics & Infrastructure board committee. A programme board structure will be established with cross-trust representation that reports into the trust-wide Portfolio Management Board

1.4.2 Skills & Leadership

Our people are essential to everything we do and it is critical that we support our workforce with skills and technologies to help them do their job. We will invest in training for all staff to develop skills that can fully exploit new digital technologies and tools.

The trust has recently appointed a Chief Clinical Information Officer (CCIO). This is a pivotal role in the transformation which is accountable for the ensuring our digital deliver meets the needs of the clinical strategy and workforce.

We will actively participate in national development programmes such as the NHS Digital Academy which has been set up to develop a new generation of excellent digital leaders who can drive the information and technology transformation of the NHS. We will work with partners in the NHS to develop our capacity and capability across Clinical IT systems, Business intelligence & analytics, Business change and project delivery, finance and commercials.

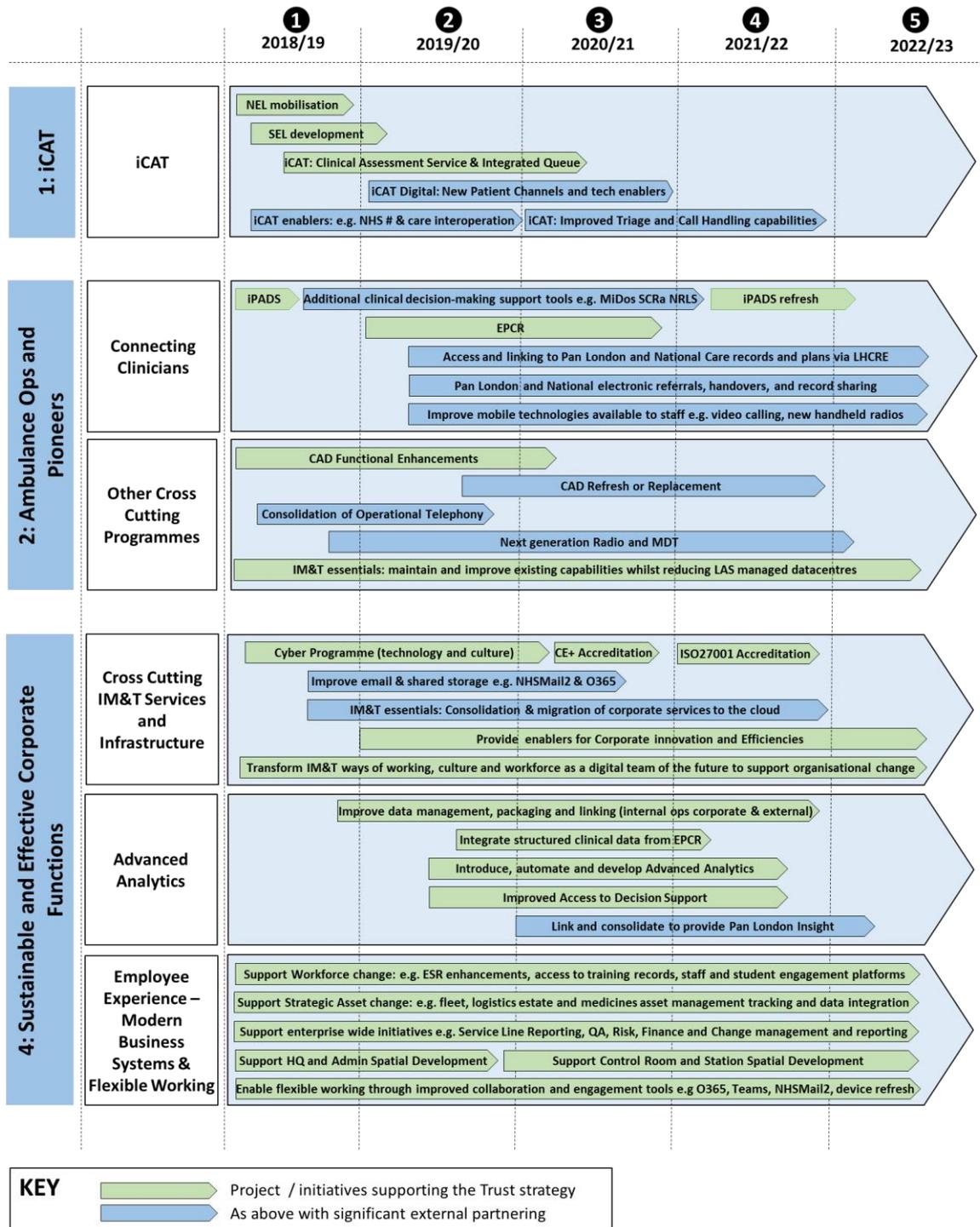
1.4.3 Exploiting Emerging Technology Trends

Emerging technologies offer exciting opportunities to dramatically improve patient outcomes and ways of working. The scope of emerging technology trends is broad, however there are three main areas of emerging technology trends that, if exploited as part of the delivery programmes, will be key enablers to our Digital Strategy in the longer term.

Artificial Intelligence and Analytics	New and improved devices	Intelligent Infrastructure
<ul style="list-style-type: none"> • Using advanced algorithms, and analysing big data and social media to provide enhanced intelligence and improved operational planning and execution. • Examples: Automated analysis of video and images, Predictive analytics, Natural Language Processing. 	<ul style="list-style-type: none"> • New tools and devices allowing for new ways of working while creating new channels for receiving information and communicating with patients. • Examples: Unmanned drones and vehicles & wearable technology 	<ul style="list-style-type: none"> • New ways to receive information about incidents to improve service levels and reduce costs. • Examples: Roadside sensors, Vehicle Infrastructure Integration, Connected homes & buildings.

1.4.4 Plan and funding

A summary roadmap for change is shown below. It will continue to be developed through our ongoing processes for business planning. In line with this process, the next 3 years are relatively firm with the roadmap also providing an indicative view out to 5 years.



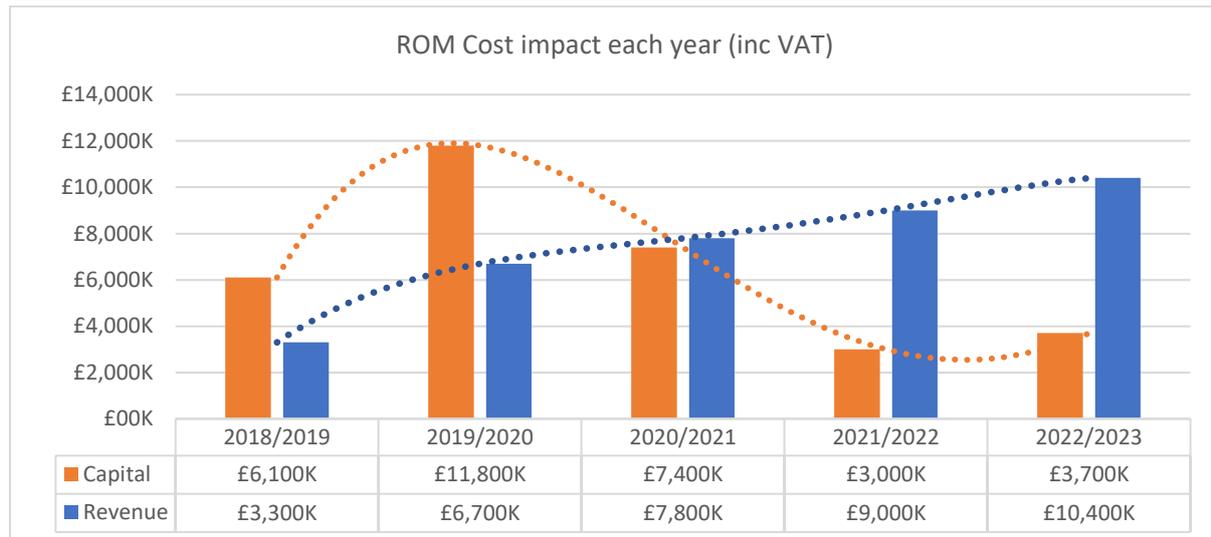
It is worth noting that there is, by intention based on Strategic Theme 3, a high degree of partnership and external dependency in many of the activities. This will again increase the complexity and management attention required to ensure delivery.

The Trust does not currently have the internal delivery capacity to enable this level of change in the timescale set. Increasingly the Trust will need to make better use of managed services, building on our use of arrangements such as the Crown Commercial Service frameworks, to deliver desired digital outcomes.

A very significant input of executive leadership and management attention across the Trust will be vital throughout the period to drive this level of activity and change.

We believe the roadmap to be ambitious – requiring an investment in the order of approximately £40-70m (including capital and revenue costs) over the next 5 years. We will need to access external funding from sources such as Health System Led Investment (HSLI) funds.

The Rough Order of Magnitude (ROM) model is shown in Appendix F. This is a ROM rather than a fully qualified cost estimate. The following table shows the estimated ROM impact per year, shown as split between the constituent Capital and Revenue.



Note: This does not include the impact of cash releasing benefits

At this stage the analysis does not include the impact of Trust efficiencies (whether directly or indirectly) attributable to the Strategy, however, this will be compiled through the business planning processes to contribute to the transformation cost.

The detail of the phasing, costs and funding across years will be refined through Trust business planning activity and the development of individual business cases across the 5 years of the strategy.

1.4.5 Alignment with NHS Long Term Plan and Tech Vision (2)

The new NHS long term plan, published in January 2019, outlines how across all parts of the NHS technology will be upgraded and that “over the next ten years investments in technology will result in an NHS where digital access to services is widespread. Where patients and carers can better manage their health and conditions. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today.”

Aligned with the new long term plan, The Secretary of State for Health & Social Care, the Rt Hon Matt Hancock MP, launched his Tech Vision for the NHS in October 2018. The tech vision sets out real challenges to overcome:

- legacy technology and commercial arrangements
- complex organisational and delivery structures
- a risk-averse culture
- limited resources to invest

² <https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care>

- a critical need to build and maintain public trust

At the heart of this vision are 4 guiding principles we should maintain to make this work:

- user need
- privacy and security
- interoperability and openness
- inclusion

We will adopt the vision wherever possible and use it to guide our delivery plans.

Appendix G, National Alignment, shows in more detail how this Strategy aligns with the NHS Long term plan, the Tech Vision for the NHS and the National Ambulance Digital Strategy.

1.5 Conclusion

Our vision to be a world-class ambulance service for a world-class city is underpinned by a Trust strategy which sets out a case for significant business transformation. As the only NHS provider Trust that operates across London, we are uniquely positioned to play a leading role in the wider digital transformation of urgent and emergency care across the capital.

Modern and transformational digital, data and technology capabilities will be intrinsic to our future and to improvements in patient care to Londoners; yet the state of our digital services and basic IT, like much of the NHS, is far behind where it needs to be to realise this ambition.

Overall the planned digital roadmap is rightly ambitious, and requires significant investment and executive leadership. Whilst these challenges could be eased by extending the timeline, this would be at the expense of a slower pace of delivery.

The potential benefits to our patients, public, partners and our people make this a worthwhile plan to pursue vigorously.

The remainder of this document describes the digital vision, and how we will achieve it in more detail.

2 Digital Transformation of a World-Class Ambulance Service

A world-class ambulance service needs to be at the forefront of using all technology and digital innovations to provide the best possible service to London. Delivery of our Trust Strategy requires us to be innovative and to embrace digital transformation across the organisation.

This section sets out our vision for the future, outlining how digital, data and technology will support the Trust's strategic themes between now and 2023.

2.1 Our Vision – Technology and Data Supporting Digital Transformation

This Digital, Data and Technology Strategy plays a critical role in the delivery of our services, and a central role in supporting the achievement of strategic change in the way LAS delivers care.

“Technology is a critical component of the NHS modernisation required to meet rising demand and expectations and improve outcomes”

Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care

Our vision is:

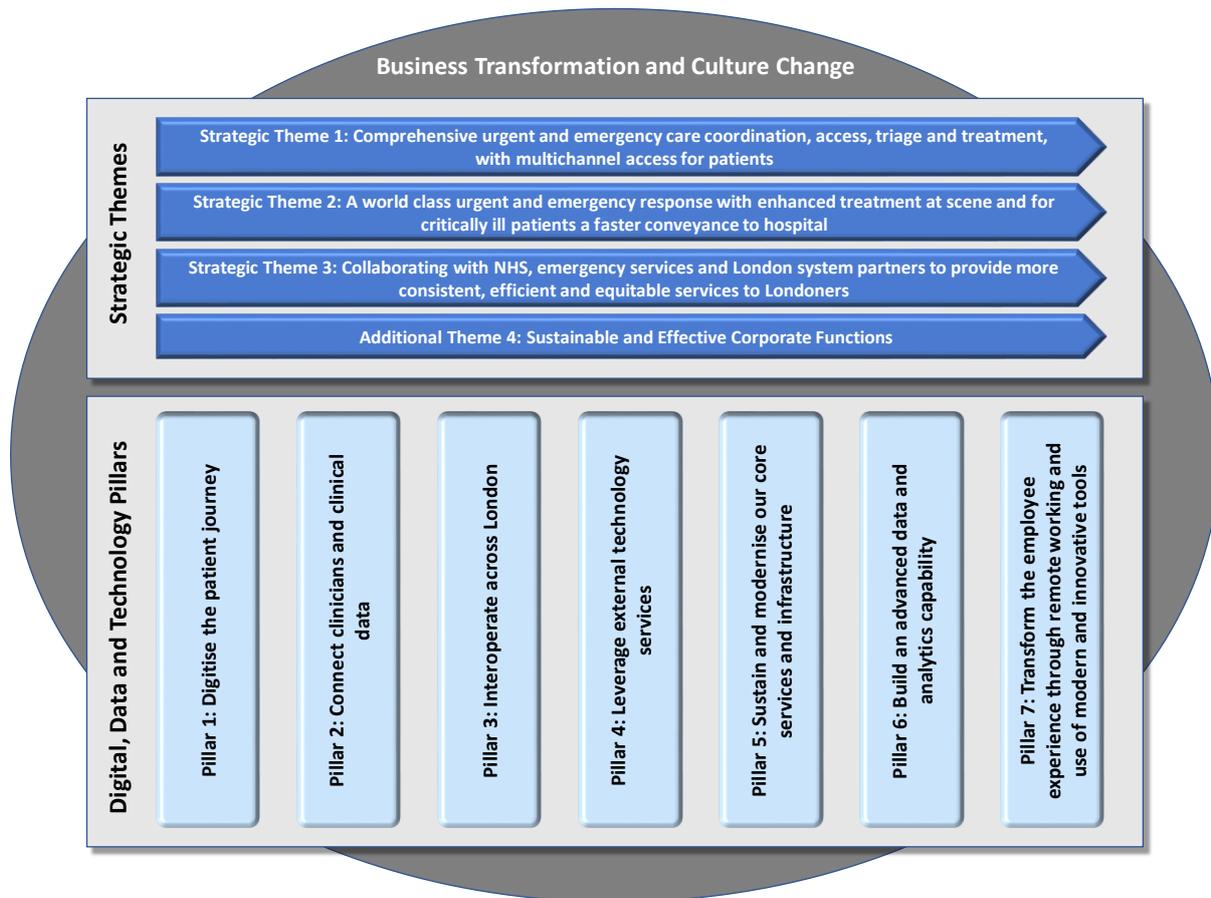
**To drive digital transformation
through modern and innovative use of technology and data
for the benefit of patients, the public, our people, and our partners**

- **Digital** in this context refers to the use of technology to drive transformative change - directly affecting Patients and the Public, Our People, and Our Partners.
- **Technology** underpins digital transformation by providing the tools, infrastructure and applications to support our work.
- **Data** is a valuable asset which we need to make sure we are managing, analysing and sharing to support decision making by our strategic and operational teams.

This transformation requires us to move away from fragmented digital, data and technology approaches to collectively enable and stimulate improvements in patient care. We will move to a combined mind-set, providing innovative yet robust technology solutions to manage new and diverse information collected and held by ourselves and our partners, engaging and empowering our people, patients, partners and the public in increasingly digital forms.

We will digitally empower our people to effectively deliver care for our patients; we want patients to be digitally connected to all health services, and we aim to be digitally working with partner organisations.

2.2 Our Approach - Pillars supporting Business Transformation



The diagram illustrates how our vision can be achieved, based upon enabling our three strategic transformation themes and supported by the additional theme of sustainable and effective corporate functions. Each of the themes is enabled by Digital, Data and Technology – and we have identified seven key areas of activity which provide the supporting pillars from a digital, data and technology perspective. A wider agenda of business transformation and culture change underpins the whole picture.

In terms of the seven pillars, these have already been introduced in the previous section so here we elaborate more specifically the support each one will provide. The following chapters then explain in more detail how the relevant pillars support each strategic theme.

Pillar 1: Digitise the patient journey

We will:

- Implement electronic patient records, migrating from paper to a digital clinical records system
- Introduce new channels such as video-calling to enhance our interaction with patients to improve clinical outcomes
- Integrate workflows across 999 and 111 to deliver appropriate, seamless patient care regardless of the number called.
- Invest in resilience and interoperability of our Computer Aided Dispatch (CAD) capability
- Capture the NHS Number whenever possible and use it to help identify patients and access data
- Identify frequent callers to better manage their care

- Enable electronic prescribing by appropriate clinical staff across our services
- Introduce additional clinical decision-making support tools
- Enable electronic referrals and handovers, supported by access to the directory of services which is a live resource providing information on appropriate care pathways.
- Explore the potential of voice automation and evaluate its suitability in call handling

Pillar 2: Connect Clinicians and Clinical Data

We will:

- Upgrade the mobile technologies available to our staff including implementation of the Ambulance Radio Programme which replaces the national Airwave system.
- We will adopt the national in-vehicle mapping and dispatch tools funded by the Department of Health to replace our locally developed Mobile Data Terminals.
- Expand upon the deployment of iPads to front-line clinicians to enable mobile access to core clinical applications
- Provide access to external patient records so that our clinicians can be better informed about a patient's history
- Enable electronic referrals and handovers, supported by access to the directory of services which is a live resource providing information on appropriate care pathways.
- Use video-calling to allow clinicians to provide peer support and advice to each other (e.g. real-time access to specialist consultants, mental health nurses, pharmacists or GPs for advice regarding a case).

Pillar 3: Interoperate across London

We will:

- Connect with other Health and Social Care providers across London (for example via the LHCRE), enabling interoperability between our systems to provide access to patient records, information about service availability, and automated handovers, appointment bookings and referrals.
- Link our data with that of partners across London to provide a complete picture of the patient journey and outcomes, thus gaining insight into the wider health and social care system and optimising and transforming the way we work

Pillar 4: Leverage external technology services

We will:

- Play a leading role in pan-London healthcare data interoperability such as the One London programme funded by NHS England's Local Health and Care Records Exemplar (LHCRE) programme.
- Accelerate delivery by aligning with national and regional initiatives which can help us. There are many opportunities to leverage external skills and opportunities, and by doing so we can achieve more, at greater pace and lower cost, than we could by working alone
- Identify technologies and solutions which are needed but can already be provided by others or are commodities. This includes the use of cloud wherever relevant. These opportunities will be embraced through partnerships and commercial arrangements, thus reducing costs and freeing up our time for the transformational innovation needed.

Pillar 5: Sustain and modernise our core services and infrastructure

We will:

- Consolidate, secure, and modernise our infrastructure to support resilient ambulance and 111 operations - The intention is to make sure required services are maintained

and functional, with appropriate resilience, consolidating software and services, and updating our data centres only where necessary. The primary approach is to move services to the Cloud where practical. Where end-of-life systems cannot move to the Cloud immediately, the services they provide will be assessed to either be moved to third party data centres, be run as hosted services or be replaced as best fits their provision.

- Implement recommendations from recent reviews such as Carter and the Operations Centre Review
- Implement NHS accredited email such as NHSMail2 or Microsoft Office 365
- Refresh our 999 and 111 telephony infrastructure
- Upgrade our mobile communications and devices, to ensure that we put modern connectivity in the hands of crew staff
- Continue to address cyber vulnerabilities by investing in modern infrastructure, protective controls, threat intelligence and data loss prevention capabilities and education across the organisation
- Transform our ways of working within the IM&T directorate. To achieve this step-change we will need to change our culture, and develop our workforce and the capabilities of our digital team of the future to support organisational change

Pillar 6: Build an advanced data and analytics capability

We will:

- Become patient data oriented with the patient at the centre of all our decisions
- Implement a self-service analytics platform that provides an integrated single source of truth for all data and intelligence decisions
- Transform to a proactive, evidence-based organisation, recognising data as a valuable corporate asset which we need to manage and exploit
- Improve the management of our data - assuring its quality, linking it across patient, operational, corporate and external systems, and packaging it in ready-to-use formats. Holding data in an unstructured or disparate way may act as a barrier to modernising ways of working and mobility whereas having good quality and structured data available will be a critical enabler when it comes to designing and implementing our strategic objectives around iCAT, pioneer services and partnership working
- Develop asset management capability for predictive maintenance across estates and fleet
- Better exploit our data - developing our tools and infrastructure for Business Intelligence, applying advanced analytics such as forecasting and machine learning, and producing accessible information to support decision making. This will improve the quality of decisions made in the Trust – all the way from the individual patient to the boardroom
- Transform our ways of working within the Performance directorate. To achieve this step-change we will need to change our culture, and develop our workforce and the capabilities of our digital team of the future to support organisational change

Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

We will:

- Modernise our internal business systems to support more efficient ways of working and the wellbeing of our staff. New robust systems will ensure that we can run our organisation more efficiently, properly train our people, and be able to manage a more complex fleet and multi-skilled workforce.

- Enable flexible working for our people. The majority of our staff are mobile and we have other pressures such as costly estate which means we should be more flexible in where and how our people can work.
- Be bolder and more innovative in our use of technology - to the benefit of Patients and the Public, Our People, and Our Partners. We need to take advantage of the opportunities which technology innovation can bring - putting in place processes to support innovation, whilst balancing the potential benefits against the risks inherent in providing a safe and efficient service.

These activities described under these pillars are important, but alone they are not enough. To deliver benefit it is vital that they are embedded within a wider organisational business transformation and culture change:

Business Transformation and Culture Change

We will:

- Recognise that the transformation described in this document is far-reaching and about far more than just technical solutions.
- Deliver appropriate training develop skills to fully utilise new digital technologies and tools. Our people are essential to everything we do and it is critical that we support our workforce with skills and technologies to help them do their job.
- Give proper attention to the planning of implementation and business change, involving staff who will be using new technology in the planning for its introduction.
- Make better use of managed services, building on our use of Crown Commercial Service frameworks, to help deliver desired digital changes services and outcomes
- Consider how technology can help improve job satisfaction. For example, by eliminating tedious tasks, or by providing feedback on outcomes
- Work at pace to implement these important changes and improve what we do
- Enable a wider business and culture change from “Board to Floor” thus ensuring that the benefits of digital transformation are unlocked.

2.3 Benefits – what it means to Patients, Public, Our People and Our Partners

The benefits to our patients and public, our people, and our partners are summarised below:

Patients and Public
<ul style="list-style-type: none"> • Can use a range of ways of contacting and communicating with us, and experience a single point of access; whether in person on scene, on the phone or on-line • Achieve better outcomes, due to a wider range of treatment and referral options, and improved learning and information flows across the system • Receive a more personalised service, based on more complete and personalised knowledge of their circumstances and condition • Are confident that we are using technology innovatively and appropriately for the benefit of Londoners, whether as individual patients or members of the public during a crisis.

Our People
<ul style="list-style-type: none"> • Are connected wherever they are – whether on-site, on-scene, or at-home • Are connected to data – including patient records and service information • Are empowered by modern and resilient technology – which is easy to use and “just works” • Are empowered by advanced decision support – which provides guidance based on previous experience and best-practice • Are empowered by training and career development – giving confidence in using digital tools and developing specialist skills • Are supported by modern ways of working and managing their personal needs in a modern digital world • Are empowered by an innovative and agile culture – to make improvements which improve patient outcomes and increase job satisfaction • Work together – using voice and video technology to communicate with colleagues and get help and advice wherever they are.

Our Partners
<ul style="list-style-type: none"> • Provide access to patient records and history • Enable us to provide an integrated “one-stop” approach to referrals and appointment booking • Work together to design efficient and high-quality patient pathways which may be complex but can be enabled by advanced in technology and communications • Share data with us, so that we can “join up” across the wider system to better understand our patients, clinical outcomes, patterns of demand and pressure in other parts of the patient’s chain of care • Work with us to determine standards and technology that we can leverage to accelerate systems implementation • Work with us to identify opportunities for collaborative implementation and use of technology and data to avoid duplication of effort and complexity.

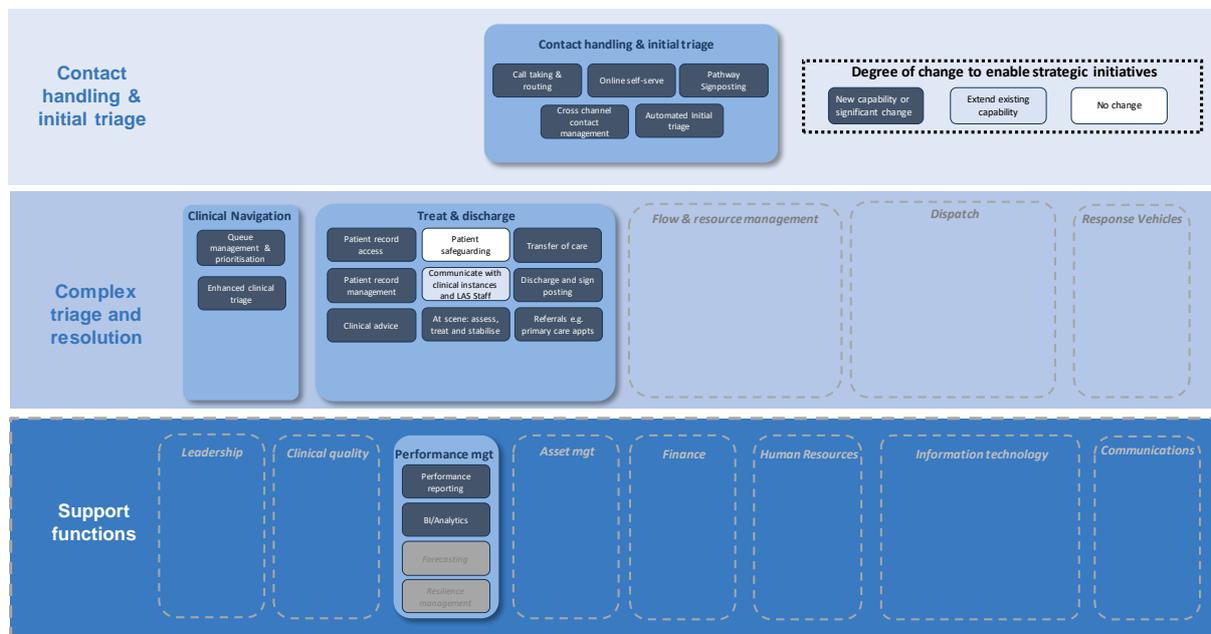
These benefits are further brought to life using a set of “day in the life” case studies in Appendix A – What will it mean for me?

3 Strategic Theme 1: integrated Clinical Assessment and Triage (iCAT)

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

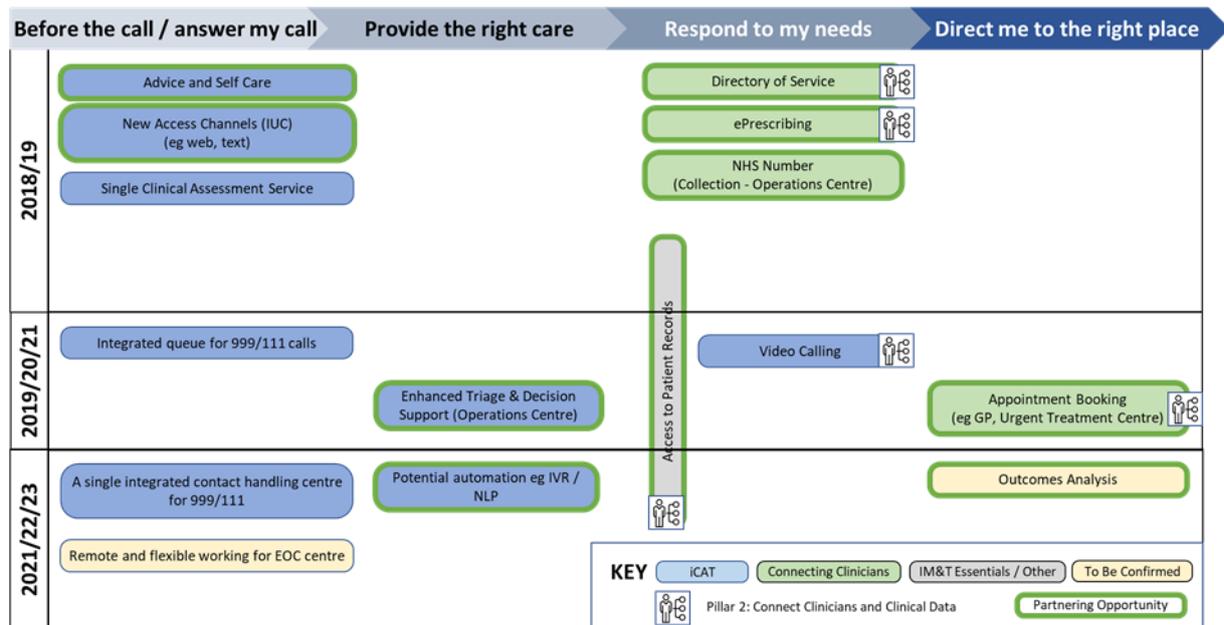
At the heart of our strategy is the idea that we want to manage and coordinate the flow of patients through urgent and emergency services, making it as easy as possible for people to access the help that they need. Our response is to develop an integrated clinical assessment and triage service: iCAT London, which will sit behind both NHS 111 and 999, providing integrated urgent and emergency care.

To set this Strategic Theme in context, it is useful to refer to our Business Capabilities Map. (See *Appendix B - Business Capabilities Map* for more about this and for a copy of the entire map). This theme corresponds to the development of our capabilities in “Contact Handling and Initial Triage”, as well as in those aspects of “Complex Triage and Resolution” which can be performed via the Clinical Assessment Service. “Performance Management” also plays an important role in closing the feedback loop. Relevant areas of the Business Capabilities Map are highlighted below:



3.1 Pillars 1 & 2: Digitise the patient journey & Connect clinicians and clinical data

This theme is strongly supported by both of the first two pillars. The diagram below is based on “Pillar 1: Digitise the Patient Journey” - and shows the steps of a typical patient journey with the enabling digital, data, and technology features. However some of these steps in this digitised patient journey also enable on “Pillar 2: Connect Clinicians and Clinical Data”, and these items are highlighted in the diagram. Relevant implementation projects and timeframes are also indicated.



Pillar 1: Digitise the Patient Journey

We will:

- Use new channels such as video-calling to enhance our interaction with patients
- Monitor opportunities for other emerging channels such as telehealth, apps, email, social media etc. based technology developments and National policy guidance
- Transform our operations centres, putting in place advanced and integrated infrastructure for call-taking with a single queue across 999 and 111, and providing enhanced triage and clinical systems to enable integrated Clinical Assessment and Triage. Thus supporting the Trust in flexing services to better manage patient’s needs
- Capture the NHS Number whenever possible and use it to help identify patients
- Introduce additional clinical decision-making support tools
- Deliver electronic prescribing, by appropriate clinical staff
- Deliver electronic referrals and handovers, supported by access to the directory of services which is a live resource providing information on appropriate care pathways

Pillar 2: Connect Clinicians and Clinical Data

We will:

- Provide access to external patient records so that our clinicians can be better informed about a patient's history
- Deliver electronic referrals and handovers, supported by access to the directory of services which is a live resource providing information on appropriate care pathways

In more detail, key points along the process are:

3.2 Contact Initiated

As an alternative to phoning, patients may wish to contact us via other channels such as the web or messaging as well as, in future, potential via automated alerts from telehealth devices. In some cases patients may even be able to find the advice they need (or make an appointment) online - and so not need to make direct contact at all. This is an example of where we can leverage external capabilities – integrating with the National development of “111 Online” rather than having to invest in our own local implementation.

Internal work on telephony and queuing will then enable both 111 and 999 contacts to be handled via a single queue, as well as routed as necessary to the Clinical Assessment Service for specialist advice.

Developments in our technology infrastructure will also give us increased flexibility regarding where the call handler is located; whether in one of our Operations Centre or, potentially, at home.

3.3 Triage

The Trust currently uses three triage systems – NHS Pathways and Manchester Triage System (MTS) in 111 and the 999 clinical hub and Medical Priority Dispatch System (MPDS) in 999 call handling. Each system has its strengths however none can address all of the requirements of the service nor the opportunity to deliver a more tailored and sophisticated response.

Having information available on a patient as soon as they contact us including minimum patient dataset and past history of interactions with the NHS will enable a more personalised service and a more appropriate triage.

Powered with more information on an individual patient, and a vast evidence base of previous patient contacts and outcomes, new triaging tools and modules will assist in rapidly routing calls towards the most appropriate response. Whilst we will need to implement these tools ourselves, national initiatives such as the Clinical Triage Programme can assist with direction and standards.

In terms of innovation, we also intend to evaluate options for automating - where appropriate - some aspects of calls. For example, using technologies such as Interactive Voice Response (IVR), Natural Language Processing (NLP), and machine learning, to improve quality assurance auditing of calls or provide faster automated responses to callers where appropriate.

3.4 Advice / Treatment

The Clinical Assessment Service gives us new options for Advice / Treatment which do not necessarily require dispatch of an ambulance (Hear & Treat).

Putting in place the infrastructure for video calling will enhance the ability to diagnose remotely, as well as providing a richer interaction and “human face” for the patient.

Our clinicians in the Clinical Assessment Service will need to be fully connected with access to patient records – taking advantage of work to integrate with National and Regional systems to access these. They will also need to make use of external Directory of Service information and tools, to help navigate the wide range of potential treatment pathways.

In some cases our clinicians may also be able to treat the patient remotely – making use of integration with ePrescribing to remotely provide necessary medication.

3.5 Dispatch

To sustain the delivery of care to patients we must maintain our current key operational capabilities so that we can dispatch appropriate resources and manage the overall lifecycle of our patient contacts.

Currently we rely on a wide variety of interconnected technical systems surrounding our core CAD system (CommandPoint), such as separate mapping and triage systems, to provide the overall capabilities needed. This is a legacy model originally designed some twelve years ago at which point this approach was feature rich and moved the Trust away from an in house developed CAD system.

The majority of our dispatch systems and services including our CAD, 999/111 telephony infrastructure, mobile data communications and devices and radio systems, are due for refresh and enhancement during the timeframe of this strategy.

Whilst there is a continuous programme to maintain, update and upgrade these services, this has been done in the main using a traditional in-house refresh or renewal approach. This has resulted in the Trust relying on and managing a number of outdated legacy systems designed to suit the needs of the past. The combined web of systems is overly complex and does not provide the modern functional and disaster recovery capabilities you would expect “out of the box” from modern CAD and mobile data systems. The Trust invests heavily in, largely bespoke, developments and changes to the core CAD and MDT systems, where as other Ambulance Trusts benefit from more agile, standardised and shared developments. From the Carter report it is evident that compared to other Ambulance Trusts this approach has led us to maintain a capability that is inflexible and costly to manage, secure and refresh.

With the drive for our staff to routinely have seamless access to patient data that is available in other NHS care settings and digitally interoperate with other care partners, there is an emerging ongoing need to integrate the CAD environment with a number of new services and partners in more dynamic way.

Consequently the CAD capability roadmap in particular will involve more than just a technical refresh. The solution will need to cater for developing requirements for our “future CAD”, delivering functional and interoperability enhancements to provide this. Early work considering the implementation of recommendations from recent reviews such as Carter and the Operations Centre Review leads us to take a fresh view on the future of the Control Services environment. It is clear that other Ambulance Trusts enjoy similar, and increasingly better capabilities at a lower overall cost. Their systems incorporate many enhancements the LAS is looking to develop and other advanced functionality, as core elements.

Examples are:

- | | |
|--|--|
| 1. CAD2CAD national | Transfer of incidents between Trusts |
| 2. NHS number lookup | To identify patients and enable end-to-end patient record |
| 3. SCR | To view and pull-in SCR information automatically based on the patient's NHS number |
| 4. 999 – 111 | Transfer of calls and patient details from the 999 environment to 111 call centres |
| 5. Integration to the new national ICCS | To enable us to connect our CAD to ESN and maintain consistency of fleet and clinician status/locations with CAD. |
| 6. Integration to the new national mobilisation application | To enable us to connect our CAD to the new national mobilisation application provided by the DHSC Ambulance Radio Programme to all ambulance services. |
| 7. Seamless business continuity capabilities | To meet cyber patching, software upgrade and operational requirements (without going to paper) |
| 8. Flag “at risk” or “care plan” based on patient details | Making use of the patient identity rather than geographic location to identify risks and existing care plans |
| 9. Advanced mobile location | To make use of new technology developed to locate caller's smart phones and hence patients with greater accuracy |
| 10. Pathways | Integrated Pathways triage protocols at point of contact |
| 11. Multi-disciplinary 111 and 999 call-takers | To provide greater operational flexibility |

Arguably the level of investment in providing the above enhancements to our current CAD solutions would be better invested in implementing a replacement CAD service which is already capable of providing these facilities as part of its core “out of the box” delivery. The Trust will need to consider the choice of approach carefully, not only to consider the overall cost and benefits implications, but also the pace and priority of the work along with the interdependencies with and the Trust's ability to deliver this change amongst other priority enhancements such as EPCR.

The mobile data elements of the dispatch capability will be replaced by the new national mobile data capability (known as the National Mobilisation Application)

3.6 Discharge / Next Steps

In many cases it may be that the Clinical Assessment Service identifies that the patient does need further help, but that this is not urgent enough to warrant an ambulance response. In these situations the clinician will need to use integration with National and Regional appointment booking systems – for example to make the patient an appointment with their GP, or at an Urgent Treatment Centre.

Finally, we need to monitor the effectiveness of our service, to make sure that new treatment approaches are having positive patient outcomes - providing feedback to our clinicians and the giving us the opportunity to adjust and improve where necessary. This is an example of how we can develop our exploitation of data. We will collate information about each call, link it to outcomes from the wider system, and apply analytics and machine learning to gain insight which can reduce variation and drive service improvement.

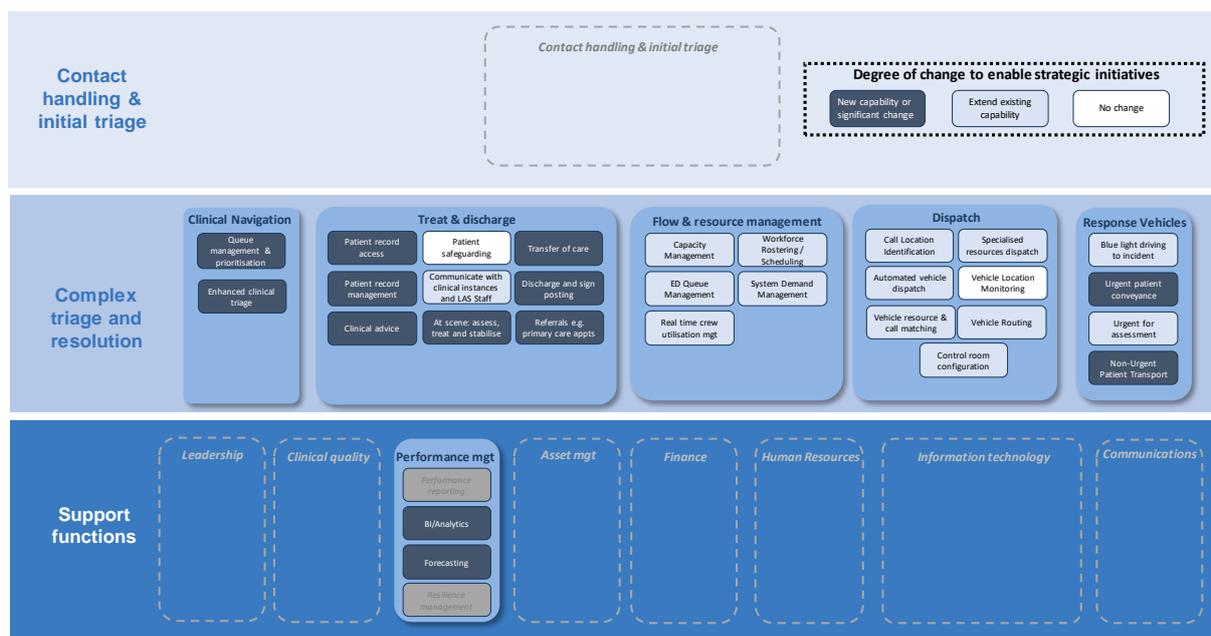
4 Strategic Theme 2: Ambulance Operations and Pioneer Services

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

Meeting the challenges of improving London’s urgent and emergency care requires an ambulance service which places a clear emphasis on assessment and enhanced treatment at scene and in community settings, with transport to alternative care settings where required to access established pathways of care. Transport to hospital should be used for those patients who require the assessment and treatment skills and equipment available only within an emergency department.

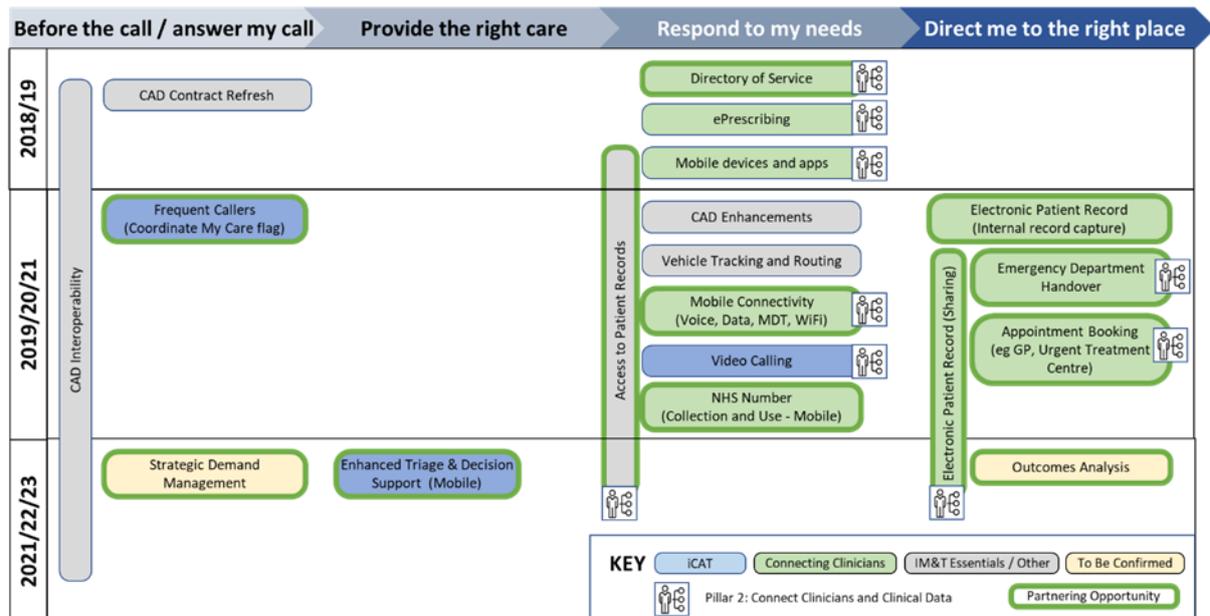
We will continue to support delivery of high quality care to all patients, especially those most critically ill and injured. Providing enhanced treatment at scene will enable us to use our staff and vehicles in the most effective way, preventing escalation and helping to manage demand on the wider health system.

This theme corresponds primarily to the development of our capabilities in “Complex Triage and Resolution; continuing to improve what we already do, but also providing a wider range of new care options for our patients. “Performance Management” again plays a role, especially in terms of service planning. Relevant areas of the Business Capabilities Map are highlighted below:



4.1 Pillars 1 & 2: Digitise the patient journey & Connect clinicians and clinical data

This theme is also strongly supported by both of the first two pillars. The diagram below again illustrates this - based on the steps of a digitised patient journey with the items relating to connecting clinicians and clinical data highlighted, plus an indication of relevant implementation projects and timeframes.



Pillar 1: Digitise the Patient Journey

We will:

- Implement electronic patient records, migrating from paper to a digital clinical records system
- Identify frequent callers to better manage their care
- Modernise our CAD, enhancing functionality and interoperability
- Introduce additional clinical decision-making support tools

Pillar 2: Connect Clinicians and Clinical Data

We will:

- Upgrade the mobile technologies available to our staff including implementation of the Ambulance Radio Programme
- Provide access to external patient records so that our clinicians can be better informed about a patient’s history
- Enable electronic referrals and handovers, supported by access to the directory of services which is a live resource providing information on appropriate care pathways.
- Introduce additional clinical decision-making support tools
- Use video-calling to allow clinicians to provide peer support and advice to each other (e.g. real-time access to specialist consultants, mental health nurses, pharmacists or GPs for advice regarding a case)

In more detail, key points along the process are:

4.2 Contact Initiated

Multiple channels for communication and better streaming of calls, as described in Strategic Theme 1: iCAT, means that those patients who need to get through quickly for an emergency response will have more options to quickly connect with the right level of response.

The introduction of EPCR also has implications for later themes, and specifically for “Pillar 6: Build an advanced data and analytics capability”. It means we can collate information about each call, enriching the raw statistics with personal information and clinical details around the individual. For example, recording why we do or don’t convey the patient would provide the input data to analyse whether alternative care pathways are in place and functioning. This data can then be joined with other sources in London, such as weather, traffic and demographics, to get a much richer understanding of drivers of demand. Analytics and machine learning can be applied to gain insight into patterns of demand and to build predictive models or where and when to best focus our resources.

4.3 Triage

Better streaming and triaging of patients, as described in Strategic Theme 1: iCAT, means that those patients who do need an Emergency physical response will be more likely to be seen to within the seven and eighteen-minute targets.

With the introduction of EPCR, the data collected from calls and incidents will be based around the patient and can therefore be more easily joined up with wider health system data to create a view of the whole patient pathway. This can be used to monitor and improve the triage process with a focus on the triaging decisions taken and the final outcome for the patient.

A point to note here is to re-emphasise the importance of enhanced triage tools. With the wide range of response options and Pioneer Services available, it will be important to provide decision support to help guide rapid and consistent selection of the most appropriate response for each patient’s needs.

4.4 Advice / Treatment

A fast response is vital for critically ill patients. New Mobile Data Terminals and navigation capability in our ambulances will assist with dispatching and routing vehicles as quickly as possible. There are also enhancements planned to the CAD system to improving features, interoperability resilience and helping to optimise job cycle times.

In addition to these improvements to existing ambulance operations, new pioneer services will be available to support the CAS and provide the expert help required for patients by offering differentiated services.

Many of the other aspects of providing advice and treatment are similar to those covered under Strategic Theme 1: iCAT. However, the emphasis now is on connecting our clinicians on-scene in a See & Treat scenario. It should therefore come as no surprise that the digital, data and technology capabilities required here are similar to those enjoyed by colleagues in the Operations Centre – including access to a Directory of Service, viewing of Patient Records and, potentially, prescribing.

Video calling is another common feature, although in this context it is likely to be more about allowing a clinician on-scene to get advice and support from specialists back in the Operations Centre or indeed elsewhere in the NHS. This could include the use of body-cameras to allow hands-free operation.

The emphasis of this theme is therefore on making these capabilities available to ambulance crews and Pioneer Services in mobile, on-scene, See & Treat scenarios. To this end projects such as implementation of the Ambulance Radio Project will provide the voice, data and Wi-Fi connectivity needed, whilst the provision of iPads will provide mobile staff with the ability to access these applications.

4.5 Discharge / Next Steps

A key activity here is the implementation of an Electronic Patient Record (EPCR) to record details of the patient interaction. Capturing this information in a structured electronic form has a transformative potential – both in terms of informing analysis of our own operations, and in allowing sharing with other healthcare professionals. National standards for this data are being developed as part of the Ambulance Dataset project, and we will need to align with these. Reducing the number of times that a patient’s information is re-taken as part of a clinical handover will greatly improve patient experience whilst reducing this risk of information being missed.

Also enabled by the EPCR is the ability to provide electronic data transfers for Emergency Department Handover. This will streamline the administrative aspects of this process, helping to reduce job cycle times and allow our crews to be more quickly back on the road responding to patients.

The ability to refer and book appointments for clinicians on-scene in a See and Treat scenario should be the same as for their colleagues in the Operations Centre. The new strategy makes this capability vital if unnecessary conveyance to hospital is to be avoided.

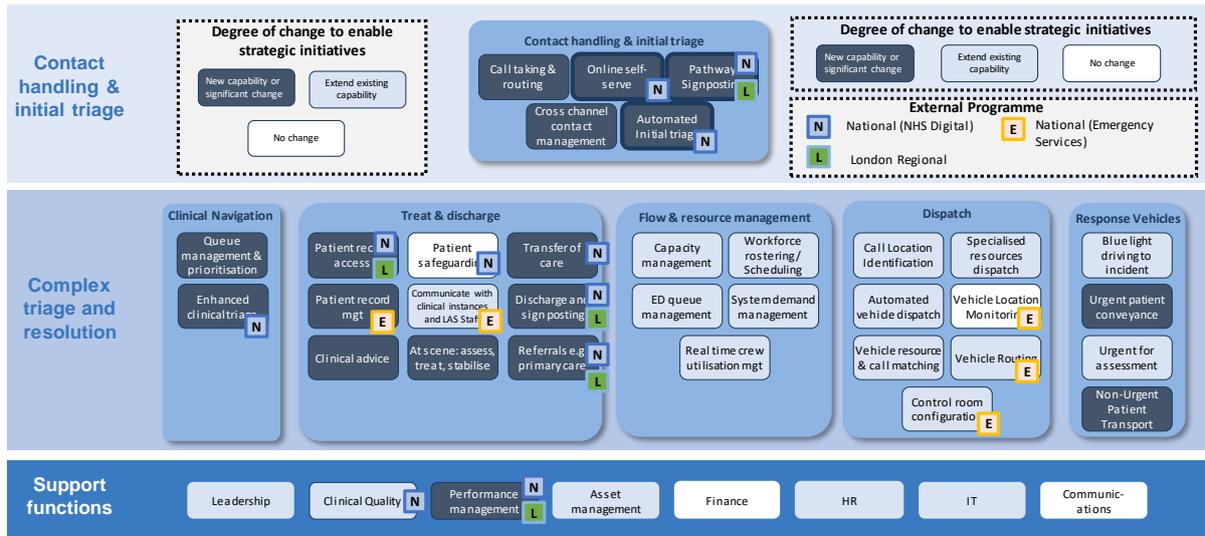
Finally we need to monitor the effectiveness of our service - to make sure that new Pioneer Service and treatment approaches are having positive patient outcomes. This again links to “Pillar 6: Build an advanced data and analytics capability” in terms of relying on information being captured and monitored as part of a structured evaluation programme as well as an ongoing feedback loop.

5 Strategic Theme 3: Partners

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

We will develop collaboration, partnership and innovation across the full range of public services in London and will support all opportunities to improve patient outcomes and experiences and improve public value.

Increased interaction with partners represents a significant change in how we will deliver our digital, data and technology capabilities. This cuts across all aspects of the Business Capabilities Map - with opportunities in many areas as illustrated below:



These partnership opportunities may be broadly divided into those which involve interoperating across London to support the patient journey, and those which relate to how we source our technology solutions.

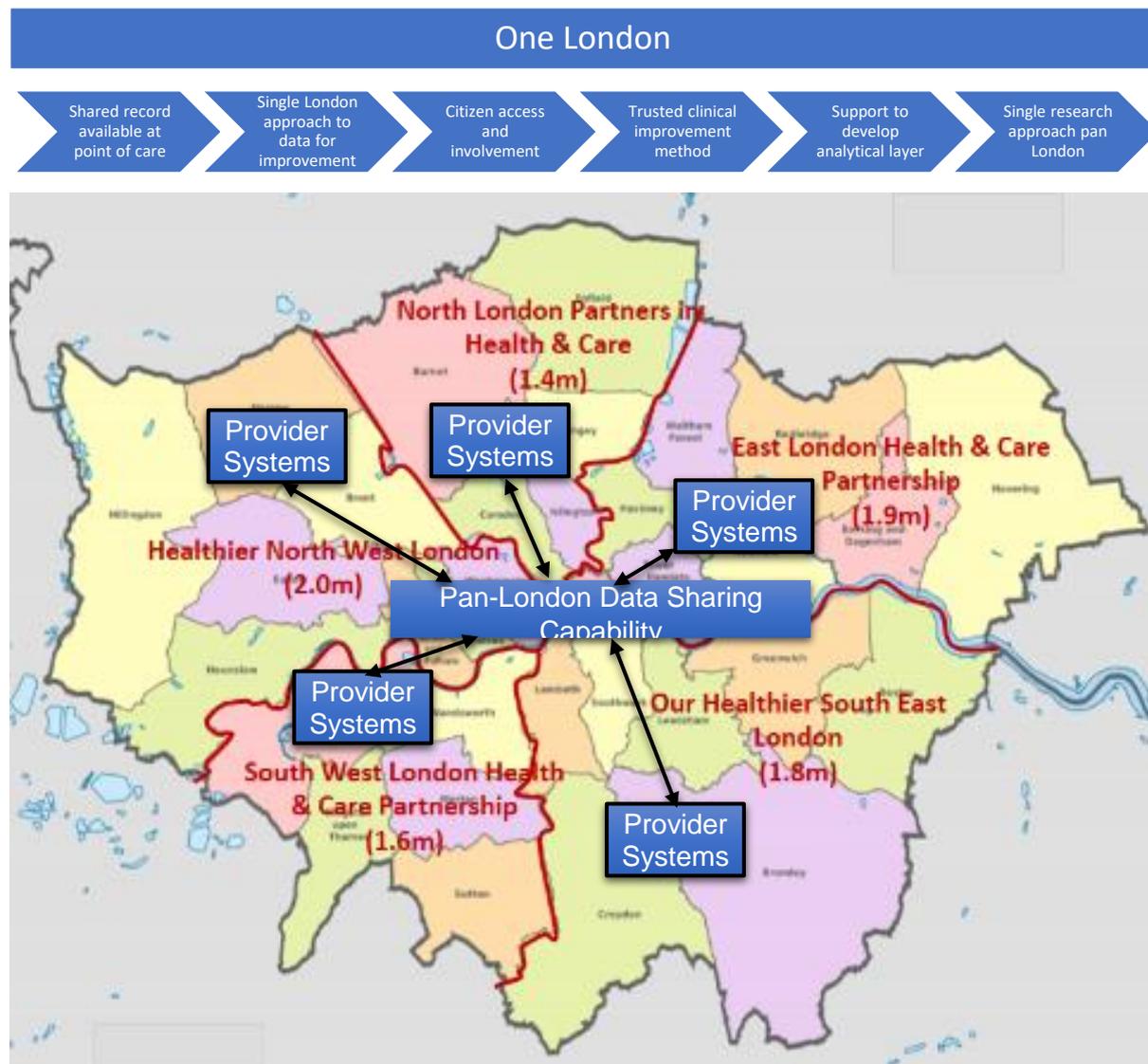
Note that this theme is somewhat different to the others - in that it is not a programme of work in itself, but rather it defines how we will go about implementing the activities described under each of the other themes

5.1 Pillar 3: Interoperate across London

5.1.1 Direct Patient Care

Pillar 3: Interoperate across London	
We will:	<ul style="list-style-type: none"> Connect with other Health and Social Care providers across London (for example via the LHCRE), enabling interoperability between our systems to provide access to patient records, information about service availability, and automated handovers, appointment bookings and referrals.

Whilst an incident is in progress we need to partner with other health and social care services to provide the best possible response and patient outcomes. We are working closely with the London One London Local Health and Care Records Exemplar (LHCRE) programme, and anticipate this playing a key role in providing this integration.



The London LHCRE is tasked initially with developing a normalised, longitudinal, shared care record for each patient registered in London - and longer-term it will interoperate with LHCREs elsewhere to provide yet wider access to patient records. The approach will be based on open standards and the LHCRE will act as a broker for interoperability between health and social care organisations in London.

We are closely involved in the development and piloting of this important initiative, and will play our part by contributing data from our own Electronic Patient Record into LHCRE. The LHCRE will provide us with a single-point-of-contact, based on open APIs, with which to integrate our systems with. It will therefore be able to assist us in particular with:

- **Access to Records** – enabling interoperability between systems to provide access to patient records held by partners, so that our clinicians can be informed of the wider patient history and preferences
- **ePCR Sharing and Referrals** – sharing our own electronic records with others, such as the patient's GP

Note that enabling interoperability across London again underscores the importance of capturing the NHS Number as a definitive patient identifier across systems.

5.1.2 Pan London Insight

Pillar 3: Interoperate across London

We will:

- Link our data with that of partners across London to provide a complete picture of the patient journey and outcomes, thus gaining insight into the wider health and social care system and optimising and transforming the way we work

The London Ambulance Service is the only pan-London Trust and therefore has a unique view of the health of the London population. As we become a primary integrator of access to urgent and emergency care we will need to go beyond working only with our own data and begin working with partners to gain insight across the wider Pan London healthcare system. This will involve linking data at three levels:

- Internal LAS datasets (e.g. ePCR, CAD, case mix);
- Wider London healthcare datasets (e.g. patients' health record and plans, outcomes from Emergency Departments); and
- Other non-healthcare datasets (e.g. population demographics weather, traffic flow).

Our goal is to monitor the full patient pathway. With automated access to more external data sources through new shared technology platforms (for example 111 activity data, GP records, patient pathway, and hospital admission data), we will be able to model demand, and to understand the impact of care throughout the urgent and emergency care system and provide further evidence for interventions that would improve the effectiveness or efficiency of care.

We again anticipate the London LHCRE playing a key role here to develop Pan-London analytic and population health capabilities. We will provide the LHCRE with data, and it then collates and links this with data from other providers across London - providing the results of analysis as an output. We expect this to be able to assist us with:

- **Demand Management** - Deep data insights around demography, weather, transport and infrastructure required to enable us to better predict demand. It is important to understand the geographic variation in the demand profile across London, and how the provision of services differs in each STP, this helps to understand the impact on patient outcome in different areas. This can be done to some extent within our existing capabilities but requires additional data to provide richer insight.
- **Outcomes Analysis** - Linking of emergency, urgent and hospital admission data will allow us to model and interpret full pathways to understand the flow of our patients and impact of response and pathway on patient outcomes for both emergency and non-emergency patients.
- We see the LHCRE as a key partner in understanding the full patient pathway through health and social care.

There will also be opportunities to join our data with other types of partners across London, for example:

- **Academic Institutions** - We have established partnerships with academic institutions. This gives us access to cutting-edge research with a broader application than could be achieved alone in-house providing extra scope and capacity for innovative projects, and enhancing our appreciation of best practice analytics in other fields and industries. These benefits are applicable more widely than the London Ambulance Service, and often the appeal for universities to work with us is the quantity and richness of our data, as well as the ability to gain pan-London insight.

- **Vehicle Routing** - Gaining a real-time understanding of traffic flows in London to make better dispatch choices; additionally to help planning by understanding where demand might arise based on historic travel patterns and commuter routes.
- **Workforce Analysis** - Tracking of the NHS workforce across London. For example, looking at trends in paramedics within the education system, those likely coming into local recruitment populations, the existing paramedic cohort, and those retiring. Such staff grouping information would allow us to model the full workforce pathway, and horizon scan for imbalances in supply and demand of specific skills across emergency and urgent care services across London

5.2 Pillar 4: Leverage external technology services

5.2.1 National and Regional Enablers

Pillar 4: Leverage external technology services
<p>We will:</p> <ul style="list-style-type: none"> • Accelerate delivery by aligning with National and Regional initiatives which can help us. There are opportunities to leverage external skills and opportunities, and we can achieve more, at greater pace and lower cost, than we could by working alone

External enabling initiatives are in progress at several levels which can help us to achieve this transformation:

- **National: NHS Digital** - A wide range of programmes with an emphasis on interoperability and standards
- **National: Emergency Services** - The workstreams of the Ambulance Radio Programme: Voice, Data, ICCS, Vehicle Solutions
- **Regional: Pan-London** - Numerous pan-London initiatives, including Healthy London Partnership (HLP) workstreams, and more recently the LHCRE.

The following table lists external opportunities which have been identified as relevant to LAS, categorising them based on the steps of a patient journey:

Contact Initiated

- NHS Online / 111 Online (NHS Digital)
- HLP: 111 Online (Pan-London)

Triage

- NHS Pathways / Clinical Triage Programme (NHS Digital)
- HLP: Senior Clinician Module (Pan-London)

Advice / Treatment

- Ambulance Radio Programme (National Emergency Services)
- PDS / SCR(s), National Record Locator Service (NHS Digital)
- Strategic Authentication (NHS Digital)
- Access to Records (NHS Digital)
- HLP: Patient Relationship Manager / Access to Records (Pan-London)
- London Care Records / LHACRE (Pan-London)
- Ambulance Dataset (NHS Digital)
- 111 Prescribing (NHS Digital)
- HLP: ePrescribing (Pan-London)

Discharge / Next Steps

- MiDoS (Pan-London)
- Directory of Service (NHS Digital)
- HLP: Direct Appointment Booking (Pan-London)
- Ambulance Messaging (NHS Digital)

To take advantage of these opportunities we will engage in a partnership-based style of working, and to do this it is important that these external projects be “paired” with internal delivery projects within LAS. The internal project team can then work with the external partner – steering the direction of the opportunity and incorporating the external outputs for the benefit of LAS. *Appendix D – External Opportunities* provides more information about each of these external opportunities - and pairs each one with the internal project(s) within LAS which are best-placed to incorporate its outputs.

5.2.2 External Technology Services

Pillar 4: Leverage external technology services

We will:

- Identify technologies and solutions which are needed but can already be provided by others or are commodities. This includes the use of cloud wherever relevant. These opportunities will be embraced through partnerships and commercial arrangements, thus reducing costs and freeing up our time for the transformational innovation needed.

Our IT costs per capita have been assessed as the highest in the country for an ambulance trust and so we need to look for efficiencies to provide better value for money to the public. At the same time our internal teams are stretched, and the ongoing demands of daily operations are preventing us from focusing our attention on the transformational activities which we want to progress.

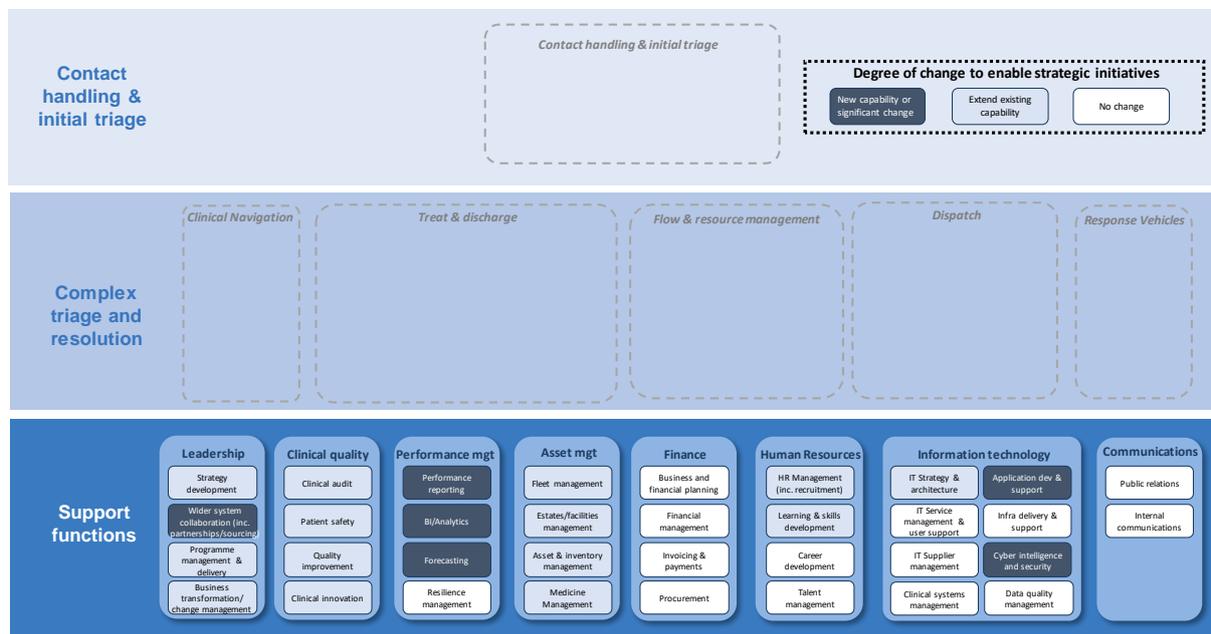
For both these reasons we need to review our approach to sourcing technology services. For areas where we are not innovating or providing a differentiated service for LAS then we need to consider developing strategic partnerships with suppliers. For example: considering areas such as cloud where we may be able to outsource commodity activities. This will also require us to further formalise our management of suppliers and SLAs.

6 Additional Theme 4: Sustainable and Effective Corporate Functions

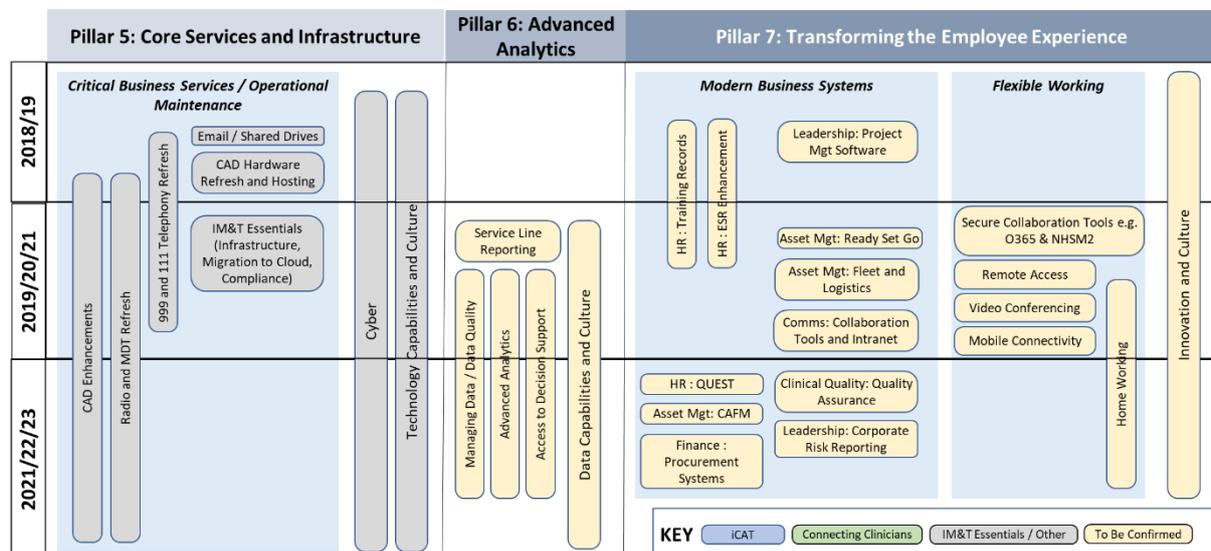
Sustaining and consolidating our core technical infrastructure, developing our exploitation of data, modernising our corporate systems, and innovating to transform our working practices

Whilst our focus is on transformation based upon the three strategic themes, we also need to attend to the technology and information flows which support the internal running of our organisation. There is a continuous need to maintain, update and upgrade our information and technical architecture to support operational and corporate capabilities and our staff. This section looks at what this means – both for critical ambulance operations, and to support our internal organisational transformation.

In terms of the Business Capabilities Map, in this section our focus is on the Support Functions which play a key role in enabling our operations:



The next diagram again illustrates how this internal transformation is enabled, highlighting key activities within each of the three remaining pillars.



6.1 Pillar 5: Sustain and modernise our core services and infrastructure

At the core of delivering our services continues to be the support which the information technology business capability provides for Ambulance and 111 operations - specifically secure and resilient Operations Centres, the communications infrastructure, and mobile technology in the hands of crew staff.

6.1.1 Critical Business Services and Operational Maintenance

Pillar 5: Sustain and modernise our core services and infrastructure
<p>We will:</p> <ul style="list-style-type: none"> • Continue to consolidate, secure, and modernise our infrastructure to support resilient ambulance and 111 operations - The intention is to make sure required services are maintained and functional, with appropriate resilience, consolidating software and services, and updating our data centres only where necessary. The primary approach is to move services to the Cloud where practical. Where end-of-life systems cannot move to the Cloud immediately, the services they provide will be assessed to either be moved to third party data centres, be run as hosted services or be replaced as best fits their provision. • Implement recommendations from recent reviews such as Carter and the Operations Centre Review • Upgrade and increase resilience of email and shared drives • Refresh our 999 and 111 telephony infrastructure • Upgrade our mobile communications and devices, to ensure that we put modern connectivity in the hands of crew staff • Refresh, enhance, and develop the interoperability of our CAD • Implement requirements mandatory for GDPR and Compliance

Our CAD, 999/111 telephony infrastructure, and mobile communications and devices are critical services, and all are due for enhancement, refresh or replacement during the timeframe of this strategy. The CAD will involve more than just a technical refresh – also developing requirements for our “future CAD” and delivering functional and interoperability enhancements to provide this. This will also need to take into consideration the implementation of recommendations from recent reviews such as Carter and the Operations Centre Review.

Alongside CAD, access to emails, office productivity tools and shared drives are viewed as key critical services. There are tactical projects underway to improve stability in all of these areas. Elements of the mail and shared drives systems are being renewed to counter immediate reliability issues, with a medium term view of moving such services to the cloud. Whilst they are tactical, these projects form a large part of the current technical work required, underpinning continuity and delivery of solutions to close strategic gaps. The Trust will move from this tactical approach to a more strategic cloud based approach for these services to provide secure email and office productivity tools (e.g. NHSMail2, Office 365) to enable the Trust and its staff to leverage patient benefits form improved collaboration and interoperation internally and with our health-care partners.

There is also a continuous need to apply appropriate IT Governance and service management rigour to manage systems in place to ensure that critical data, systems and services continue to support the Trust’s objectives. For example, every technical service should have a service owner to manage and drive change. This will include effective

management of change and delivery, scheduled testing and maintenance, proactive service and performance management, and organisational resilience in terms of staffing.

Other essential IM&T activities include:

- **Infrastructure enhancements** – The intention is to make sure required services are maintained and functional, with appropriate resilience, consolidating software and services across departments, and update our data centres only where necessary. The primary approach is to move services to the Cloud where practical. Where end-of-life systems cannot move to the Cloud immediately, the services they provide will be assessed to either be moved to third party data centres, be run as hosted services or be replaced as best fits their provision.
- **GDPR** – implementing the implications of GDPR for our organisation
- **Compliance** – compliance with legal requirements

6.1.2 Cyber

Pillar 5: Sustain and modernise our core services and infrastructure
<p>We will:</p> <ul style="list-style-type: none"> • Implement the recommendations of the 2017 Cyber Review

The 2017 cyber review recommended three key focus areas covering:

- Architectural design –ensuring the IT architecture is protected through use of zoning and firewalls and that systems are regularly patched and kept up to date
- Day to day management of the IT systems –ensuring that security good practice is in place through good test and release processes and there is clarity on which is the primary and secondary datacentres
- Security governance –ensuring there are clear lines of governance and accountability and that all teams follow agreed policy reporting regularly on the security status of the systems under their management

There are tactical projects in place to improve the performance in these areas, however the threat from cyber is continually evolving and it is not practical on-going for the Trust to react to and manage all of the changing cyber threats alone. The Trust must look to evolve the protection it has using more modern techniques, partnerships and services. As an example, this will include a move to the monitoring and analysis of what is happening within our networks and datacentres by expert cyber threat intelligence and analytic capabilities outside the Trust to identify any concerning patterns of technical or human behaviours, correlated dynamically with up to the minute knowledge of evolving cyber threats.

The move of our data, cyber and operational services to the cloud is often perceived as a security and data management challenge, however it is a clear opportunity to provide more sustainable services. By discarding legacy internal solutions, which are difficult to maintain securely, and move to more common services designed, which are maintained and invested in centrally we can provide improved security and data protection by design. An example of this is the opportunity to take up modern data loss prevention capabilities natively delivered by commodity cloud storage and email services.

In terms of assurance, the Trust holds Cyber Essentials accreditation and along with all other Trusts will be looking to attain Cyber Essentials Plus. This represents a significant shift in the level and scope of technical controls needed both internally and at our border. The Trust also has ambitions to obtain ISO27001 accreditation for some or part of the Trust's business areas. This will again require a shift in approach, particularly in relation to effective

data protection controls being applied to information management processes across these business areas.

6.1.3 Technology Capabilities and Culture Transformation

Pillar 5: Sustain and modernise our core services and infrastructure
<p>We will:</p> <ul style="list-style-type: none"> • Transform our ways of working within the IM&T directorate. To achieve this step-change we will need to change our culture, and develop our workforce and the capabilities of our digital team of the future to support organisational change

To achieve this step-change we must consider the changes required in culture to achieve our digital transformation, and develop our workforce and capabilities. This includes:

- Developing the right workforce;
- Developing the right capabilities;
- Developing the right solutions;
- Partnering with stakeholders;
- Aligning on common principles and architectures.

We also need to consider how to ensure our systems are secure by design (see also 6.1.2 *Cyber*) as well as our approach to partnering and to buy vs build (see also 5.2.2 *External Technology Services*)

The following design principles will be used to shape our digital, data and technology operations and culture. These are summarised below and described further in *Appendix C – Digital and Data Operations and Culture*.



6.2 Pillar 6: Build an advanced data and analytics capability

The business capability for “Performance Management” and the analysis of data will become increasingly central in allowing us to continually improve our operational performance and provide clinical decision support - as well as allowing us to collaborate in the identification of opportunities across the wider healthcare system.

6.2.1 Managing Data and Data Quality

Pillar 6: Build an advanced data and analytics capability

We will:

- Transform to a proactive, evidence-based organisation, recognising data as a valuable corporate asset which we need to manage and exploit
- Improve the management of our data - assuring its quality, linking it across patient, operational, corporate and external systems, and packaging it in ready-to-use formats. Holding data in an unstructured or disparate way may act as a barrier to modernising ways of working and mobility whereas having good quality and structured data available will be a critical enabler when it comes to designing and implementing our strategic objectives around iCAT, pioneer services and partnership working
- Ensure we take advantage of the significant new data opportunities which will become available once structured clinical data is added from the Electronic Patient Record

Data is a vital organisational asset, and we need to recognise it as such and manage it throughout its lifecycle. The data we hold and access to support staff helping patients must be structured in a way that supports our patients' digital interaction, our staff's use of the data and data interoperability with other care partners.

Whether we are referring to internal data, data about patients in the wider system, or other external data, we need to be clear what data we have or access and understand its meaning regardless of structure or origin. Data needs to be managed in a composition and location that supports easy, shared access, processing and analysis. Building on the work of our existing Data Quality Team and Data Quality Strategy, we will also use data assurance mechanisms to ensure the data quality is maintained. We need to combine and package data so it can be reused and shared, and provide rules and access capabilities governed through managed and enabling information policies and mechanisms. For example, implementing the analytics capability we describe below depends on having joined up data and common patient records.

In order to achieve this we will need to more proactively manage data throughout its lifecycle:

- Identify data needs of the organisation and understand its meaning;
- Store and protecting data to support easy, shared access and processing;
- Provision and package data so it can be reused and shared;
- Process, move and combine to provide a unified consistent data view
- Continually improve the quality of data including accuracy, timeliness, relevance and acceptance of definitions; and
- Govern with clear and supportive mechanisms for effective data usage.

The matrix below outlines a data and analytics best practice maturity model. We can map our current capabilities against the different grades, outline the level of maturity we require, and create a plan to achieve that goal. It is recommended that a full assessment be done as part of strategy implementation, however an initial view is that in most cases we would currently be at the "Developed" level, with an ambition to progress to "Advanced" and in some cases "Optimised" within the lifetime of this strategy.

	Basic	Developed	Advanced	Optimised
 Analytics	Reactive reporting Spreadsheet dashboards distributed via email. Analysts aligned to business functions.	Descriptive analytics Pockets of analytics tools enabling self-service slicing and dicing of data.	Predictive Analytics Automated self-service analytics maintained by a central analytics team	Prescriptive Analytics Productionised analysis of structured, unstructured and real time data.
 Insight	Insight limited to describing what happened	Insight used to inform decision makers <i>why</i> something happened	Analytical insight used to <i>forecast</i> what <i>will</i> happen	Actionable insights inform what <i>should</i> we do?
 Culture and Operational execution	The importance of analytical insight is understood but the culture is <i>resistant</i> to take advantage of the insight	Limited business decisions using analytical insight to improve operational efficiency	Decision makers are <i>well informed</i> with proactive insight from analytics, and <i>capable of acting</i> to maximize resulting business value	Business processes <i>continuously adapt and improve</i> using analytical insight in-line with strategic business goals
 Architecture	Some coordination or integration between systems in an ad hoc fashion. Some duplicate data across systems	Enterprise tools implemented to <i>manage</i> data. Analytics are defined and have been applied in certain areas	All core data managed through central tool with <i>partially integrated</i> systems	All core data managed through central tool with <i>fully automated integration and provisioning</i> across systems.
 Governance	Some or no awareness of data issues and need for data governance	<i>Wider awareness</i> of need for data governance and data quality with corporate initiatives	A governance model that <i>delegates</i> responsibility for data quality <i>embedded</i> within <i>everyone's</i> role	<i>Fully integrated</i> governance and culture of fully managed information and data quality

As well as continuing to develop and evolve our Business Intelligence (BI) capability we need to recognise that there is likely to be step change in the volume of data being handled across the organisation as well as the ongoing demand for analysis and insight of that data. We will therefore need to ensure that the capacity of our BI team reflects the demand from the wider organisation. We will also need to ensure that as much of our regular reporting and analysis is automated where possible to further increase the capacity of the team.

6.2.2 Advanced Analytics and Access to Decision Support

Pillar 6: Build an advanced data and analytics capability

We will:

- Better exploit our data - developing our tools and infrastructure for Business Intelligence, applying advanced analytics such as forecasting and machine learning, and producing accessible information to support decision making. This will improve the quality of decisions made in the Trust – all the way from the individual patient to the boardroom

We have been evolving our business intelligence and analytical modelling skills for a number of years, and are well practiced in gaining insights through sophisticated modelling approaches and crafting and communicating a story from qualitative and quantitative information. A variety of daily decisions are already enabled by the wide availability of our data and due to the work we do with other non-technical teams to facilitate the interpretation of the wealth of this data.

Our core capabilities in analytics are shown below:



Benchmarking



Horizon scanning



Intelligence, reporting and predictive modelling



Performance and demand management

By continuing to develop this analytics capability we can:

- Gain insights from data and identifying trends;
- Manage care delivery in near real time;
- Develop evidence-based recommendations to drive improvements in the effectiveness or efficiency of care; and
- Shape the design of future services.

This capability will provide feedback within the organisation to both improve operational performance and provide clinical decision support. It will also be potentially relevant externally – for example, providing feedback to commissioners to ensure alternative pathways are in place and functioning.

Looking to the future, there is much that can be learned from industry leaders in the analytics arena, from financial to retail sectors. Some examples of service and service-user improvements achieved from analytical insight which are applicable in a healthcare setting are shown as follows:

Demand management	Disney is a pioneer of customer satisfaction and demand management, monitoring demand in real time and dynamically deploying resources where they are needed to manage the customer experience. Disney also use this insight strategically to forecast for the future and to determine capacity. <i>The transferable learnings here apply not only to our mission of being a high quality service provider, but in understanding the pathway and full system experience of our patients, incorporating real-time information (e.g. weather) and social contexts (e.g. tourism, demographics and economy).</i>
Performance management	Many household-name supermarkets and retailers have experience in performance management and understanding the equity of their service provision. They make use of innovative analytical techniques to monitor data and recommend improvements in specific areas. <i>It is important to us that new models of care are equitable and managed effectively to provide the best care to patients across London. Intelligence and insight will be produced by our in-house business intelligence and data science teams.</i>
Service-user satisfaction	Businesses such as British Airways and John Lewis are renowned for their customer satisfaction scores and service quality. Analytics are a pivotal part of informing business strategies in these companies. <i>As an emergency care provider, we support and serve the population of London in their greatest moment of need. We can use insight from the evaluation of patient and staff satisfaction to recommend ways to improve. This branch of analytics is essential for helping us to understand which efforts lead to positive service experiences.</i>
Personalised service	In the finance sector many companies generate marketing based on intelligence from customer data and target specific individuals with products and services they believe will be most useful/relevant. <i>Applied to healthcare, this means using ensuring that we: understand our patients' needs by using business intelligence and analytics to make accurate predictions; and respond to patients in the most appropriate way, referring them to the right care pathways. It can also mean creating more effective media campaigns to inform the public, and evaluating the impact they have made.</i>
Centralised intelligence	The Ministry of Justice has a Data Lab that generates evidence for change. The Department of Health provides guidelines for employing analytics and making use of insight and expertise. And NHS Digital has established a centre of excellence in big data and data science. <i>We aim to enhance our own in-house capabilities, from what is already a sound base, to increase the value that we add from analytics and statistical modelling to support our staff, our commissioners, and other providers of emergency care across London to care for patients.</i>

Having analysed the data, we must then empower our people with self-service and environmental intelligence via automated, interactive dashboards – as well as, where appropriate, making these tools available to our partners for viewing and exploring data. This will allow us to ensure a standard approach to organisational analysis through the use of templates and formal processes, provide value adding insight from consolidated data sources and operational systems, and enable the delivery of dynamic self-serve information. Typical tools and their benefits include:

Reporting:

- A key benefit of interactive reporting is enabling consumers to become detectives through dynamic views and filtering.

- Providing users with the ability to drill down into the details allows them to leverage their domain knowledge to drive the line of questioning.
- This reduces friction allowing insights to be uncovered in a more efficient and effective manner.

Analytics:

- Once an issue or opportunity has been discovered, interactive analytics provides visibility on actions available and their predicted impact.
- Simulations and predictive models can have their assumptions updated as new information comes available, and testing can be run to determine impacts on key performance indicators under different scenarios.
- This combines the creativity of experienced users with the computational heavy-lifting of artificial intelligence.

6.2.3 Data Capabilities and Culture Transformation

Pillar 6: Build an advanced data and analytics capability
<p>We will:</p> <ul style="list-style-type: none"> • Transform our ways of working within the Performance directorate. To achieve this step-change we will need to change our culture, and develop our workforce and the capabilities of our digital team of the future to support organisational change

We already have a well-established and trusted analytics team, who ensure an efficient flow of data insight, and support decision makers with reliable evidence-based intelligence. Our business intelligence analysts and data scientists are able to understand the impact of interventions on the system, use statistical and mathematical modelling to make predictions, determine relationships between system elements or services, and model “what-if” type scenarios. The strength of such a team is that the models built can be designed to be generic and reusable – bringing efficiencies and cost savings, compared to ad-hoc pieces of analysis being carried out.

To achieve this step-change we must consider changes to our operating model and culture - to achieve our digital transformation, and develop our workforce and capabilities. *Appendix C – Digital and Data Operations and Culture* provides examples of best practices for developing the capabilities and operating model of the data and analytics team. These would need to be further considered and customised for LAS as part of the strategy implementation work. This change will need to be part of the wider culture change and transformation within our organisation as a whole, gaining buy-in at all levels – for example in terms of the type of work, prioritisation of resource, and frequency and scale of requests made of the teams.

6.3 Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

Under our new strategy, the scope of support provided by digital, data and technology to the organisation is set to significantly expand. Initiatives in other areas, such as HR, Rostering, Training, Estates, and Asset Management, will require substantial elements of new technology systems with consolidated, structured and linked data to enable enterprise wide informational views of performance, issues and decisions. We need to embrace modern ways of working – allowing our people to work remotely where appropriate and taking advantage of technology innovations to help us perform our roles.

6.3.1 Modernised Business Systems

Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

We will:

- Modernise our internal business systems to support more efficient ways of working and the wellbeing of our staff. New robust systems will ensure that we can run our organisation more efficiently, properly train our people, and be able to manage a more complex fleet and multi-skilled workforce.

In many cases our internal business systems have been neglected and are no longer fit for purpose to support a modern organisation. Today many processes are manual, whole rooms are dedicated to the storage of paper records, and our people struggle to find the information they need to do their jobs. These outdated internal systems do not provide us with the agility needed to support organisational transformation and change.

Furthermore, once these basics are addressed then new systems can help to remove drudgery from our daily tasks, modernise our ways of working, and give new insights into operational performance and efficiency

The following areas are anticipated to require substantial elements of new IM&T systems, information management and analytical support – including implementation of new systems and/or formal management of suppliers and SLAs:

Human Resources

- ESR - Continued delivery of ESR transformation programme and developments
- Access and storage of training records
- Staff engagement platform

Strategic Assets

- Asset Management (Fleet & logistics)
- Computer Aided Facility Management (CAFM) software
- Ready set go (medicines management)
- Integration of data to achieve better utilisation of assets, using black box technology in ambulances to review road traffic accidents as part of the driver safety systems, fuel monitoring
- Consumable tracking and distribution in a similar fashion to medicines
- electronic fault tracking of vehicles
- asset management systems for predictive maintenance regimes for buildings and vehicles
- improved utilisation of support services workforce and assets through demand modelling

Finance

- Procurement Systems
- Service Line Reporting

Clinical Quality

- Quality Assurance

Leadership

- Corporate Risk reporting
- Enterprise Programme and Project Management software

Communications

- Collaboration tools and intranet

6.3.2 Flexible Working

Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

We will:

- Enable flexible working for our people. The majority of our staff are mobile and we have other pressures such as costly estate which means we should be more flexible in where and how our people can work.

The majority of our staff are mobile and those not mobile are currently dispersed across some 80+ locations across London. There are also other contributory pressures, such as a costly estate, 24-hour working, high London travel costs, and increasing demand which combined with this means we should be more flexible in where and how all our people can work. This will also help us to be an employer of choice to our staff who live the rest of their lives largely in a digital world.

This drives us to look at solutions such as mobile and cloud for technology services and access to information. We will need to progress initiatives such as seamless yet secure remote access to both internal and cloud services, collaboration tools, video conferencing, mobile devices, home-working, staff intranet etc. – so that our people are equipped for a modern, flexible and supportive work environment.

6.3.3 Innovation and Culture

Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

We will:

- Be bolder and more innovative in our use of technology - to the benefit of Patients and the Public, Our People, and Our Partners. We need to take advantage of the opportunities which technology innovation can bring - putting in place processes to support innovation, whilst balancing the potential benefits against the risks inherent in providing a safe and efficient service

Over and above our day-to-day operational imperatives, our ambition is to be more innovative in exploring new technology, and faster at adopting that which is beneficial. Possible areas which appear promising at present include: devices (e.g. drones, wearables), intelligent infrastructure (e.g. vehicle sensors, connected buildings), and artificial intelligence and analytics. *Appendix E – Emerging Technology Trends* provides more information about these topics. We need to put in place processes to trial and adopt new technologies which can drive operational productivity and provide world class care for our world class city.

7 Delivering Our Strategy

Delivering our strategy will require us to implement significant programmes of change in the areas of Digital, Data and Technology. This section sets out what needs to be done and provides a roadmap for delivery.

7.1 Delivery Approach

Delivery of this ambition for digital, data and technology transformation at LAS will require a programme of work which:

- Is multi-year, phased, and prioritised
- Balances the need for strategic transformation with “getting the basics right” in terms of the ongoing demands of operational maintenance and the development of internal business systems
- Combines internal delivery projects with partnership working and external programmes of work from the wider system
- Embeds technical delivery within a wider transformation context of staff training and organisational change
- Can flex to incorporate new technologies, changing priorities and wider system transformation

The roadmap diagram in this section summarises the approach. It shows how over the next five years we will need to deliver our strategic transformation whilst at the same time progressing essential work on the basics. Working with partners is not a separate activity but rather an intrinsic part of everything we do – as are innovation and driving efficiency.

7.2 Delivery Programmes and Projects

7.2.1 Governance and Prioritisation

The Trust’s business planning and delivery processes, under the stewardship of the Trust’s Programme Management Board (PMB), will tie delivery programmes to the transformation agenda set in the Trust and Digital Strategies. With delegated responsibility from the Executive Committee for delivering the Trust’s programmes, and in conjunction with the Logistics Infrastructure Committee, the detailed phasing of investments and benefit delivery will be shaped through the PMB’s more refined management and assessment of competing priorities and urgencies.

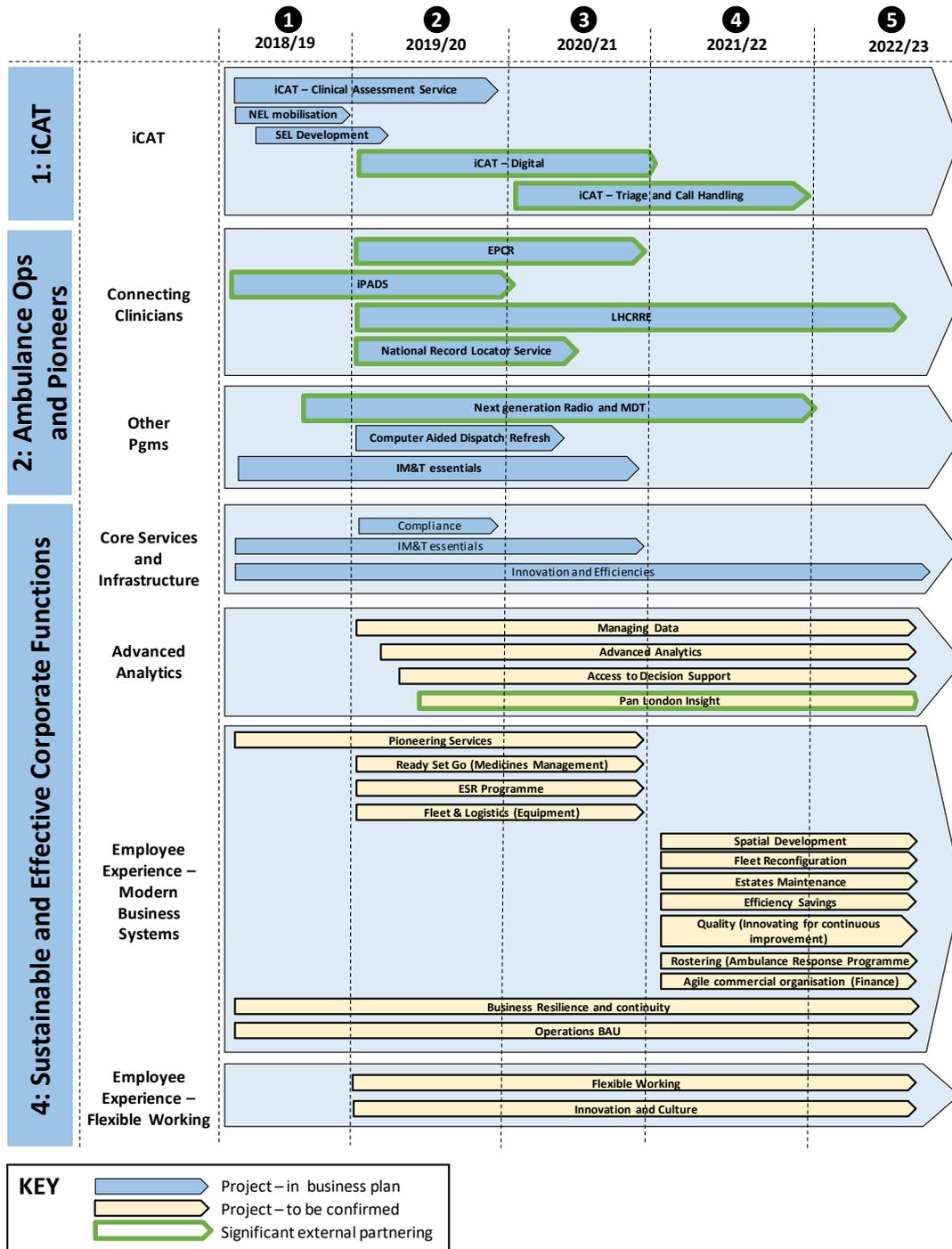
The level of change and investment required is a risk to the delivery of the Strategy. Whilst this risk will need to be balanced against other competing Trust Priorities, the digital transformation of the Trust is vital to the delivery of the Trust’s Strategy. More agile delivery models, such as building on our use of Crown Commercial Service managed service and delivery arrangements, and leveraging delivery from partnership and national initiatives must be explored to help mitigate this risk along with proactive pursuit of external funding opportunities.

A significant input of broad executive leadership and management attention will be vital throughout the period to drive the Trust’s digital transformation and the required levels of activity and change at the desired pace.

7.2.2 Roadmap

The diagram below develops the approach into a roadmap for change. The prioritisation and funding of internal delivery projects is managed via the LAS Business Planning process, and

in line with this process, the next 3 years are relatively firm with the roadmap also providing an indicative view out to 5 years. The following sections then summarise - for each of the themes - the programmes and projects needed to take forwards delivery of this strategy.



7.2.3 Strategic Theme 1: iCAT

The Clinical Assessment and Triage (iCAT) programme will integrate our services and transform LAS towards a more sustainable model of combined Urgent and Emergency care. This includes offering advanced and integrated infrastructure for call-taking, triage, clinical assessment, and onward referral. Thereby clinically personalising the service we provide to our patients based on their history, preferences, and on swift evidence-based decision making, increasing “Hear and Treat” and “See and Treat” capabilities, and reducing unnecessary completion. Where

referrals need to be made, these will be supported by access to the directory of services which is a live resource providing information on appropriate care pathways, suited to individual patient needs.

As at the latest business planning iteration the programme comprises the following workstreams:

iCAT	iCAT - Clinical Assessment Service	<i>Create a single Clinical Assessment Service for the Trust that is accessible by 999 and LAS operated IUC services.</i>
	NEL Mobilisation	<i>Mobilise the North East London Integrated Urgent Care (111) contract</i>
	SEL Development	<i>Transforming the South East London 111 service into an Integrated Urgent Care service</i>
	iCAT – Digital	<i>Develop and implement Digital and IT solutions supporting the target operating model for the iCAT 3, including integrated queue across 111 and 999 services. Patients will be able to access our services via a unified platform across telephone, the web, apps and common text and video messaging platforms</i>
	iCAT - Triaging and Call Handling	<i>Create a single contact handling centre bringing together 111 call centres and 999 EOC.</i>

7.2.4 Strategic Theme 2: Ambulance Operations and Pioneer Services

The Connecting Clinicians programme focuses on supporting our clinicians in the field. More than for any other healthcare provider in London, our work depends on effective mobile technology. Connecting our clinicians will bring huge benefits for our staff, for the London healthcare system and to patients. It will be a complex multiyear programme that will transform how the London Ambulance Service, providers, commissioners and other key stakeholders, manage and share clinical information:

- Investing in new technology infrastructure that will support our transformation as an organisation – both within our operations centres and within our vehicles
- Rolling out tablet computers to our front-line clinicians that will provide digital connectivity including location-aware directories of local pathways and access to e-learning.
- Upgrading the mobile technologies available to our staff. For example, roll out of the ESN / Airwaves / Ambulance Radio Programme, roll out of iPads to our front-line clinicians, provision of Garmin SatNav, and Mobile Data Terminal (MDT) upgrades.
- Migrating from paper to a digital clinical records system that integrates with the wider London healthcare system encompassing an electronic patient report form, access to the NHS spine, summary care records, Local Health and Care Records Exemplar, National Record Locator Service, special patient notes or 'Coordinate My Care' and seamless interoperability with the CAS.
- Introducing additional clinical decision-making support tools and better access to advice and support from the CAS will help our staff to provide better care at scene and prevent unnecessary completion to hospital.
- Engaging with technologies that provide tools for healthcare professionals. These include the capacity to access other professionals' expertise, tools to prioritise and manage their clinical workload and tools to identify the patients at greatest risk.

- In addition, work is planned on the Ambulance Radio Programme, Computer Aided Dispatch, and IM&T Essentials which will improve our core ambulance operations, including our ability to dispatch, route, and communicate with response vehicles.

As at the latest business planning iteration the relevant programme workstreams are as follows:

Connecting Clinicians (Health Informatics)	EPCR	<i>Implement a new comprehensive electronic Patient Care Record (ePCR) that records digitally our patient interaction and shares that information with other relevant organisations such as a patient's GP and care providers that we convey patients to</i>
	IPADS	<i>Builds on the roll out of iPads to our front-line clinicians to provide ambulance crews with up-to-date information about patients and other capabilities which will inform better decision making and improve interoperation with care partners.</i>
	Local Health and Care Records Exemplar	<i>In London, we are collaborating with regional health and care partners to become a Local Integrated Care Record Exemplar. This means that London will be one of the first regions in the country to benefit from full interoperability</i>
	National record locator service	<i>The creation of a National Record Locator Service "acts as a national index to be able to find out what records exist for a patient across local and national care record solutions (such as SCR)."</i>
Ambulance Radio Programme	ESN / Airwaves / Ambulance Radio Programme	<i>Integrated Communication Control System (ICCS). Use of secure national mobile data network</i>
Computer Aided Dispatch	CAD refresh	<i>CAD enhancements and hardware refresh and/or a CAD replacement</i>
IM&T Essentials	MDVS	<i>National MDT replacement scheme</i>
	MDT / Sat Nav	<i>Garmin SatNav, MDT3 Roll out, etc.</i>
	Telephony (Avaya) – 999	<i>Avaya Telephony Upgrade</i>

7.2.5 Strategic Theme 3: Partners

This theme is somewhat different to the others - in that it is not a programme of work in itself, but rather it defines how we will go about implementing the workstreams described under each of the other themes. There are therefore no additional programme workstreams specific to this theme.

7.2.6 Additional Theme 4: Sustainable and Effective Corporate Functions

In terms of Pillar 5: Sustain and modernise our core services and infrastructure, as at the latest business planning iteration the relevant programme workstreams are:

Compliance	GDPR / Compliance	<i>GDR Compliance and Datix Cloud</i>
IM&T Essentials	Asset Management	<i>Security of Assets - mobile and fixed - Asset tags</i>
	Cyber / Risk	<i>New accredit Security disruptive team. This team will attempt to identify weaknesses within the security of the trust and any new technology.</i>
	Data Centre	<i>Datacentre hardware LAS and Migration of services (inc CAD) to third party ARK</i>
	End of Life Refresh	<i>Refresh technologies, laptop, desktop, servers</i>
	IM&T System Resilience	<i>Resilience enhancements</i>
	System and Network resilience	<i>WAN, LAN, Wi-Fi, Network Enhancements</i>
	Consolidate IT / software across depts.	<i>Understand and Consolidate</i>
	Enterprise Architecture	<i>To introduce an EA capability ensuring services are designed to support the Trust's objectives</i>
	Sourcing solutions	<i>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.</i>
	Innovation and Efficiencies	<i>Improvement /Efficiency / Enablers</i>

In terms of Pillar 6: Build an advanced data and analytics capability, a new programme of work with the following workstreams is proposed. This is currently pending incorporation in the business planning process.

Data and Analytics	Managing Data	<i>Pending incorporation in business planning process</i>
	Advanced Analytics	<i>Pending incorporation in business planning process</i>
	Access to Decision Support	<i>Pending incorporation in business planning process</i>
	Pan London Insight	<i>Pending incorporation in business planning process</i>

Finally, in terms of Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools. The LAS Business Planning process has identified the programmes of business transformation activity listed below. Most, if not all, will require some aspect of technology support. This will be further confirmed as plans in each area continue to be elaborated.

To this we add support for innovation as defined in "IM&T Essentials", plus a proposed new programme to enable flexible working.

Support for Business Transformation (Modernised Business Systems)	Pioneering Services	<i>Business transformation programme</i>
	Spatial Development	<i>Business transformation programme</i>
	Fleet Reconfiguration	<i>Business transformation programme</i>
	Ready Set Go (Medicines Management)	<i>Business transformation programme</i>
	Estates Maintenance	<i>Business transformation programme</i>
	Fleet & Logistics (Equipment)	<i>Business transformation programme</i>
	Efficiency Savings	<i>Business transformation programme</i>
	Quality (Innovating for continuous improvement)	<i>Business transformation programme</i>
	Rostering (Ambulance Response Programme)	<i>Business transformation programme</i>
	ESR Programme	<i>Business transformation programme</i>
	Business Resilience and Continuity	<i>Business transformation programme</i>
	Agile commercial organisation (Finance)	<i>Business transformation programme</i>
	Clinical Education Development	<i>Business transformation programme</i>
	Operations BAU	<i>Business transformation programme</i>
	CQUINs	<i>Business transformation programme</i>
Corporate BAU	<i>Business transformation programme</i>	
IM&T Essentials	Innovation and Efficiencies	<i>Improvement /Efficiency / Enablers</i>
Flexible Working	Flexible Working	<i>Pending incorporation in business planning process</i>

7.2.7 Future Investment Directions

Whilst the majority of the strategy is delivered by programmes already incorporated into the LAS Business Planning process, there are several areas identified which need to be considered for future investment decisions. These include:

Pillar 6: Build an advanced data and analytics capability

- This is the most significant single area for future consideration. Whilst the strategic case for improving our management and exploitation of data has been made, there are currently no programmes in the portfolio to progress this. The activities involved in developing this capability are described under Pillar 6: Build an advanced data and

analytics capability, and this therefore needs to be considered further in the next round of business planning.

Pillar 7: Transform the employee experience through remote working and use of modern and innovative tools

Modernised Business Systems

- There are currently a number of planned and funded transformation programmes in the business plan which are likely to require technology support for enhancements to internal business system. See 6.3.1 Modernised Business Systems for further details. In the next round of business planning the extent of this support needs to be further clarified and the proportion of funding set aside for technology developments confirmed. In the event of a mismatch then additional investment may need to be considered.

Flexible Working

- Whilst the case for enabling more flexible working has been made (e.g. remote access, homeworking), a programme to implement it now needs to be evaluated.

Innovation and Culture

- A provision has been made for innovation, in terms of the “Innovation and Efficiencies” workstream of the IM&T Essentials programme. However given the strength of our ambition in this area this may want to be broadened, and given the inherent unpredictability of new technical developments then the provision may need to be reviewed periodically. This might also encompass taking advantage of new external opportunities (e.g. new initiatives from NHS Digital) as they arise.

In terms of releasing capital, it is worth noting that *Pillar 5: Sustain and modernise our core services and infrastructure* – and specifically the migration towards Cloud – is likely to shift technology spend towards a revenue-based model. This will therefore also be worth reviewing over the next 3-5 years.

7.3 Deliverability

Deliverability of the roadmap needs to be considered from both a financial and also a business change perspective.

In terms of finance we estimate that an investment of in the order of approximately £70M will be required over the next 5 years.

In terms of business change we believe the roadmap to be challenging. It proposes a significant transformation of our patient-facing services at the same time as major internal operational changes and system upgrades. At many points in the roadmap there are multiple major business and technology change programmes running concurrently. This will result in a high rate of change to be assimilated. Recruitment and on-boarding of new team members and/or use of external specialists is likely to be needed to support the activities.

The Trust does not have the internal capacity to deliver this level of change in the timescale set. Increasingly the Trust will need to make better use of managed services, building on our use of Crown Commercial Service frameworks, to deliver desired digital outcomes. A very significant input of executive leadership and management attention will be vital throughout the period to drive this level of activity and change.

It is also worth noting that there is, by intention based on Strategic Theme 3, a high degree of partnership and external dependency in many of the activities. This will again increase the complexity and management attention required to ensure delivery.

Overall therefore we believe the roadmap to be ambitious. Whilst these challenges could be eased by extending the timeline, this would be at the expense of a slower pace of delivery.

7.4 Ongoing Review

The overall roadmap for change therefore consists of actions within LAS and also collaboration with the wider system, and needs to include regular reviews.



LAS Planning
<ul style="list-style-type: none"> • Planning internal investment in key areas where external initiatives do not exist, or where LAS may need to drive the pace of change.
National Planning
<ul style="list-style-type: none"> • Maintaining a portfolio view of National programmes, and working to contribute and influence priority areas for LAS
London Planning
<ul style="list-style-type: none"> • Being fully involved in London-based initiatives such as LHACRE • Working strategically with partners such as Healthy London Partnership to drive implementation in areas beneficial to LAS

It is important to recognise that detailed planning horizons throughout the wider system are often quite short - this reflects the need to react to change, plus the realities of securing funding. New technology developments may also need us to react to change. This represents a risk to delivery, however an agile approach based on regular reviews, prioritisation, and change control can help LAS turn the situation to advantage.

It is therefore recommended to review and iterate the roadmap regularly on a 12-18 month basis

8 Appendix A – What will it mean for me?

This section outlines how the digital, data and technology strategy will impact different stakeholders within the system.



Robert – Ambulance Clinician
Robert is a 36-year-old paramedic who has been working for the LAS for 8 years. Robert attends a patient who requires emergency care.



Mobile Tablets



New Ambulance Technology



Mobile Devices

Mobile Tablets



Access to records – Robert will have access to patient records en route to the incident. He will be able to identify existing conditions, care plans, patient specific protocols and other pertinent information directly on his tablet.

Access to ePRF - Robert will be able to record patient details on his tablet. This will remove lengthy paper procedures with pre-populated forms, enable quicker handovers, improve patient information security, and allow easier referral to iCAT. Information will automatically upload to the wider system removing the duplication of effort when the patient arrives in hospital.

Access to NHS Services – Robert will also have real time awareness of other NHS services available, such as GP surgeries or urgent care appointments. He will be able to handover patients not requiring emergency care to other services much more efficiently. Patient information can be shared with other care agencies and contribute data back into urgent and emergency care records.

Remote access to internal tools – Robert will be able to access internal applications to keep him connected to the LAS system even when on shift. Email, learning materials, and other HR functions will all be readily available. There will also be a tool for Robert to understand his patient's outcome, creating a full reflective loop and will enhance clinical learning.



New Ambulance Technology

New and improved equipment - Robert will have access to improved hand-held radios and wireless data networks. This will allow him to effectively communicate with other healthcare professionals and treat or convey patients more efficiently. Smaller, lighter, and smarter equipment will also be available. Unmanned drones could be used to deliver blood, specialised equipment, and medicines to paramedics in congested areas.

Wearables – Robert can use wearable monitors or temporary patches on vulnerable patients. The technology will monitor vital signs of deteriorating health to alert healthcare professionals before an Ambulance is required. This will prevent hospital conveyance if patients can be treated before an emergency.



Mobile Devices

Robert will be able to use video cameras, with patient consent where necessary, to video the patient's conditions and communicate with iCAT to provide an enhanced patient assessment. Better decision support will be available to provide the most appropriate treatment for the patient.



Dan - 999 Call Handler
 Dan has worked as a call handler in the LAS for 2 years.



Access to iCAT
 Smart call handling



Remote working



Access to iCAT

Dan is now part of the professional clinical expertise to treat patients. He will be able to implement ‘hear and treat’ and “see and treat” approach to effectively care for patients, potentially mitigating the need for an ambulance.



Remote working

IM&T will enable Dan to access the calling system through a login on his home computer. This new way of working will enable staff to work more flexible hours and can work at short notice if there is a surge in demand.



Smart call handling

Dan will have access to smart call handling systems which will provide new ways to manage queues, triage, accurately dispatch, and provide clinical advice. Caller ID will be able to identify frequent callers and provide access to patient records. The additional patient information will accelerate the triage process.

Machine learning could be used for binary questions such as ‘is the patient breathing?’ before passing onto a call handler. This will reduce repetition for Dave and allow him to use his professional expertise to triage complex patients.

Dan will also have access to specialist services (e.g. falls, maternity) to support his triage decision. There will be feedback on patient outcomes to notify Dave on his performance for an enhanced learning experience.



Helen - Patient
 Helen is 60, retired, and lives alone. Whilst gardening she has a fall, fears she has broken her ankle, and has called for an ambulance.



Automated wearables



New Digital Channels

Mobile Devices



Automated wearables

Helen could use new wearable technology to monitor her health. This will notify her GP if her health deteriorates and prevent admission to A&E through early treatment.



New digital channels

Helen can call for an ambulance through her smartphone or tablet to suit her needs. She has her smart phone in her pocket in the garden so she dials 999. Using the camera she can video her ankle and show the call handler her symptoms. This allows the clinical assessment team to visually assess her ankle, providing them with more information to accurately triage and dispatch the falls team.



Access to patient records

When the falls team arrive, they already know her medical history and current medication. This allows Helen to be treated much more efficiently. The paramedic will be able to digitally collect her details removing repetition within the system and as a result improve patient experience. Once Helen is treated, her notes from the visit are recorded and can be shared across healthcare services including her GP and social care. This integration of care will better support her recovery.



Laura - Trust Corporate Staff

Laura is part of the data and performance team and has been working for the LAS for 5 years.



Access to more collaborative and integrated data



More efficient tools



Innovative analytics and more efficient tools - Laura has access to efficient data storage tools to accurately collect and record data; can follow best practice protocols for defining, extracting and analysing the resulting information; and has a robust and user-friendly interface to allow her to explore and manipulate the data in an effective and intuitive manner. All this means she can now provide deeper, more targeted insight for EOC and sector level operations, and can also support scheduling, fleet, workforce and various corporate teams. She is able to react in real-time to operational demands and request using pre-defined dashboard templates and visuals, saving her time and ensuring reproducibility of the request again in future.

With more efficient systems, Laura now has more capacity to be able to build cutting edge, bespoke dashboards and visualisations for internal and external stakeholders. Thanks to the implementation of a market-leading BI software package, Laura is able to provide assistive tools to staff across the organisation, helping them tackle a wide range of different problems from mental health to recruitment. This helps senior managers identify the impact of their operational and strategic decisions much more interactively, enables evidence-based decision making throughout the organisation, and also helps enhance the analytics capability and understanding of data across the Trust since staff are able to explore the information freely themselves.



Access to more Collaborative and Integrated Data - Laura can provide greater operational insight to drive and improve performance because she now has access to wider healthcare system data, including feeds from London Emergency Departments. This link means that Laura can generate information that influences decision making and helps improve patient care through models which help predictively identify the more appropriate patient pathway based on intel for that individual. This has a real positive impact not only on the LAS but on the wider healthcare service in London in terms of operational and cost efficiencies, but more importantly by getting the patient the right care first time.

Laura can build more intelligent, informed forecasts for the busiest periods in the calendar, including winter and Bank Holidays, thanks to collaborations with other industry partners across London. For example, access to shared weather forecasts enables Laura to prepare for extreme weather in a connected way, and can suggest periods of risk or identify hotspots of demand to be targeted with plenty of warning for actionable plans to be put in place operationally. Repetitive work can be automated, so Laura can spend more time on prescriptive analysis and driving change within the organisation. She will also be able to log in to her home device and access analytical tools. This will allow her to work more flexible hours.



Rachael - Senior Manager
 Rachael regularly interfaces with internal and external stakeholders.



Interoperability



Improved decision making

Interoperability



Rachael now has access to linked up data between the LAS, CCGs, and hospitals, allowing her to hold informed discussions with stakeholders about appropriate pathways, new services, equity in provisions and areas for improvement, allowing collective thinking of solutions and more intelligent decision-making benefitting patient outcome and improving Trust KPIs.



Improved Decision Making

Access to interactive platforms which portray key data and information in a clear, visual way at the click of a button, enables Rachel to communicate the relevant information at real-time, enhancing the quality and timeliness of decision making to impact positive change. This also helps share the more subtle elements of intelligence which are not always obvious through the raw data alone, and helps educate not only regarding the LAS operations, but also enhances analytics thinking and understanding within corporate departments. Improved access to data enables Rachel to help build a culture where decision making is evidence based.



Sam – Digital Developer
 Sam is a member of the LAS IM&T team who creates new technology and tools to improve patient care



User centric development



More efficient operations



Building new capabilities

User centric development



Sam can see the full impact of her work by co-producing new digital tools alongside the clinicians and operational teams. This creates a real sense of working satisfaction.

Building new capabilities



Sam is able to build her capability as she can work functionally across LAS beyond the borders of IM&T. She will be working in a professional healthcare informatics environment that is applying world class leading best practice and developing valuable skills for her and the Trust.

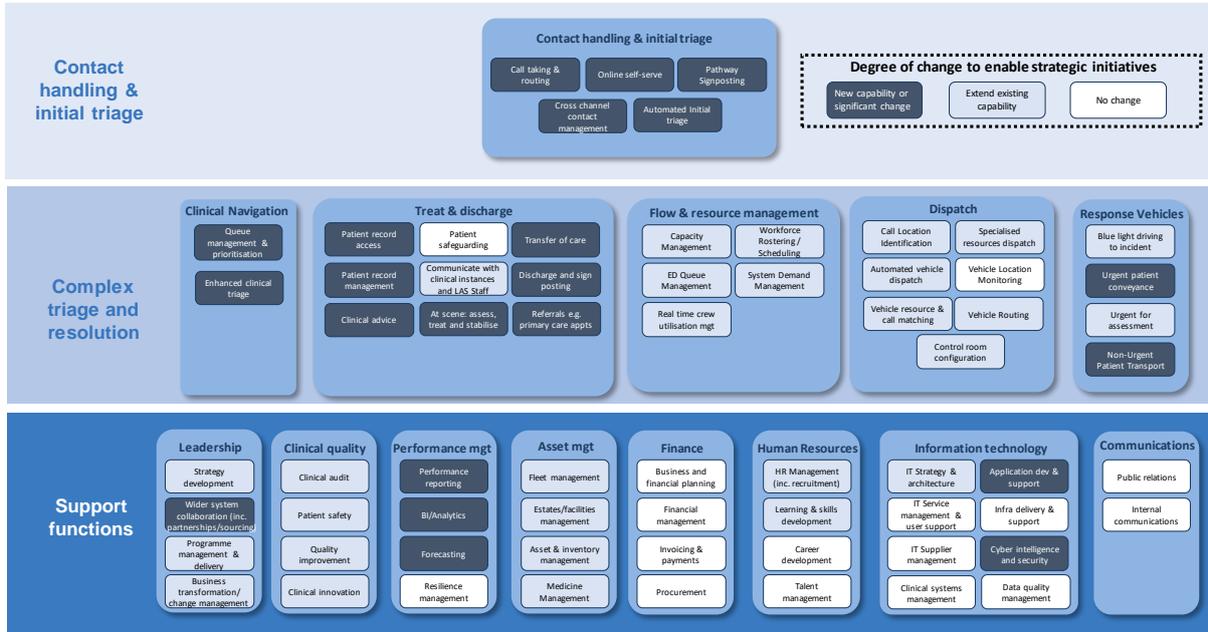
More efficient operations



Sam is able to work with the latest technologies including machine learning and testing the capability of drones. This freedom will encourage and drive forward the use of technology within the NHS. With new and improved IT systems such as the cloud, there will be less time spent on troubleshooting and solving technical issues, but on more time for innovative thinking.

9 Appendix B - Business Capabilities Map

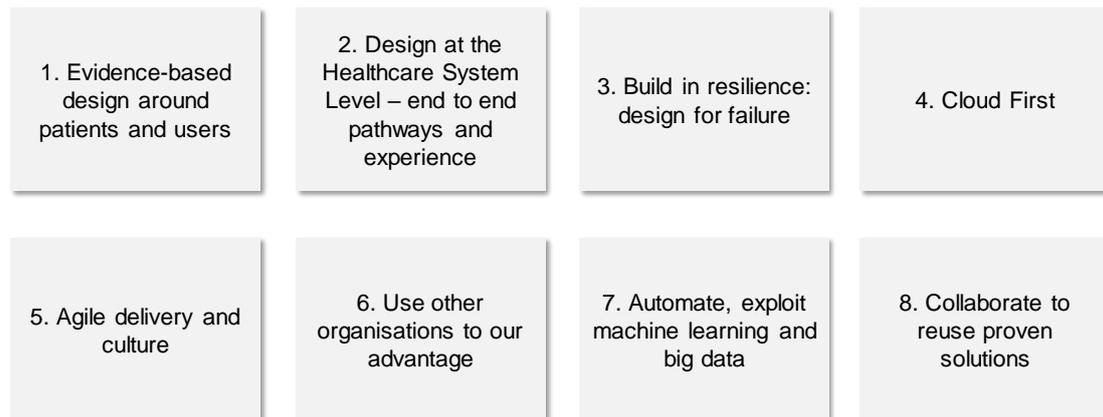
The challenges and opportunities faced by the trust around Digital, Data and Technology are further illustrated by the Business Capabilities map below. This highlights the strategic organisational change required. Extracts from this map are used throughout the document, specifically when we look in more detail at each strategic theme and further examine how digital, data and technology can enable the development of these new business capabilities.



10 Appendix C – Digital and Data Operations and Culture

10.1 Principles for Digital Operations and Culture

In order to meet the challenges of a modern, digital enabled organisation we will need to continue to transform the way that we work within IM&T and Data, Analytics – building the digital team of the future. The following design principles will be used to shape our strategy delivery:



1. Evidence-based design around patients and users

Design starts with identifying user needs. In order to identify needs we will conduct research, analyse data and talk to users. Services that are designed around users and their need are more likely to be used, and cost less to operate by reducing time and money spent on resolving problems.

2. Design at the Healthcare System Level – end to end pathways and experience

The ambition articulated by the Trust's Executive Leadership Team is to undertake a significant transformation of the London Ambulance Service over the coming years. In summary this is about becoming an urgent and emergency care provider integrated with the wider healthcare economy so that the overall system becomes more than the sum of its unlinked parts.

3. Build in resilience: design for failure

Delivery of the Trust's priorities relies on the continual effectiveness and resilience of supporting technology services. A major factor for any Ambulance Service is the need to provide stable systems. Interruptions can hugely impact on Trust performance and patient care. The utilisation of our service is significantly higher than other parts of the country (LAS crews are utilised for over 85% of their time, whilst in other parts of the country this is more likely to be 65%). This overall constant pressure with little headroom, and the need to provide service resilience to increasing demand and internal and external threats contributes significantly to the Trust's increasing reliance on IM&T services.

4. Cloud First

We want to focus our time doing value adding activity, rather than developing proven solutions that are available on the market. Cloud is a key underpinning of agile and automated delivery. It facilitates automated testing and software upgrades that can make services more resilient. It also manages large changes in demand more effectively, and can be more effective in the use of mobile devices and remote access. In 2013, the UK

government introduced a 'Cloud First' policy for all technology decisions. As the world of cloud technologies continues to accelerate, IM&T should absorb new developments and best practice.

5. Agile delivery and culture

The expectations on our service will keep growing at a fast pace. We need to be able to easily respond to changes in policy and IM&T needs to make sure that services keep meeting user needs, whilst delivering at a lower costs. Agile methods can help us to build services and platforms that:

- Meet the needs of our users
- Are adaptable to scope or policy changes
- Cost less
- Have lower defect rates
- Reduce the time to release new features or to deliver working software
- Keep improving, based on user feedback

6. Use other organisations to our advantage

We can accelerate benefits realisation by collaborating/partnering with other organisations. This will help focus our current capacity on value adding activities. By leveraging external suppliers to provide services where no internal advantage, or no committed investment we can get the benefits of efficiency and economies of scale.

7. Automate, exploit machine learning and big data

The services delivered by LAS range from those that are driven by routine and repetitive processes through to services that require human intervention. In both types of service, the quality and cost of what we deliver can be improved through automation. The same challenge is being taken up by NHS England who have clearly identified the need to use the skills, techniques and solutions around robotics and business process automation to drive productivity and efficiency gains throughout the system.

8. Collaborate to reuse proven solutions

The synergy effect stemming from shared platforms and capabilities with other Healthcare and Emergency Care providers is large. For example, information and data shared appropriately across organisational boundaries without loss of integrity, reduces the need to hold duplicate data and supports efficient service delivery.

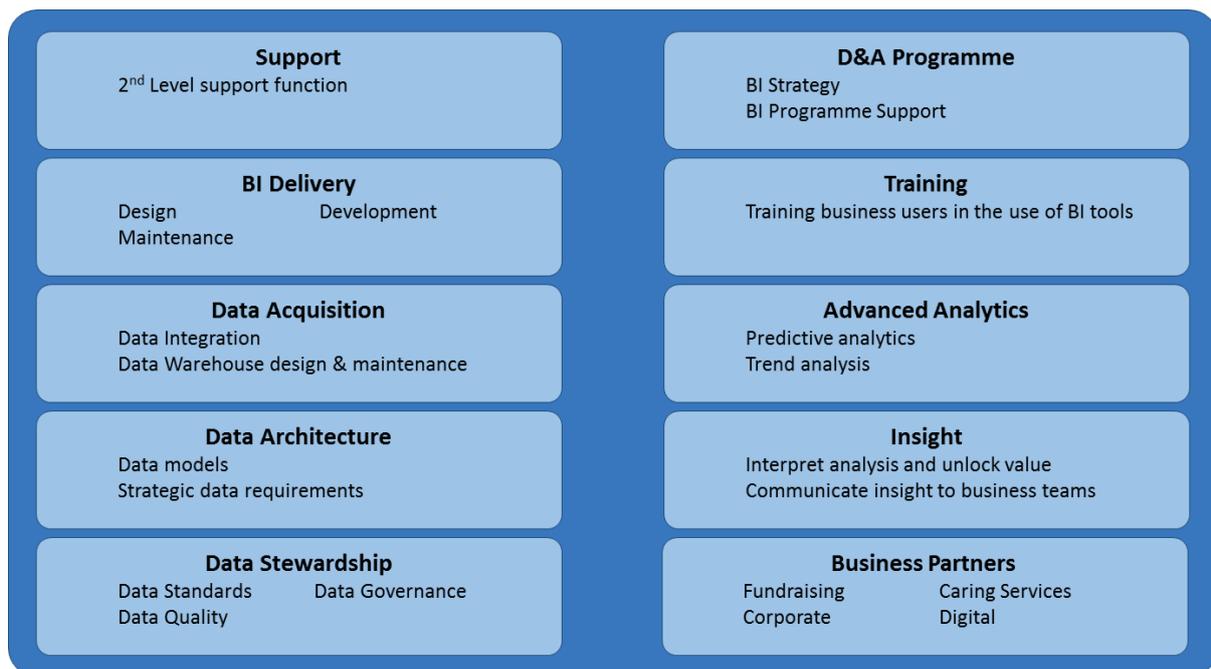
10.2 Data and Analytics Operations

In order to create a successful data and analytics team, there are some best practices and capabilities that should be applied. Examples are provided here for reference - these would need to be further considered and customised for LAS as part of the strategy implementation work.

The matrix below highlights that the people, process, and technology are all key parameters for a functional team.

	Basic	Developed	Advanced	Optimised
People	Inconsistent behaviours and outcomes. Poor communication and ad-hoc coordination	Development of plans for team and individual improvement. Some shared decision making	Building trust among team members. Conflict resolution strategies. Collaboration, shared decision making.	Alignment – executive and employee buy in. Accountability. Effective knowledge sharing and individual empowerment
Process	No formal process. Awareness that processes are necessary but few activities are defined and success is dependent on individual effort	The process is documented standardised and integrated within an organisational wide methodology	Detailed measures of the process and output quality are collected. The process and products are understood and controlled	Continuous process improvement is enabled by qualitative feedback of the process and from piloting innovative new ideas and technologies
Technology	No formal strategy or execution on technology investments. Basic reporting tools no formal infrastructure hardware or software standards.	Desktop hardware/software standards defined. Some infrastructure standardisation and rationalisation.	Formal infrastructure standards. Formal management process/tools architecture aggregated capacity management	Proactively promoting new technologies and impact to business

The diagram below illustrates the typical functional capabilities which a Data and Analytics team will need to develop:



1. **D&A Programme** - The D&A programme function oversees and coordinates all of the activities the Data & Intelligence team. The D&A programme function defines D&I objectives and strategy and tracks the success of that strategy over time. Business users can get advice and coaching on how to use D&I analysis and interpret the results. The D&A programme function also acts as the project office for all BI related projects.
2. **Data Stewardship** - The Data stewardship function is responsible for data standards, data quality and data governance.
3. **BI Delivery** - The BI delivery function oversees the design, development, testing and maintenance of self-service dashboards and all other applications that transform data into BI.
4. **Support** - The support function acts as the second-level support for BI problems. The support function analyses the problem in detail and gets back to the user with a solution. If a solution cannot be solved in-house it is passed to the software vendor.
5. **Data Acquisition** - The data acquisition function handles the back-end data activities. It takes care of data integration and data store development, testing and maintenance as well as the overall warehouse design.
6. **Advanced Analytics** - The analytics function specialises in statistical analysis, modelling and forecasting to discover previously unknown patterns and make predictions about the future. It handles complex analytical requests from the business that can't be answered using self-serve dashboards.
7. **Insight** - The insight function puts context around the analytics to develop understanding and enable the business units to make informed decisions.
8. **Training** - The training function trains business users in BI concepts and applications. It provides coaching and BI product specific training and certification.
9. **Data Architecture** - The data architecture function designs data models, provides a standard common business vocabulary and defines strategic data requirements.
10. **Business Partners** - The business partners are part of the business units with 'dotted line' reporting to D&A. They act as a bridge between the business and the D&A team. They undertake analysis of data relating to their area of expertise.

11 Appendix D – External Opportunities

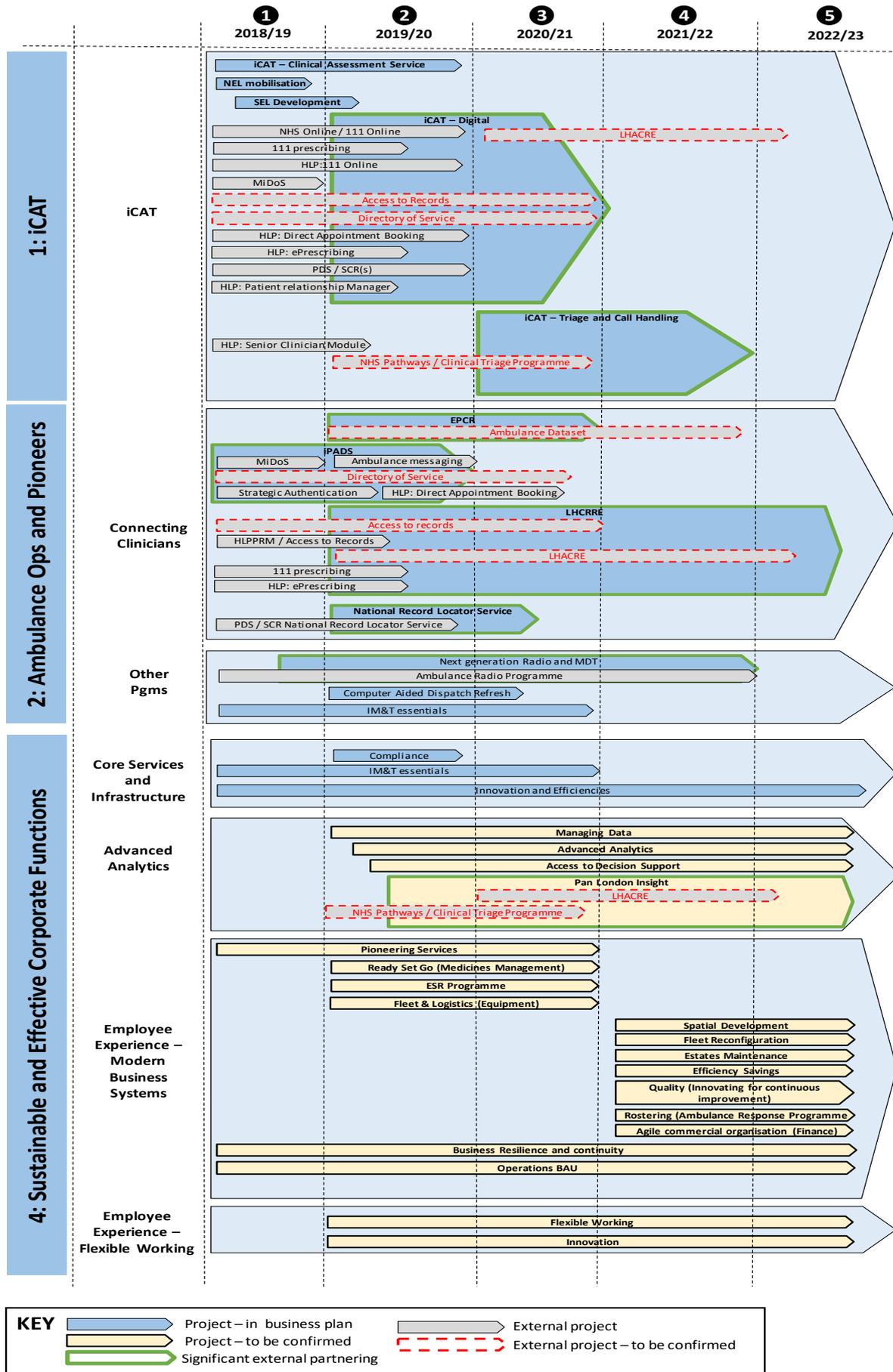
The tables below “pair” these external opportunities with the internal projects within LAS which appear best placed to incorporate their outputs.

Connecting Clinicians				
Internal Programme	Internal Project	External Programme	Partner Organisation	Relevance
Ambulance Radio Programme	ESN / Airwaves / Ambulance Radio Programme	Ambulance Radio Programme	National: Emergency Services	Upgraded connectivity for ambulances
Connecting Clinicians	EPCR	Ambulance Dataset	National (NHS Digital)	Standards for data required from an EPCR
	IPADS	MIDoS	Regional: Pan-London	Service information within London
		Directory of Service	National (NHS Digital)	Accuracy, Availability, Access, and Appointment Booking
		Strategic Authentication	National (NHS Digital)	Secure logon mechanisms for mobile working
	National record locator service	PDS / SCR(s), National Record Locator Service	National (NHS Digital)	Discovery and access to patient records
	Local Health and Care Records Exemplar	Access to Records	National (NHS Digital)	Discovery and access to patient records
		HLP: Patient Relationship Manager / Access to Records	Regional: Pan-London	Discovery and access to patient records
		London Care Records / LHACRE	Regional: Pan-London	Discovery and access to patient records
	Not currently in scope	Ambulance Messaging	National (NHS Digital)	Messaging standards for Emergency Department transfer
		111 Prescribing	National (NHS Digital)	ePrescribing
		HLP: ePrescribing	Regional: Pan-London	ePrescribing
		HLP: Direct Appointment Booking	Regional: Pan-London	Appointment booking

Integrated Clinical Assessment and Triage (iCAT)				
Internal Programme	Internal Project	External Programme	Partner Organisation	Relevance
iCAT	iCAT - Digital	NHS Online / 111 Online	National (NHS Digital)	Public-facing website for 111
		HLP: 111 Online	Regional: Pan-London	Public-facing website for 111
		London Care Records / LHACRE	Regional: Pan-London	Discovery and access to patient records
		PDS / SCR(s), National Record Locator Service	National (NHS Digital)	Discovery and access to patient records
		Access to Records	National (NHS Digital)	Discovery and access to patient records
		HLP: Patient Relationship Manager / Access to Records	Regional: Pan-London	Discovery and access to patient records
		MiDoS	Regional: Pan-London	Service information within London
		Directory of Service	National (NHS Digital)	Accuracy, Availability, Access, and Appointment Booking
		111 Prescribing	National (NHS Digital)	ePrescribing
		HLP: ePrescribing	Regional: Pan-London	ePrescribing
		HLP: Direct Appointment Booking	Regional: Pan-London	Appointment Booking
	iCAT - Triaging and Call Handling	NHS Pathways / Clinical Triage Programme	National (NHS Digital)	Development of standards and approaches for modular triage, call automation, and outcomes analysis
		HLP: Senior Clinician Module	Regional: Pan-London	New triage module

Pan London Insight				
Internal Programme	Internal Project	External Programme	Partner Organisation	Relevance
Not currently in scope	Not currently in scope	London Care Records / LHACRE	Regional: Pan-London	Population Health analytics
		NHS Pathways / Clinical Triage Programme	National (NHS Digital)	Collation of data for clinical outcomes analysis

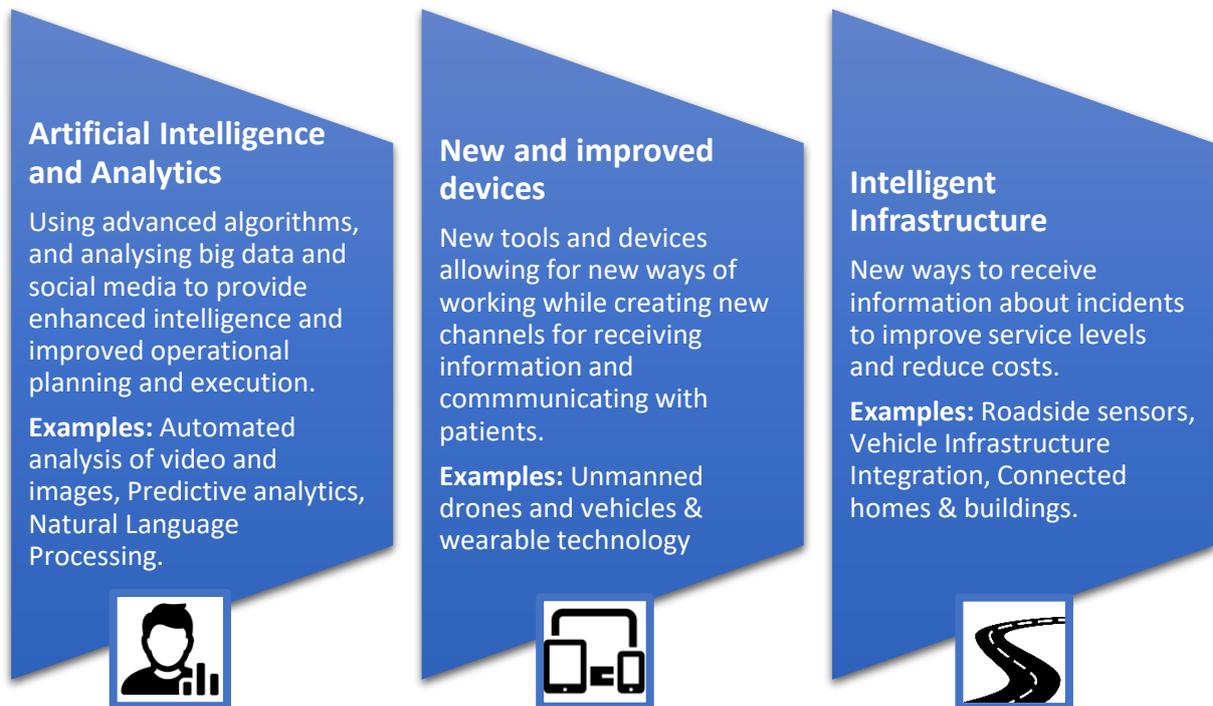
The diagram below additionally overlays these external opportunities onto the roadmap:



12 Appendix E – Emerging Technology Trends

NB: The material below is reproduced from the National Ambulance Digital Strategy.

Emerging technologies offer opportunities for transformational change – dramatically improving patient outcomes and ways of working. We see three main areas of emerging technology trends that are key for the Ambulance Sector to consider in the longer term. These emerging technologies could enhance the digital capability of the service we provide while improving patient outcomes. It however worth remembering that Digital incorporates a much wider scope than the below themes.



Examples: Artificial Intelligence & Analytics

Artificial intelligence	Artificial Intelligence (AI) based solutions can for example be used to create digital assistants that can enhance decision making and triage in real time. These assistants can help takers to perform triage by analysing the conversation in real time, looking for verbal and nonverbal (tone of voice/breathing patterns) signals while considering metadata and symptom descriptions. Data provided during the call can be compared to historic calls to find patterns and enabling recommendations, in real time. Other examples include semantic analysis and natural language processing of social media that cover incidents to identify public sentiment. Incident reporting can, for example, come through social media or other relevant internet applications. Uses of social computing also include language detection and assisted incident classifications.
Automated analysis of CCTV – Image recognition	Intelligent video recognition systems including identification of location from video and images. For example, Services could include automated analysis of CCTV data to pick out rapidly emerging situations, such as traffic accidents.
Analytics and	With increased numbers of connected devices and infrastructure comes the opportunity to analyse, draw conclusions about, and even predict

predictive Ambulancing	incidents. Predictive responses and resource management could be facilitated after the analysis of historic data sets to identify potential emergency or traffic hotspots.
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Examples: New and improved devices

Unmanned drones and vehicles	Although relatively immature emerging technology, unmanned drones and vehicles could enable remote surveillance and intervention from the control room. Drones could also enable the ability to examine large geographical areas, which may otherwise be inaccessible, rapidly remotely and safely. Moreover, unmanned vehicles would be especially useful for delivering medical equipment to remote locations
Wearable technology	Wearable technology, usually installed on clothing or directly in contact with the body (e.g. glasses, wristbands etc.) is becoming ubiquitous, cheaper and could be used by patients and staff members to address a wide variety of problems faced by Ambulance Trusts today. Patients' appetite for wearables provides an opportunity for Ambulance Trusts to improve services by collecting more and relevant health data. Smart watches/clothes that monitor health indicators of patients, or smart glasses with augmented reality overlay used by Ambulance Staff can provide new capabilities and allow for more hands-free action.

Examples: Intelligent Infrastructure

Roadside sensors	Intelligent transport systems can be harnessed to prevent accidents and improve emergency response to incidents. Roadside sensors collecting data that could help the Ambulance Control Rooms in guiding drivers to alternative routes while automatically feeding that information to GPS navigation systems. Traffic light preemption using, for example, acoustic sensors linked to preemption systems is another example.
Vehicle Infrastructure Integration	Enabling roads, traffic signals and vehicles to talk to each other and share crucial information automatically. This could, for example, improve road safety by allowing vehicles to perform automated emergency maneuvers preventing incidents.
Connected homes & buildings	<p>Connected homes and buildings can allow occupants to remotely control and program a variety of automated home electronic devices for safety purposes. Sophisticated intelligent systems can learn about users' behaviors and lifestyles, and connected homes solutions in the safety and security space are already available on the market. Their integration with the wider emergency services systems may bring additional benefits in the future, such as:</p> <ul style="list-style-type: none"> • Improving emergency response by providing real time information on what is happening inside a building, without the need for the occupant to alert and communicate with Ambulance Trusts. • Allowing fast intervention of emergency personnel within the premises. • Tailored emergency solutions, e.g. elderly care assistance service to avoid ambulance callouts or delayed transfers from hospitals.

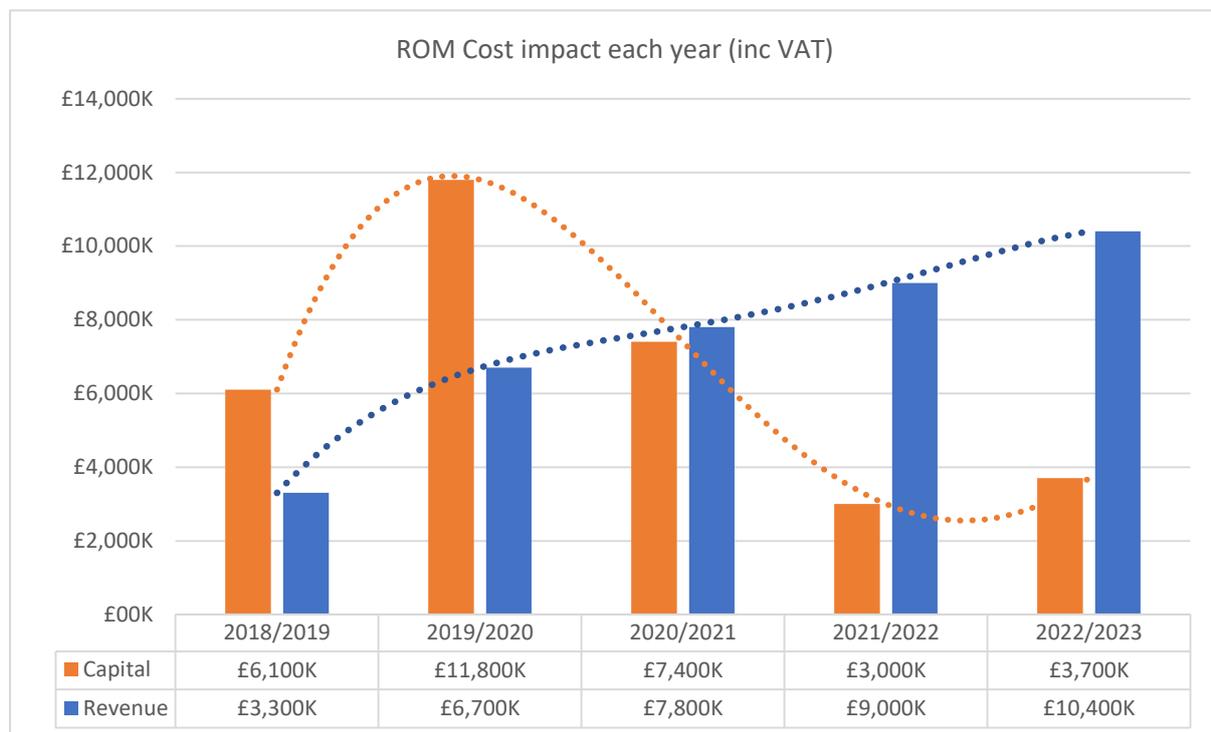
13 Appendix F – ROM Cost Estimation

An exercise has been taken to identify the cost impact of the strategy over time. This is a Rough Order of Magnitude (ROM) rather than a fully qualified cost estimate.

The detail of the phasing across years and detailed costs will be refined through Trust business planning activity and the development of individual business cases across the 5 years of the strategy.

13.1 Overall Capital and Revenue Impact

The following table shows the estimated total impact per year, split between the constituent Capital and Revenue impact.



Note: This does not include the impact of cash releasing benefits

The average annual impact is approximately £14M (Capital and Revenue) with the major outlying impact being in 2019/20 due to the implementation of the Trust’s ePCR and the initiation of other work on the major themes.

It should be noted the most significant revenue increases are in the first year of full iPad use, due to the airtime and services charges associated with providing mobile services for our mobile staff.

It should also be noted that the additional Capital spend reduces significantly from 2020/21 onwards as more services are delivered in the cloud; consequently the Revenue impact increases over time. This is evidenced by the trend lines

At this stage the analysis does not include the impact of Trust efficiencies (whether directly or indirectly) attributable to the Strategy, however, this should be compiled through the business planning processes and the development of individual business cases across the 5 years of the strategy.

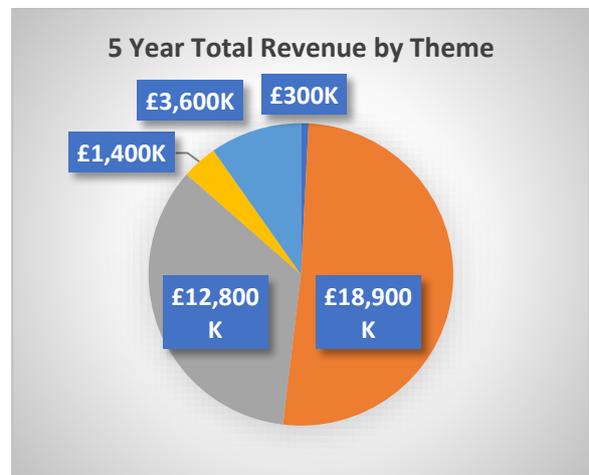
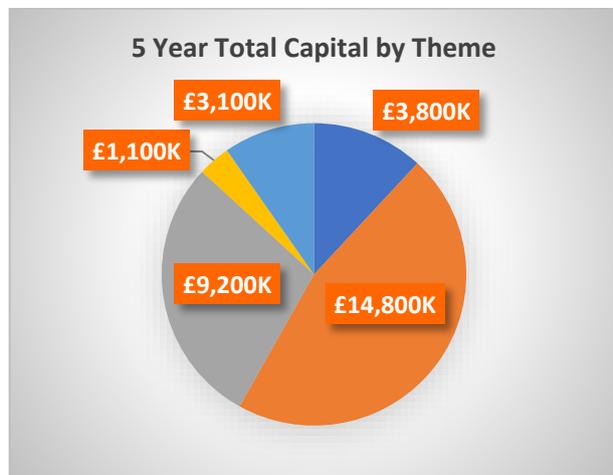
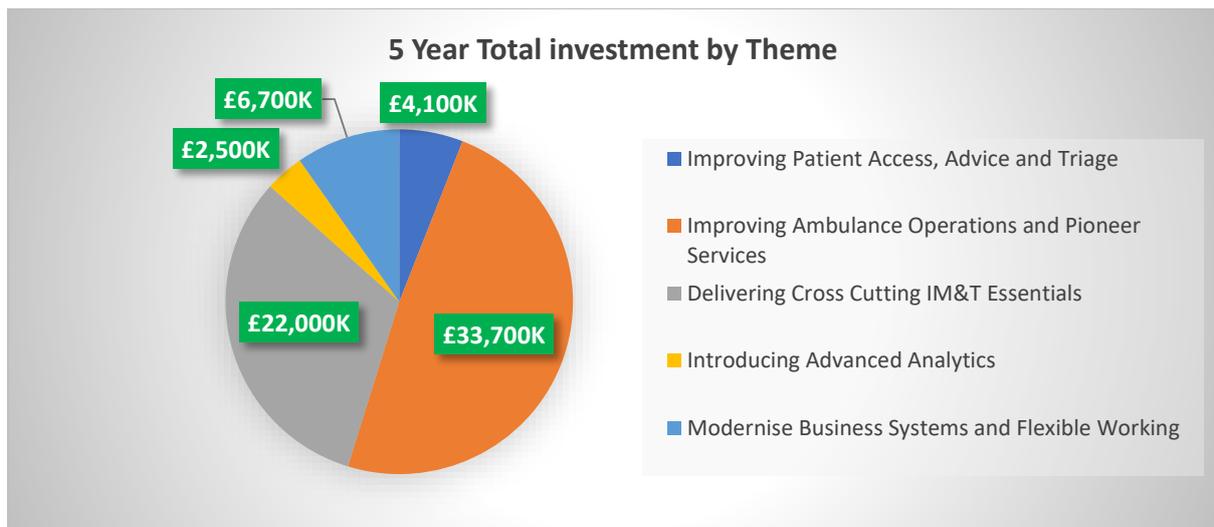
13.2 ROM Cost associated with Themes and Pillars

A more detailed view of the costs against each of the major themes is shown below with tabulated annual costs and overall five year costs. This is followed by a view of the propositional costs against each of the major themes.

5 Year Capital by year and theme					
Theme	Sum of Capital 18/19	Sum of Capital 19/20	Sum of Capital 20/21	Sum of Capital 21/22	Sum of Capital 22/23
Improving Patient Access, Advice and Triage	£1,200K	£1,800K	£500K	£00K	£00K
Improving Ambulance Operations and Pioneer Services	£100K	£4,700K	£4,100K	£1,700K	£2,800K
Delivering Cross Cutting IM&T Essentials	£3,700K	£2,600K	£1,200K	£600K	£300K
Introducing Advanced Analytics	£00K	£500K	£300K	£200K	£100K
Modernise Business Systems and Flexible Working	£600K	£1,200K	£600K	£300K	£100K
Grand Total	£5,600K	£10,700K	£6,700K	£2,800K	£3,300K

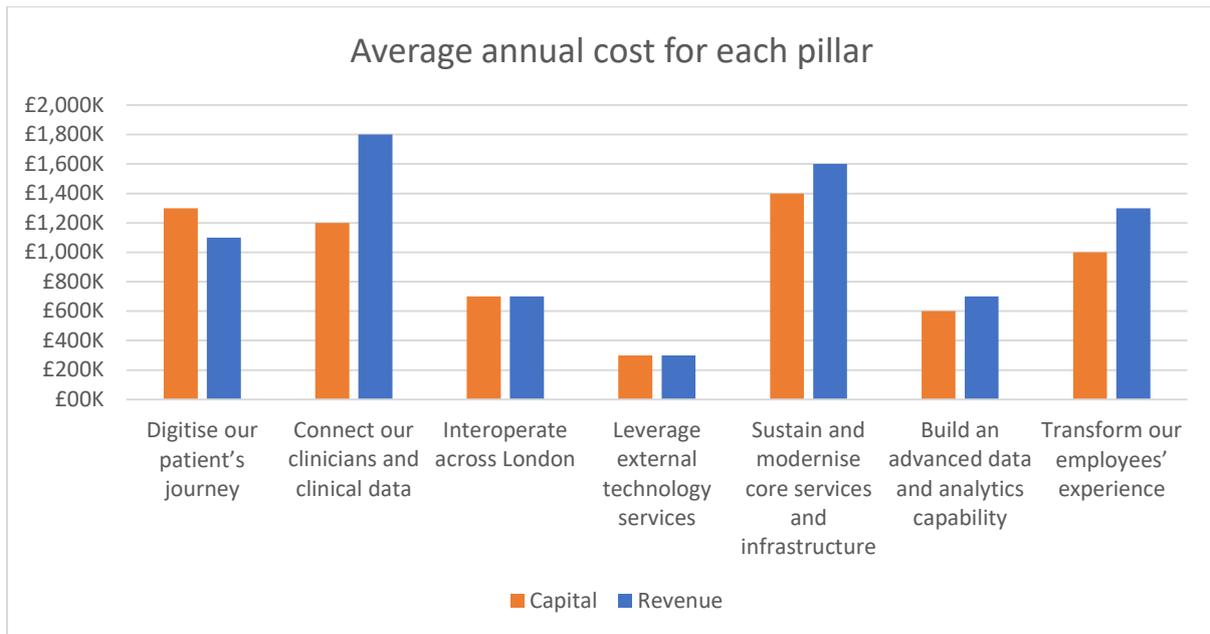
5 Year Revenue by year and theme					
Theme	Sum of Revenue 18/19	Sum of Revenue 19/20	Sum of Revenue 20/21	Sum of Revenue 21/22	Sum of Revenue 22/23
Improving Patient Access, Advice and Triage	£00K	£100K	£100K	£100K	£100K
Improving Ambulance Operations and Pioneer Services	£2,100K	£3,400K	£3,500K	£3,800K	£4,400K
Delivering Cross Cutting IM&T Essentials	£800K	£1,900K	£2,400K	£2,900K	£3,500K
Introducing Advanced Analytics	£00K	£200K	£300K	£400K	£400K
Modernise Business Systems and Flexible Working	£00K	£500K	£900K	£900K	£1,000K
Grand Total	£3,000K	£6,100K	£7,100K	£8,200K	£9,400K

The following shows the proportional ROM investment required to deliver the digital aspects of the themes



Note: This does not include the impact of cash releasing benefits

The following shows the average annual investment in each of the seven pillars.



Note: This does not include the impact of cash releasing benefits

14 Appendix G – National Alignment

14.1 National Ambulance Digital Strategy

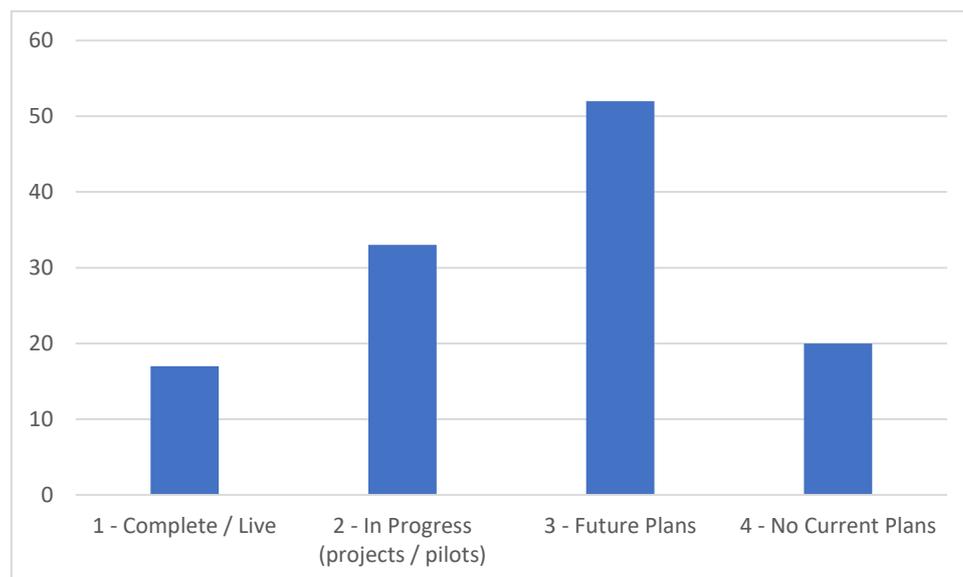
A National Ambulance Digital Strategy is currently being developed and co-authored by NHSD and the national Ambulance IM&T leads. This is being developed based on the domains of activity categorised in the Commissioning Framework:

<https://www.england.nhs.uk/wp-content/uploads/2018/09/commissioning-framework-and-national-urgent-and-emergency-ambulance-services-specification.pdf>



Through our involvement in co-authoring the National Strategy we have insight into what it will contain. A mapped comparison has been carried out and of the 122 elements of the National Strategy against the LAS Digital Strategy.

Over 83% of the national Strategy elements have either been implemented or are in progress or are in our future plans. The breakdown is as follows:



The more detailed mapping analysis which also takes into account phasing shows that:

Alignment is generally good, with essentially the same topics covered.

- The majority of the “short term” National items are either already complete or in progress at LAS, and the majority of the longer term National items included in future plans
- The LAS focus on “Partnering” fits well with the National strategy
- The comparison emphasises the importance of the LAS work on EPR and Data / Analytics – which contribute to a significant number of the National topics

There are a few minor areas of misalignment to consider as detailed planning progresses, e.g.:

- **Timing** - Minor differences in timing, where LAS priorities may validly cause something to be done slightly earlier or later

- **Drones** - noted nationally, not currently in LAS plans
- **Call handovers to other Trusts** – noted nationally, not explicitly in LAS plans.

Other points of detail should be considered for incorporation in the medium to long term

There are also a couple of significant areas of note:

- **Channels** – LAS strategy is to receive 999 phone calls, plus other contact channels via “111 Online” – and this approach may be justified based on LAS offering both 999 and 111. The National Strategy does highlight opportunities for other new channels specifically into 999, plus additional longer-term opportunities such as monitoring devices and sensors, integration with partner organisations, etc. However the National Strategy also recommends further National work to investigate further at a policy level what is appropriate and to define a “999 Channels Architecture”. Awaiting the results of this before proposing significant investment may therefore be seen as a reasonable approach.
- **Wider Referrals** – Whilst in the plan for the CHub and ePCR, the LAS strategy is “lighter” on referrals integration than the National Strategy. E.g. booking appointments with GP, UTC, Patient Transport, Social Care etc. This is emerging as a cornerstone of the IUC co-ordination so should be taken into account in plans moving forward.

The following heat maps based on the national roadmap below visually show the phased alignment.

14.2 The NHS Long Term Plan and Tech Vision (3)

The new NHS long term plan, published in January 2019, outlines how across all parts of the NHS technology will be upgraded and that “over the next ten years investment in technology will result in an NHS where digital access to services is widespread. Where patients and carers can better manage their health and conditions. Where clinicians can access and interact with patient records and care plans wherever they are, with ready access to decision support and AI, and without the administrative hassle of today.”

There are a number of milestone set which the plan to deliver this Strategy will need to comply with

NHS Long term Plan	LAS Alignment: The LAS are.....
During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in The Future of Healthcare.	Working with NHSD through the Nationals Ambulance Strategy to agree the standards needed in our sector. Working as part of the One London LHCRE programme of defined standards
By 2020, five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021.	Playing a central role in pan-London healthcare data interoperability through the One London LHCRE programme.

³ <https://www.gov.uk/government/publications/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care/the-future-of-healthcare-our-vision-for-digital-data-and-technology-in-health-and-care>

<p>In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years.</p>	<p>Planning for access and input to care plans through the On-London LHCRE programme</p>
<p>By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.</p>	<p>Planning to obtain the defined NHS Security standard (Cyber Essentials Plus) and implement accredited email services.</p>
<p>In 2021/22, we will have systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.</p>	<p>Planning to integrate and link information and intelligence using improved information management and intelligence capabilities.</p> <p>Committed to digital transformation with a CIO as a member of the Trust Executive Committee, who attends the Trust Board in a non-voting role, and a CCIO supporting the clinical change in the organisation.</p>
<p>By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices.</p>	<p>Planning to provide front liner clinician access to CPIS processes and appropriate information.</p>
<p>By 2023/24 every patient in England will be able to access a digital first primary care offer (see 1.44).</p>	<p>Working with digital providers across the London care system through the On-London LHCRE programme</p>
<p>By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country.</p>	<p>Working with digital providers across the London care system through the On-London LHCRE programme</p>

The following provides a wider view of how the digital strategy pillars support the “practical priorities to drive NHS Digital transformation” stated in the NHS long term plan.

	Pillar 1	Pillar 2	Pillar 3	Pillar 4	Pillar 5	Pillar 6	Pillar 7
Practical priorities to drive NHS digital transformation	Digitise the patient journey	Connect Clinicians and Clinical Data	Interoperate across London	Leverage external technology services	Sustain and modernise our core services and infrastructure	Build an advanced data and analytics capability	Transform the employee experience through remote working and use of
Create straightforward digital access to NHS services, and help patients and their carers manage their health.	Introduce new channels such as video-calling to enhance interaction with patients Integrate workflows across 999 and 111 to				Refresh our 999 and 111 telephony infrastructure		
Ensure that clinicians can access and interact with patient records and care plans wherever they are.	Implement electronic patient records, migrating from paper to a digital clinical records system Capture the NHS Number whenever possible and use it to help identify patients	Expand upon front-line iPad deployment to enable mobile access to core clinical apps Provide access to external patient records so clinicians are better informed about a patient's history	Connect with other H & SC providers across London (for example via the LHCRE), enabling interoperability between systems to provide access to patient records, information about		Upgrade our mobile communications and devices, to ensure that we put modern connectivity in the hands of crew staff		Enable flexible working for our people. The majority of our staff are mobile and we have other pressures such as costly estate which means we should be more flexible in where and how our people can
Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole	Introduce additional clinical decision-making support tools Explore the potential of voice automation and evaluate its suitability in call handling	Use video-calling to allow clinicians to provide peer support and advice to each other (e.g. real-time access to specialist consultants, mental				Better exploit data, developing tools and infrastructure for BI, applying advanced analytics such as forecasting and machine learning, and	
Use predictive techniques to support local health systems to plan care for populations.	Identify frequent callers to better manage their care					Better exploit data, developing tools and infrastructure for BI, applying advanced analytics such as forecasting and machine learning, and	
Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.	Explore the potential of voice automation and evaluate its suitability in call handling Enable electronic referrals and handovers, supported by access to the DoS	Expand upon iPad deployment to front-line clinicians to enable mobile access to core clinical applications				Implement self-service analytics to provide an integrated single source of truth for all data and intelligence decisions Improve the management of our data - assuring its quality, linking it across	Modernise our internal business systems to support more efficient ways of working and the wellbeing of our staff. New robust systems to run our organisation more efficiently, properly
Protect patients' privacy and give them control over their medical record.			Connect with other H & SC providers across London (for example via the LHCRE), enabling interoperability between systems to provide access to patient records, information about		Continue to address cyber vulnerabilities by investing in modern infrastructure, protective controls and education across the organisation Implement NHS accredited email e.g.		
Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical			Link our data with that of partners across London to provide a complete picture of the patient journey and outcomes, thus gaining insight into the wider health and social care	Play a leading role in pan-London healthcare data interoperability such as the One London programme funded by NHS England's Local Health and Care Records Exemplar		Become patient data oriented with the patient at the centre of all our decisions Transform to a proactive, evidence-based organisation, recognising data as a	
Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.	Invest in resilience and interoperability of our Computer Aided Dispatch (CAD) system				Continue to address cyber vulnerabilities by investing in modern infrastructure, protective controls and education across the organisation Implement NHS accredited email e.g. NHSMail2 or MS O365 Consolidate, secure, and modernise our infrastructure to support resilient operations		
Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.	Enable electronic prescribing by appropriate clinical staff across our services	Upgrade mobile technologies including the national Programme replacing the national radio system. Adopt the national in-vehicle mapping and		Accelerate delivery by aligning with national and regional initiatives which can help us.		Improve the management of our data - assuring its quality, linking it across patient, operational, corporate and external systems, and packaging it in ready-to-use	
Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.				Identify technologies and solutions which are needed but can already be provided by others or are commodities. This includes the use of cloud wherever			Be bolder and more innovative in our use of technology - to benefit Patients and the Public, Our People, and Our Partners., taking advantage of the

	Short term (0-2 Years)	Medium term (0 – 5 Years)	Long term (0 – 10 Years)
0. GENERAL REQUIREMENTS	<p>OPP 0.2 – RESILIENCE & CYBER</p> <p>ENAB-0.1-01: Implementation of NHSE "Cyber Essentials" recommendations</p> <p>ENAB-0.1-02: Process in place to act on CareCERT bulletins</p> <p>ENAB-0.1-03: Implementation of Carter and EOC Review recommendations (once published)</p> <p>ENAB-0.1-04: Process in place for Major Incident & Event Planning</p>	<p>ENAB-0.1-05: Use of cloud-based services to reduce ambulance service duplication of IT infrastructure and the reliance on physical ambulance estate/ IT provision</p>	
	<p>OPP 0.2 – INFORMATION GOVERNANCE</p> <p>ENAB-0.2-01: Following existing information governance best practices</p> <p>ENAB-0.2-02: Collaborating with other Ambulance Trusts and with NHSD/NHSE on any specific new scenarios and needs</p> <p>ENAB-0.2-03: Consider additional controls important in mobile scenarios – device & data encryption, authentication capabilities for secure identify management, screen filters, screen locking etc.</p>		
1. BEFORE THE CONTACT	<p>OPP 1.1 – PUBLIC EDUCATION AND CONDITION MANAGEMENT CAMPAIGNS</p>		
	<p>ENAB-1.1-01: A data-store containing structured data about service usage (including time, location, clinical disposition), such that the causes of demand can be analysed</p>	<p>ENAB-1.1-02: Linkage to external data sources (eg weather, geographic, socio-economic) to ENAB-1.1-03: Analytics and machine learning to identify patterns, and specifically to highlight high volumes of potentially preventable incidents</p> <p>ENAB-1.1-04: Campaign Management software to plan and execute targeted communications</p>	<p>ENAB-1.1-05: Digital communication channels with the public eg email, SMS, YouTube, social media</p> <p>ENAB-1.1-06: Enriching service usage data by flagging patients with known Long Term Conditions, so that specific analysis of their needs and frequent issues is possible.</p>
	<p>OPP 1.2 – FREQUENT CALLERS</p> <p>ENAB-1.2-01: A data-store which allows individual callers to be identified (eg by name, DoB, phone number)</p> <p>ENAB-1.2-02: A data-store which allows individual callers to be identified by NHS Number</p> <p>ENAB-1.2-03: Reporting which allows frequent callers to be identified</p> <p>ENAB-1.2-04: Reporting which allows the reasons for each frequent caller to be analysed</p> <p>ENAB-1.2-05: Process in place for providing personalised support to frequent callers</p>		<p>OPP 1.3 – TELEMEDICINE</p> <p>ENAB-1.3-01: An inventory of approved monitoring devices, which can be distributed to members of the public</p> <p>ENAB-1.3-02: Device monitoring software - to receive feeds from devices, monitor thresholds, provide alerts</p> <p>ENAB-1.3-03: Integration of alerts from monitoring devices into EOC process - eg a message which can raise a call / schedule a callback with appropriate information and priority</p> <p>ENAB-1.3-04: Ability for EOC / Ambulance clinicians to view the detailed monitoring data from a patient's device</p>
<p>OPP 1.4 – STRATEGIC DEMAND MANAGEMENT</p>			
	<p>ENAB-1.4-01: A data-store containing structured data about service usage (including time, location, clinical disposition), such that the causes of demand can be analysed</p>	<p>ENAB-1.4-02: Link to external data sources (eg geographic, socio-economic) to enrich understanding of demand</p> <p>ENAB-1.4-03: Analytics and machine learning to identify patterns and causes</p> <p>ENAB-1.4-04: Use of predictive modelling / demand simulation to assist with future resource planning</p>	
2. HANDLE THE CONTACT	<p>OPP 2.1 – MODERN TELEPHONY</p> <p>ENAB-2.1-01: Use of VOIP</p> <p>ENAB-2.1-02: Video calling - clinician to clinician</p> <p>ENAB-2.1-03: Video calling - clinician to patient</p> <p>ENAB-2.1-04: Call location awareness</p>	<p>OPP 2.2 – MULTI CHANNEL CONTACT - CITIZENS</p> <p>ENAB-2.2-01: Video calling - clinician to patient</p> <p>ENAB-2.2-02: Call gateway via SMS</p> <p>ENAB-2.2-03: Call gateway via Email</p> <p>ENAB-2.2-04: Call gateway via Web</p> <p>ENAB-2.2-05: Call gateway via Mobile App</p> <p>ENAB-2.2-06: Call gateway via / monitoring of Social Media</p>	<p>OPP 2.3 – MULTI-CHANNEL CONTACT - DEVICES AND SENSORS</p> <p>ENAB-2.3-01: Device messaging gateway - to receive messages in standard formats from different types of devices</p> <p>ENAB-2.3-02: Event-handling software to group, analyse, and prioritise data streams from multiple device sources</p> <p>ENAB-2.3-03: Integration of alerts from patient wearables into EOC process - eg a message which can raise a call / schedule a callback with appropriate information and priority</p> <p>ENAB-2.3-04: Integration of alerts from in-vehicle sensors into EOC process - eg a message which can raise a call / schedule a callback with appropriate information and priority</p>
	<p>ENAB-2.4-01: Caller identification and routing - passing calls from partner organisations (eg police, fire, care homes) to specialist call handlers</p>	<p>OPP 2.4 – MULTI-CHANNEL CONTACT - PARTNER ORGANISATIONS</p> <p>ENAB-2.4-03: Triage technology made available to partner organisations, thus helping them to more accurately assess patient needs</p> <p>ENAB-2.4-04: Directory of Service technology made available to partner organisations, thus helping them to more directly identify the most appropriate treatment options</p>	<p>ENAB-2.4-02: Systems integration enabling partner organisations to bypass the phone (where appropriate) and place incidents directly into the queue</p>
	<p>ENAB-2.5-01: Call routing which can flag frequent-callers and pass to specialist call handlers</p> <p>ENAB-2.5-02: Call routing which can flag repeat-callers within a given timeframe</p>	<p>OPP 2.5 – CALL AUTOMATION</p> <p>ENAB-2.5-03: Use of menu-based systems (IVR) to automate some aspects of the triage process</p>	<p>ENAB-2.5-04: Use of Natural Language Processing and/or Chatbots to entirely automate some aspects of calls</p>
	<p>OPP 2.6 – CALL HANDOVERS</p>		
	<p>ENAB-2.6-01: Call transfer to other emergency services (eg Police / Fire)</p>	<p>ENAB-2.6-02: Call transfer to 111</p> <p>ENAB-2.6-03: Voice handover to another Ambulance Trust</p> <p>ENAB-2.6-04: Agreement on procedural / commercial aspects for dispatch by another Ambulance Trust. (The process itself may be manual e.g. calling the partner EOC or logging on to their CAD)</p> <p>ENAB-2.6-05: Automated arrangements for dispatch by another Ambulance Trust (</p>	
	<p>OPP 2.7 – VIRTUAL EOC</p>		
	<p>ENAB-2.7-01: Softphone technology which allows calls to be answered from multiple locations</p> <p>ENAB-2.7-02: Secure, remote access to email</p> <p>ENAB-2.7-04: Secure, remote access to corporate applications (eg HR, Rostering, Finance)</p> <p>ENAB-2.7-05: Staff can work from any desk within the EOC</p>	<p>ENAB-2.7-03: Secure, remote access to EOC applications (eg CAD, Triage, Clinical systems)</p> <p>ENAB-2.7-05: Policies, procedures, and equipment in place for EOC homeworking</p>	
	<p>OPP 2.8 – ENHANCED TRIAGE</p> <p>ENAB-2.8-01: Modular, standards-based triage - specialist modules from multiple vendors to be "plugged in"</p> <p>ENAB-2.8-02: Datastore capturing triage information and decisions (to enable subsequent linkage to outcomes)</p>		
	<p>OPP 2.9 – COMPUTER AIDED DISPATCH</p> <p>ENAB-2.9-01: Implementation of Carter and EOC Review recommendations relevant to CAD (once published)</p> <p>ENAB-2.9-02: Algorithms / ML providing decision support for dispatch management - maximising utilisation and outcomes by matching Emergency, Specialist, and Urgent resources to the most appropriate incidents</p> <p>ENAB-2.9-03: Integration (messaging or shared CAD) to provide visibility of resources in another Ambulance Trusts</p> <p>ENAB-2.9-04: Implementation of technologies for in-vehicle routing, for example based on advanced routing algorithms and traffic patterns</p>		

3. PROVIDE THE RIGHT CARE

OPP 3.1 - FIRST RESPONDER NOTIFICATIONS
 ENAB-3.1-01: A database of First Responders and their levels of skills and training
 ENAB-3.1-02: An App (or other mechanism) to identify, notify, and maintain contact with the most relevant First Responders when an incident occurs

ENAB-3.2-01: Drones to provide oversight and monitoring of major incidents

OPP 3.2 – UNMANNED VEHICLES
 ENAB-3.2-02: Drones to deliver medical equipment and supplies into difficult-to-reach locations

ENAB-3.2-03: Driverless or Auto-Pilot vehicles

OPP 3.3 - CONNECTING CLINICIANS
 ENAB-3.3-01: Secure and reliable mobile connectivity, including voice, video, data and WiFi
 ENAB-3.3-02: Mobile devices for clinicians e.g. tablets / iPads
 ENAB-3.3-03: Mobile access to core applications, incl. dispatch and routing, clinical applications and decision support
 ENAB-3.3-04: Mobile access to voice and video conferencing. For example to collaborate with colleagues in Operations Centres, Care Homes, and with remote clinicians across the wider health system
 ENAB-3.3-05: Body Cameras - to assist with incident management, clinical collaboration, and staff safety
 ENAB-3.3-06: Mobile connected devices - eg in-ambulance patient monitoring
 ENAB-3.3-07: Mobile access to other corporate and administrative applications – for example email, calendars, rostering, expense management

OPP 3.4 - CLINICAL HUB
 ENAB-3.4-01: Call queuing and routing which integrates a Clinical Hub into the call handling process
 ENAB-3.4-02: Access to core applications for Clinical Hub staff, including clinical applications and decision support
 ENAB-3.4-03: Voice and video calling with patients
 ENAB-3.4-04: Voice and video calling with ambulance paramedics
 ENAB-3.4-05: Voice and video calling with other clinicians (eg hospital consultants)

OPP 3.6 - PRE-POST CALL COMMUNICATIONS
 ENAB-3.6-01: Use of text / email / web-links to provide the patient with information and advice to refer to whilst waiting for the ambulance
 ENAB-3.6-02: Use of text / email / web-links to provide the patient with information and advice to refer to after the incident eg health education, details of any follow-up appointments booked etc

ENAB-3.5-02: Voice and video calling with other clinicians (eg in clinical hub, hospital consultants)

OPP 3.5 – ON SCENE DECISION-SUPPORT
 ENAB-3.5-01: Mobile use of triaging tools - to assist with ongoing, on-scene patient management

4. RESPOND TO MY NEED(S)

OPP 4.2 -WORKFORCE MANAGEMENT
 ENAB-4.2-01: Modern integrated HR system(s) covering personal details, recruitment, talent mgmt., staff development
 ENAB-4.2-02: Modern integrated HR system(s) to manage staff skills and training
 ENAB-4.2-03: Digital training tools and materials eg online courses, videos
 ENAB-4.2-04: Communications tech to support a dispersed workforce. Eg mobile email, video conferencing, social media tools
 ENAB-4.2-05: Rosterung software, with remote access for mobile staff

OPP 4.3 –VEHICLE AND ASSET MANAGEMENT
 ENAB-4.3-01: Asset Management system to record and track assets
 ENAB-4.3-02: RFID tagging for high value equipment and items
 ENAB-4.3-06: Systems / Apps for vehicle prep (eg checklists)

ENAB-4.3-03: Proactive maintenance planning - eg using sensors and AI to predict failures
 ENAB-4.3-04: Integrated maintenance and stock-control / ordering systems – to help ensure that necessary parts are on-hand in appropriate quantities
 ENAB-4.3-05: Vehicle telematics (inc fuel measuring)

OPP 4.4 – MEDICINES MANAGEMENT
 ENAB-4.4-01: Medicines management system for controlling medicines and consumable stock
 ENAB-4.4-02: Barcoding to control medicine issue and stock control

ENAB-4.4-03: A database linking medicines usage to incidents
 ENAB-4.4-04: Reports and analytics to identify trends and patterns in medicines usage – to help standardise best-practice and reduce variation, and to identify opportunities for efficiency improvements

5. DIRECT ME TO THE RIGHT PLACE

OPP 3.1 – SERVICE INFORMATION
 ENAB-5.1-01: Standalone tool / app providing Clinicians (both mobile and in the clinical hub) with access to information from the Directory of Service

ENAB-5.1-02: Integration of information from the Directory of Service via into other systems (eg CAD, Triage tools, ePCR etc)
 ENAB-5.1-03: Enriched service information, including opening hours, waiting times etc

OPP 5.2 - ACCESS TO RECORDS
 ENAB-5.2-01: NHS Number tracing using PDS
 ENAB-5.2-02: Access to SCR for a patient

ENAB-5.2-03: Access to CPIS safeguarding indicators for a patient
 ENAB-5.2-04: Access to GP records for a patient
 ENAB-5.2-05: Access to End of Life Preferences for a patient
 ENAB-5.2-06: Access to other local shared Care Plans for a patient

OPP 5.3 – ELECTRONIC PATIENT RECORDS
 ENAB-5.3-01: Implementation of Electronic Patient Record (EPR)

ENAB-5.3-02: Data export from EPR aligned to Ambulance Dataset Standards
 ENAB-5.3-03: Integration / messaging to provide EPR information to the patient's GP following an incident.

OPP 5.4 -EMERGENCY DEPARTMENT HANDOVER
 ENAB-5.4-01: Message to electronically transmit the patient forms to receiving A&E department

OPP 5.5 - WIDER SYSTEM REFERRALS
 ENAB-5.5-01: Message to electronically refer / book appointment with Urgent Care (eg 111, or UTC)
 ENAB-5.5-02: Message to electronically refer / book appointment with Patient Transport Services (for non-urgent conveyance)
 ENAB-5.5-03: Message to electronically refer / book appointment with a GP
 ENAB-5.5-04: Message to electronically refer / book appointment with Social Care
 ENAB-5.5-05: Message to electronically refer / book appointment with Mental Health

OPP 5.6 – ELECTRONIC PRESCRIBING
 ENAB-5.6-01: Electronic Prescribing from Clinical Hub

ENAB-5.6-02: Electronic Prescribing from mobile / on-scene

OPP 5.7 - Outcomes Feedback
 ENAB-5.7-01: A data-store containing data from the EPR in a structured and standardised format, suitable for outcomes analysis
 ENAB-5.7-02: Linkage to patient outcomes - eg at hospital - in order to understand the full pathway
 ENAB-5.7-03: Linkage to other sources, for example patient and staff satisfaction, demographic and geo-spatial data
 ENAB-5.7-04: Analytics and machine learning to identify patterns and provide feedback to help identify the most effective interventions and drive improved outcomes

KEY

- 1 - Complete / Live
- 2 - In progress (projects / pilots)
- 3 - Future Plans
- 4 - No Current Plans



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Business Plan 2019-20			
Agenda item:	09(i)			
Report Author(s):	Murray Keith, Head of Business Planning			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Business planning update to Informal Board Development Session in February 2019 (ref: TBD/18/28)			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
This paper provides an update to the Board regarding progress on the development of the Annual Business Plan. This includes details of our financial and operational plan for 2019/20 and beyond.				
Recommendation(s):				
The Board is invited to endorse the Business Plan, subject to ongoing commissioner negotiations				
Links to Board Assurance Framework (BAF) and key risks:				
BAF Risk 52 There is a risk that the Trust will not deliver the required financial targets through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	<input type="checkbox"/>			
Performance	<input type="checkbox"/>			
Financial	<input type="checkbox"/>			
Workforce	<input type="checkbox"/>			
Governance and Well-led	<input type="checkbox"/>			
Reputation	<input type="checkbox"/>			
Other	<input type="checkbox"/>			
This report supports the achievement of the following Business Plan Workstreams:				
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>			
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>			

Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

London Ambulance Service Business Plan: 2019/20

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1 Chair's Introduction

<strategy team working on intro>

2 CEO Forward

<strategy team working on forward>

DRAFT

3 Introduction to the Business Plan

3.1 Brief intro to LAS

We are the busiest ambulance service in the country. Over 6,000 staff serve 8.8m people in the capital, responding to nearly 2 million 999 calls and over 1.1 million incidents each year. While our main role is to respond to emergency 999 calls, many of our patients have less serious conditions but need simple access to urgent care for assessment and advice. Instead of being sent to hospital by ambulance on blue lights, they often need more appropriate care somewhere other than at hospital. We also, therefore, provide a range of care in addition to our 999 call handling and conveyance service, including:

- NHS 111 and Integrated Urgent Care Service – delivering integrated NHS 111 and clinical assessment service in North East London and South East London;
- Dispatching and providing clinicians for collaborative responses e.g. London's Air Ambulance, Joint Response Unit with the Metropolitan Police;
- 'Hear and Treat' clinical telephone assessment;
- Planning for, and responding to, large scale events or major incidents.
- Providing dedicated specialist responses to deal with Hazardous and Major Incidents

3.2 The purpose of the business plan, how it was created

Due to rising demand for our services and financial pressures across the NHS, we face challenges to deliver the outstanding care Londoner's rightly expect from us. This Business Plan helps us determine what we will prioritise our fixed budget to deliver and how this will allow us to meet our strategic objectives.

Our Regulators also require us to produce a Business Plan each year to show how we are meeting our statutory and contracting duties and that, in particular, our capacity and budget assumptions are aligned with our commissioners' intentions. This business plan will support London's five Sustainability and Transformation Partnerships to produce new five year plans detailing how we will transform healthcare in the capital and improve outcomes for patients.

3.3 Integrated Business planning model, how it has been used

This business plan is underpinned by our integrated business planning model developed over the past six months. The model uses the historic relationship between resourcing, productivity and performance to calculate the resources we need to deliver the required Ambulance Response Programme (ARP) performance targets with our planned productivity levels. The model also considers how we expect demand to grow over the next five years and the implications of making changes to our current operational response, e.g. treating more people on scene rather than conveying to hospital. In turn, this informs our financial plan for future years, detailing the resources we need to deliver performance, and the required operational productivity and back office efficiency needed if we are to improve our financial performance.

4 What we have achieved in 2018/19

2018/19 has been another busy year for the Trust. In addition to our 999 service, in 2018/19 we mobilised two new contracts in London to provide 111 Integrate Urgent Care services in North East London and South East London. These contracts demonstrate the first step to delivery of our strategic theme of becoming the primary integrator of urgent and emergency care in London.

We have published our new five-year strategy, and have begun implementation of many of the key elements of this. This has been done through the delivery of our 2018/19 business plan. A summary of the progress against the four P's set out in the strategy is below, and further detail of progress against each 2018/19 business plan deliverable is set out in Appendix 1.

Our patients:

We continue to provide a high quality service for our patients, performing in the top three Ambulance Services in England across 13 key metrics included in the National Ambulance Services Balanced Scorecard. We have frequently been the best in class for the Category 1 Mean and 90th Centile measures, and have remained within the national standards even in period of extreme demand during winter. Our C2 mean performance remains stable and whilst the year to date position stands just above the national standard this demonstrates that although challenged, patient safety in this category can be seen to be maintained whilst long waiting times minimised. The Trust has also met all our Quality priorities and is in the process of developing new priorities for 2019/20.

Our people:

The Trust has made good progress against the 2018/19 business plan deliverables with respect to our people. We have completed the restructure of our main organisational directorates and are currently refreshing the EOC recruitment trajectories in line with the new organisational structure. We are confident that the restructure and planned recruitment and training activities will enable us to reach establishment within the first quarter of 2019/20. In the past year we published our new five year strategy. This set out our new Vision, Purpose, Values and Behaviours and we have been rolling them out via a number of routes including the CEO Roadshows. The roadshows have proven to be a very popular vehicle to share new information and receive direct feedback from frontline and corporate staff.

We have also responded to all the key issues identified in the 2017 Staff Survey and delivered the actions within the Workforce Race Equality Standard (WRES) Action Plan.

And finally, the Trust has implemented the Clinical Education Strategy, training all paramedics throughout the year in addition to providing leadership and management training to non-front line staff. This includes the new Visible Leader and Engaging Leader leadership programmes.

Public value:

The Trust continues to seek to provide maximum public value for the service provided to the public. In 2018/19, we have met our control total, delivered the £12.3m CIP programme with 80% delivered recurrently, delivered all of the capital plan and met the majority of our CQUIN targets for the year

Our Partners:

The Trust have made good progress against the strategic ambition of becoming London's primary integrator of urgent and emergency care services in London, having been awarded and mobilised new Integrated Urgent Care / 111 contracts in North East and South East London.

Additionally, in 2018/19 we have continued to engage well with our partners to address key issues such as demand management, the use of alternative care pathways and delays in hospital handover. We also continue to engage with our emergency services partners in London to explore opportunities for collaboration to improve our response to incidents and increase the efficiency of emergency services in London.

5 Our Strategy, Vision, Purpose, Values and Behaviours

Our vision is:

To build 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 on line

The London Ambulance Service has four goals:

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



Our values and behaviours

We can only realise our vision through the adaptability, determination, flexibility and engagement of our people: how our people feel about working for us; how new people feel about coming to work here and how engaged we all are in our work. These are all vital to us to provide outstanding care for our patients. Our new values and behaviours articulate how we as an organisation and as individuals should work. Our values demonstrate the qualities that we embody and our new set of organisational behaviours detail how we will demonstrate these values every day.

VALUES The Qualities we embody	BEHAVIOURS How we demonstrate our values in actions
Respectful	<ul style="list-style-type: none"> • Caring for our patients & each other with compassion and empathy • Championing equality and diversity • Acting fairly
Professional	<ul style="list-style-type: none"> • Acting with honesty & integrity • Aspiring to clinical, technical and managerial excellence • Leading by example • Being accountable and outcomes orientated
Innovative	<ul style="list-style-type: none"> • Thinking creatively • Driving value and sustainable change • Harnessing technology and new ways of working • Taking courageous decisions
Collaborative	<ul style="list-style-type: none"> • Listening and Learning from each other • Working with partners • Being open & transparent • Building trust

6 Drivers of Change

The scale of the service we provide grows each year alongside demographic pressure. Our business plan is based upon us meeting more patient demand each year. The Trust forecast expects face to face incidents to continue to rise at 1.2% each year. Furthermore, cases are becoming ever more complex, with the amount of time a job takes - our Job Cycle Time – continuing to increase. The Ambulance Response Programme (ARP) has also set more demanding response time targets, effective from November 2017, giving a target response time for every patient for the first time.

It's clear that unless we develop a proactive response to this growth in patient demand, case complexity and expectation of performance improvement the Trust will experience upward pressure on our costs. Therefore, working alongside commissioners the Trust is seeking to evolve new ways of

working to respond to these pressures without compromising quality but still remaining within the required financial envelope.

6.1 Meeting Demand

In 2018/19 we have experienced substantial additional costs related to the delivery of the standards demanded by ARP nationally. This has directly led to our deficit position in 2018/19. The number of patient needing help will also grow next year – in addition to the more demanding response standard. In 2019/20 we will require more ambulance hours than ever before to meet this, which will come at an additional cost.

Meeting patient demand at the new standard will necessitate the Trust increasing resource, but this isn't sustainable for a constrained healthcare system. Therefore, we recognise the need to realise greater productivity benefits to meet the public need with the available resources.

Finally, we know about certain cost pressures that we face which make even maintaining our current service challenging, for example: the National Living wage applies cost pressure to our contracts which will be passed onto us, whilst CNST contributions continue to rise.

6.2 Lord Carter's report into unwarranted variation in NHS ambulance trusts

The Carter report, published in September of last year demonstrated the differences between the ten ambulance trusts providing services in England. We believe savings of these proportions are available if we apply ourselves over the three years of this plan. Benchmarking against peer groups has highlighted a number of key areas we know we can improve are:

- Corporate expenditure: the Carter review shows the LAS to be in the middle of the ten UK ambulance trusts for Corporate spend as a share of turnover. A reduction of 11% corporate spend would move us up to 4th place and 16%, 3rd place. Whilst some different accounting policies and organisation structures may explain some of the difference nationally we accept there is opportunity to improve here. Improving our cost efficiency away from the front line forms a core part of this year's plan.
- Key patient groups: We have the highest Job Cycle Time for dealing with mental health calls. We are targeting this group through having mental health specialist clinicians in our control room to support callers early in the triage process, and also by supporting our clinicians on scene.
- Hear and Treat: LAS was shown to be an area where the Trust was an outlier. However, we believe there may be some inconsistencies in the categorisation and counting between Trusts which we are currently exploring.

6.3 Efficiency Requirements

In order to deliver a sustainable NHS all providers are required to deliver efficiency savings each year, to allow the health service's budget to stretch to more care for more patients each year. Each year in our business plan we will deliver cost efficiency. This will allow us to balance our budget, free up the money to invest in the developments necessary to improve our operational productivity, and

will allow us to play our part in creating a sustainable NHS by reducing the real terms cost per incident in each year. As a minimum we plan to play our part by delivering national target 1.1% efficiency saving from our budget each year.

We have in the past been delivering efficiency savings - 3.4% is forecast in 2018/19, largely through reducing the size of our corporate functions and through less reliance on overtime and incentives for frontline staff with the improvement in recruitment. Whilst these will continue to be a key part of our plan, this approach is not sustainable. Therefore, in later years of this plan we will be investing in the frontline to allow them to deliver more, better and different types of care.

6.4 Being a System Partner

We know the wider health service is under extreme pressure as the population grows and ages faster than budgets grow. We feel it first-hand, read it in the news and hear it from our colleagues in other trusts.

In 2015 the NHS committed to delivering £22bn of savings in return for a £8bn investment. Savings on such a scale are unlikely to be achieved by each trust working in isolation, but could happen through changing how patients move along care pathways. We realise that we, as the only pan-London healthcare provider, have a key role to play. Working with other providers to give patients alternatives to A&E has therefore become a key part of our plan.

7 Improving productivity and quality

This section outlines the planned productivity changes over the next five years, and the planned available patient facing vehicle hours produced to deliver performance. Over the next year, we plan to reduce ED conveyance.

7.1 Emergency Department Conveyance

As outlined above, reducing avoidable and unnecessary conveyances to A&E is a crucial part of our strategy and integral to supporting NHS providers in London to deliver the NHS Long Term Plan. This is because of the following factors:

- 1. Patients:** Where patients can remain at home or receive more effective care through their GP or a more suitable alternative care pathway this should happen. Throughout this plan we are targeting taking fewer patients to A&E than we would under our current way of working.
- 2. The ambulance service:** Conveying a patient to A&E takes time – to get there, to hand the patient over at hospital and to get back on the road. On average, calls where we don't take the patient to A&E are shorter than call where we do. From the Carter review, we know this trend is consistent across the country. Whilst if we spend more time with the patient to help them stay at home the gap between the time for a conveying and non-conveying will likely reduce, there is clear opportunity for that by avoiding waiting in queues outside A&Es, the trust to improve the number of patients we can see whilst improving the care we offer.

- 3. The wider NHS:** A&Es are under huge pressure, with A&E's across London struggling to meet their 4 hour waiting time targets. As a significant part of A&E demand is contributed by us, it's our responsibility to play our part in relieving A&E demand. Furthermore we have the opportunity to mitigate avoidable hospital admissions if we can avoid bringing the patient to A&E in the first place. This in turn relieves pressure on the inpatient wards. Both effects means that our target reduction in patients taken to A&E has the potential to make significant savings.

7.2 Hear & Treat

Our five year strategy outlines our ambition to become the primary integrator of Urgent and Emergency Care, on scene, on phone and on-line. To do so, we will develop an integrated clinical assessment and triage (iCAT) service that will support NHS 111 and 999 services and provide added clinical capability to treat patients safely over the phone, or on scene through clinical support for our frontline paramedics.

7.3 Hospital Handover

When we've decided a patient needs to go to A&E, we should do it quickly, getting the patient the care they need, and freeing our crew up to deal with the next patient. To do so, this means working with hospitals in London, both EDs and other hospital services to reduce delays in handing over patients to Hospital care. Over the next year, we plan to reduce hospital handover time from 19.00 mins to 18.05 mins.

7.4 Handover to Green

Handover to green is the key part of Job Cycle Time which is within our control. Whilst our job cycle time is in line with other ambulance trusts', we see an opportunity to improve this, and plan to do so consistently over the course of the next five years. Over the next year, we plan to reduce handover to green time from 17 mins to 16 mins.

7.5 Delivering performance: High level outputs of the business planning model

In order to sustain our performance level in the face of growing demand in 2019/20 we plan to put out more ambulance hours than ever before. This will sustain our performance in line with national targets whilst we invest in making the operational improvements necessary to meet growing demand more cost-effectively than by growing patient facing vehicle hours just as quickly.

There are three core drivers of the operational requirement for patient facing vehicle hours. These are:

- 1. Activity growth:** The scale of the service we provide grows each year due to demographic pressure. Our business plan is based upon us meeting more patient demand each year. Based on long term trends, we expect face to face incidents to continue to rise at 1.2% each year. As 2019/20 will be a leap year, we expect the total number of incident we'll attend grow by 1.5%.

2. **Hitting the ARP Performance targets:** Historically, the C2 mean has been the most challenging target to hit, therefore, we will plan to meet or exceed the C2 mean, and by doing so will also meet or exceed the other ARP performance measures. This target will be met initially quarterly then each month, at a pan-London level as we are commissioned to do by London's CCGs. This will of course be subject to the commissioner contract agreement.
3. **Improving the productivity of ambulance operations:** Over time, the impact of the productivity changes outlined above (reducing avoidable conveyances to ED, addressing Hear & Treat, and reducing Hospital Handover and Handover to Green time) we will reduce the number of vehicle hours we need to deliver the set performance targets.

To deliver the available patient facing vehicle hours (PFVH) we will need a changing workforce. We expect to grow our substantive workforce next year, filling existing vacancies and new posts, and we will continue to make use of overtime and Private Ambulances to give us the flexibility to manage the peaks and troughs in demand.

8 How we will measure our success in 2019/20

This section outlines the goals and relevant outcomes we plan to achieve and how we will measure their delivery in 2019/20. The outcomes are closely aligned with the five-year strategy, and have been shaped by the external financial pressures and new reports such as the Carter Report.

For each of the outcomes we have a set of metrics we will use to report on progress against delivery. A summary of the outcomes is in [Table 1](#), and further details on the metrics is outlined in the following sections.

Goal	Outcome
Patients	1: Deliver the national quality standards for 999
	2: Deliver the national quality standards for 111 / IUC
People	3: Improve workplace experience, engagement and recognition
	4: Become a more inclusive organisation, increasing diversity within our workforce
	5: Improve the health & wellbeing of our staff
	6: Deliver our training and development programmes for all staff
	7: Improve leadership and management across the Trust
Public Value	8: Deliver strong financial performance
	9: Increase the efficiency and productivity of the organisation
Partners	10: Maximise safe non-conveyance to ED
	11: Optimising the delivery of 111 / IUC services across London
	12: Delivering statutory responsibilities and mandatory standards

Trust Corporate Scorecard

	Outcome	Exec Lead	Indicator (KPI Name)	Frequency	Basis	17/18	18/19	2019/20 Target
Our Patients	1. Deliver the national quality standards for 999	PW	Category 1 response - Mean	Monthly	hh:mm:ss	00:07:13	00:06:29	00:07:00
		PW	Category 1 response - 90th centile		hh:mm:ss	00:11:53	00:10:47	00:15:00
		PW	Category 1T response - Mean		hh:mm:ss	00:13:08	00:11:28	00:19:00
		PW	Category 2 response - Mean		hh:mm:ss	00:21:33	00:19:22	00:18:00
		PW	Category 2 response - 90th centile		hh:mm:ss	00:44:41	00:39:43	00:40:00
		PW	Category 3 response - Mean		hh:mm:ss	01:00:28	00:54:14	01:00:00
		PW	Category 3 response - 90th centile		hh:mm:ss	02:28:11	02:10:58	02:00:00
		PW	Category 4 response - 90th centile		hh:mm:ss	03:32:59	03:05:44	03:00:00
		PW	Call Answering Time - 90th centile		hh:mm:ss	00:01:06	00:00:24	TBC
		FW	Hands on Chest - Time to Compression (bystander / professional)		N/A	N/A	TBC	
		FW	ROSC at Hospital		%	32.5%	36.5%	30%
		FW	Survival to Discharge following Cardiac arrest	Monthly - 4 Month Time Lag	%	9.4%	8.8%	TBC
		FW	Outcome from acute ST-evaluation myocardial infarction – call to angiography		hh:mm:ss	02:10	02:03	TBC
		FW	Outcome from stroke – call to hospital		hh:mm:ss	01:17	01:10	TBC
		FW	Sepsis		%	N/A	88.3%	TBC

	Outcome	Exec Lead	Indicator (KPI Name)	Frequency	Basis	17/18	18/19	2019/20 Target
Our Patients	2. Deliver the national quality standards for 111 / IUC	PW	Percentage of answered calls answered in 60 seconds	Monthly	%	96.4%	69%	>=95%
		PW	Total complaint calls - Priority 1: dealt within 15 min		(n)	n/a	46%	>=95%
		PW	Total complaint calls - Priority 2: dealt within 30 min		(n)	n/a	36%	>=95%
		PW	Total complaint calls - Priority 3: dealt within 120 min		(n)	n/a	36%	>=95%
		PW	Total complaint calls - Priority 4: dealt within 180 min		(n)	n/a	45%	>=95%
		PW	Total complaint calls - Priority 5: dealt within 240 min		(n)	n/a	57%	>=95%
		PW	Total complaint calls - Priority 6		(n)	n/a	n/a	>=95%
		PW	% of calls with no onward referral from anyone within the service		%	n/a	n/a	TBA
		PW	% of calls transferred to 999		%	8.0%	8.04%	<10%
		PW	% of calls recommended to ED		%	10.0%	7.94%	<5%

Note: Example 111 Figures for NEL (January 2019)

	Outcome	Exec Lead	New Indicator 2019/20	Frequency	Basis	17/18	18/19	2019/20 Target
Our People	3. Improve workplace experience, engagement and recognition	PG	Staff Survey engagement score	Yearly	(n)	5.9	6.2	3.46
		PG	Staff survey completion	Yearly	%	53.6%	65%	≥65%
		PG	Vacancy rate (% of establishment)	Monthly	%	5%	4.6%	5%
		PG	Staff turnover (No. of leavers)	Monthly	%	11%	12.7%	<10%
	4. Become a more inclusive organisation, increasing diversity within our workforce	PG	Workforce race Equality Standards	Annual	(n)	7.8	8	8.3
		PG	BME Staff Survey engagement score	Yearly	(n)	3.43	TBC	3.49
		PG	% of BME Staff	Quarterly	%	14%%	14.9%	17.5%
	5. Improve the health & wellbeing of our staff	PG	Staff Sickness levels (%)	Monthly	%	5.2%	5.3%	4%
		TB	Health and Safety (Rate of incidents, RIDDOR by Cause, Assaults)	Monthly	Days	<15 days	TBC	TBC
		TB	MSK related staff injuries (staff survey)	Yearly	%	<50.0%	TBC	<50%
		TB	MSK reduction in moderate harm	Monthly	(n)	<25	TBC	<25
		PG	Bullying and Harassment incidents (decreasing)	Yearly	%	32.0%	TBC	29%
		FW	Flu vaccination rate (increasing - CQUIN)	Monthly	%	n/a	58%/65%	75%
		TB	Adverse Staff Events (by harm)	Monthly	(n)	TBC	TBC	TBC
	6. Deliver our training and development programmes for all staff	PG	Statutory & Mandatory Training (85% or above)	Monthly	%	87.0%	88%	85%
		PG	Staff appraisal compliance (85% or above)	Monthly	%	86.0%	84%	85%
		TB	Level 3 safeguarding training completed (85% or above)	Monthly	%	>85%	>85%	>90%

	Outcome	Exec Lead	New Indicator 2019/20	Frequency	Basis	17/18	18/19	2019/20 Target
Our People	7. Improve leadership and management across the Trust	PG	% of management staff through leadership programme	Monthly	%	TBC	TBC	TBC
		PG	Survey feedback for line management and team management	Annual	(n)	TBC	TBC	TBC
		PG	Volunteer satisfaction / feedback score	Annual	(n)	TBC	TBC	TBC

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	Outcome	Exec Lead	New Indicator 2019/20	Frequency	Basis	17/18	18/19	2019/20 Target
Public Value	8. Deliver strong financial performance	LB	Control Total (Deficit)/Surplus	Monthly	£m	(2.4)	4.3	(1.56)
					£m	TBA		N/A
		LB	Use of resources index/indicator		(n)	1.00	1.00	1.00
		LB	% of Capital Programme delivered		%	93.0%	100%	95%
		LB	YTD Outturn vs budget		£m	8.2	(0.1)	TBC
		LB	Cash position		£m	30.3	19.7	TBC
		LB	SOCI		£m	5.7	4.3	TBC
		LB	Agency Ceiling Compliance (%)		%	100%	119%	100%
	9. Increase the efficiency and productivity of the organisation	LB	Capital plan	£m	25	21.8	TBC	
		LB	CIP Savings YTD	£m	£9.2m	12.3	£3.1m	
				%	52%	100%	25%	
		LB	CIP Savings achieved - % Recurrent	£m	£8.4m	9.8	£9.2m	
				%	48.0%	80%	75%	
		LB	Commercial income generation	£m	n/a	n/a	0.25	
		LB	Corporate spend as a % of turnover	%	TBC	TBC	TBC	
		£	TBC	TBC	TBC			
		BM	Average Jobs per shift		(n)	TBC	TBC	TBC

	Outcome	Exec Lead	New Indicator 2019/20	Frequency	Basis	17/18	18/19	2019/20 Target	
Our Partners	10. Maximise safe non-conveyance to ED	RF	Progress on digitisation of ePCR	Quarterly	%	N/A	N/A	TBC	
		PW	Pre-handover improvement	Monthly	minutes	TBC	TBC	TBC	
		PW	See and Convey – to ED			%	TBC	61.7	TBC
		TB	Falls conveyance reduction			%	TBC	TBC	TBC
		TB	Mental health patient conveyance to ED			%	TBC	TBC	TBC
		PW	Hear and Treat %			%	TBC	TBC	TBC
	11. Optimising the delivery of 111 / IUC services across London	LB	Savings delivered to wider urgent & emergency care system through management of IUC services (£m)	Quarterly	£m	TBC	TBC	TBC	
	12. Delivering statutory responsibilities and mandatory standards	TB	CQC rating - Overall	Quarterly (internally)	Rating	RI	G	O/S	
		TB	CQC rating - Well-led			RI	G	G	
		TB	CQC rating - safe			RI	G	G	
		TB	CQC rating - caring			G	O/S	O/S	
		TB	CQC rating - effective			G	G	O/S	
		RF	Cyber Essentials Plus Accreditation	Monthly	Rating	TBC	TBC	TBC	

Table 1

9 How we will deliver our targets in 2019/20

This section outlines the deliverables and the respective interventions that will contribute towards the delivery of our goals and the respective outcomes. Interventions are the prioritised service developments, capital projects and specific BAU activity.

For each outcome, we have identified the deliverables to help achieve our targets. This is underpinned by the key milestones and interventions that support delivery. Behind this, there is a set of programmes and projects, established to align with the five-year strategy, and reported through the Trust's Portfolio Management Board. These programmes and projects will deliver the capital plan and service developments.

A summary of the deliverables and the interventions is outlined in the following sections. **Table 1,**

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9.1 Our Patients

	Outcome	Deliverables	Interventions
Our Patients	<i>Outcome 1: Deliver the national quality standards for 999</i>	1. We will deliver our national performance and quality standards by optimizing our operational response model and delivering our operational plan	<ul style="list-style-type: none"> • Avaya 999 Upgrade • EOC CAD: New CAD planning • EOC CAD updates • Emergency Services Network: Replacement MDT (MDVS) • Falsified Medicines Directive (FMD) Scanning System Request • Ora-morph storage and handling
	<i>Outcome 2: Deliver the national quality standards for 111 / IUC</i>	2. We will deliver our national 111 / IUC performance and quality standards through provision of an appropriate commissioned clinical decision support system and organisation of clinical teams in 111, 999 and Clinical Hub, to provide holistic clinical oversight, thereby making the best use of all available clinical resources.	<ul style="list-style-type: none"> • iCAT - Development programme • iCAT - increase in CHUB resource

9.2 Our People

	Outcome	Deliverables	Interventions
Our People	Outcome 3: Improve workplace experience, engagement and recognition	3. We will complete action plans across all functional and operational areas of the business to respond to the key issues identified in the 2018 Staff Survey and implement the planned actions in time for the 2019 Staff Survey.	<ul style="list-style-type: none"> • Bank: Feasibility & Implementation • EOC Desks and Chairs • ESR Transformation • Appraisal improvement programme to address appraisal quality • Reverse mentoring
		4. We will complete the restructuring and recruitment of all Directorates to produce an efficient and lean organisation.	
		5. We will implement new business systems and technology to support more efficient and flexible ways of working and the wellbeing of our staff, enabling us to be more innovative in use of technology.	
	Outcome 4: Become a more inclusive organisation, increasing diversity within our workforce	6. We will continue to deliver our Workforce Race Equality Standard (WRES) Action Plan, and develop a response to the newly required Workforce Disability Quality Standard (WDQS) together with other measures, to improve diversity, inclusivity and equality across all areas of the organisation.	<ul style="list-style-type: none"> • Dignity at work programme to explicitly address bullying and harassment • Cultural and inclusivity training
	Outcome 5: Improve the health & wellbeing of our staff	7. We will improve the health and wellbeing of our staff, improving our occupational health service whilst also addressing health & safety issues to ensure both the physical and mental health of our staff created by high risk of trauma and stress.	<ul style="list-style-type: none"> • Life-packs, Tempus packs and Defibrillators • Occupational Health review • Health and Safety Action Plan • Health and Wellbeing work plan • Mental Health wellbeing plan

	Outcome	Deliverables	Interventions
	<i>Outcome 6: Deliver our training and development programmes for all staff</i>	8. We will continue to implement our Clinical Education programme to deliver mandatory training and upskill our operational workforce.	<ul style="list-style-type: none"> • Level 3 Safeguarding training • EOC Training Relocation • Training Estate Transformation • Student Digital Records and Management System • Student Records Archive
		9. We will securely archive our existing student records and move to a digital student record management system for future training delivery following the CQC recommendations, mitigating the associated BAF risk.	<ul style="list-style-type: none"> • Training Estate: Additional Education Centre • Additional staffing to deliver 2019/20 CES programme • Conflict Resolution Training • Training of Rotational Paramedics • Upskilling Band 6's
	<i>Outcome 7: Improve leadership and management across the Trust</i>	10. We will roll-out training and development for all our leadership and management staff across functional and operational teams.	<ul style="list-style-type: none"> • Deliver management led culture change programme

9.3 Public Value

	Outcome	Deliverables	Interventions
Public Value	Outcome 8: Deliver strong financial performance	11. We will deliver our control total and maintain our use of resources rating with NHSI.	<ul style="list-style-type: none"> • CIP Programme • Ongoing budget management, performance management and business planning
		12. We will establish a new approach for the contract with commissioners and STPs, by incentivisation of behaviours that improve outcomes for our patients whilst providing better support for the London's health system.	
	Outcome 9: Increase the efficiency and productivity of the organisation	13. We will deliver and share visibility with commissioners of our Cost Improvement Programme (CIP) efficiency savings in 2019/20 whilst developing further efficiencies to inform the 5Yr STP Plans.	<ul style="list-style-type: none"> • CIP programme schemes • Implement ED, Hospital Handover, and OOS Action Plans • Post-Handover • Workshops Improvement and Compliance • Urgent Care Advanced Paramedic Practitioners • Improved Alternative Care Pathway usage • Pre-Handover • Fleet Replacement DCAs, EPRR • Fleet Improvement: Driver Safety and Security Systems, including CCTV • Bunkered Fuel • Estates Asset Management • Estates Consolidation
		14. We will rationalise our corporate, operations and training estate making best use of digital technology to improve existing space, and ensuring our facilities and estate enables flexible working.	
		15. We will identify new commercial opportunities to generate additional income of £1m for the Trust by 2022. We will review a range of areas including provision of training and utilisation of sponsorship opportunities.	
		16. We will modernise and manage our fleet with new driver safety and security systems, whilst introducing engineering quality standards within the workshops, and in parallel ensuring all our vehicles meet the requirements of London's Ultra Low Emission Zone (ULEZ) before exemption period is complete.	

9.4 Our Partners

	Outcome	Deliverables	Interventions
Our Partners	Outcome 10: Maximise safe non-conveyance to ED	17. We will improve the quality of care we deliver to patients through ongoing digital transformation to reduce our reliance on paper forms and to digitally connect and share information with other relevant health system partners.	<ul style="list-style-type: none"> • Connecting Clinicians: ePCR • Pioneer: Mental Health • Pioneer: Maternity • Pioneer: Falls • Training of Rotational Paramedics • Upskilling Band 6's
		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	
19. We will begin delivering our new 'pioneer services' set out in our strategy, specifically focusing on mental health, falls and supporting staff to refer to alternative care pathways across the London health economy that improves outcomes for patients and reduces conveyances to ED.			
	Outcome 11: Optimising the delivery of 111 / IUC services across London	20. We will work with the London Health system to achieve our vision to become the primary integrator of emergency and urgent care (999, all 111/IUC providers), including bidding for 111 contracts as necessary and strengthening relationships with other health system partners.	<ul style="list-style-type: none"> • iCAT development

	Outcome	Deliverables	Interventions
	<p>Outcome 12: Delivering statutory responsibilities and mandatory standards</p>	<p>21. We will deliver the key elements in our Quality Plan for 2019/20 to improve patients' experience and quality of care for patients.</p> <p>22. We will respond to the CQC recommendations by continuing to improve the quality and security of our drug management through the roll-out of our Secure Drug Rooms, Primary Response / ALS bags, Vehicle-based multi-dose drug packs and enabling IT applications and the delivery of all other actions within the Towards Outstanding plans by April 2020.</p> <p>23. We will be fully compliant with Data Protection Legislation, ensuring the Trust understands the importance of data protection, and reviews new projects and policies against their impact on information governance.</p> <p>24. 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 and strategic commitment to collaborate, innovate and maximise the efficiency of our combined public service provision.</p>	<ul style="list-style-type: none"> • Carry over of 2018/19 cyber programme • Cyber managed service • GDPR Compliance • EPRR: Command and control to meet national standards • Ready Set Go: Secure Drug Rooms: Phase 1 completion • Ready Set Go - Secure Drug Rooms: Phase 2 • Cyber 19/20+ programme • Security: Estates • Ready Set Go: Primary Response Bags and Advanced Life Support Bags • Ready Set Go: Multi-dose • Quality Improvement Plans • Delivering our quality account priorities for 2019/20

10 How we will fund our plan

This section shows our overall income & expenditure, cash flow and balance sheet plan, the capital plan and the operational workforce required to meet performance at the planned productivity levels outlined in Section 7.0. The plan maintains the current arrangements regarding the NHS 111 Integrated Urgent Care contracts (South East London and North East London). **N.B. The financial plan is subject to agreement of contract with commissioners – negotiation is still ongoing. Tables are from 12th February submission to NHSI. These will be updated for final submission.**

10.1 Trust Income

The table below sets out the income plan for 2019/20 that delivers a balanced budget, against the expenditure plan in Section 10.2.

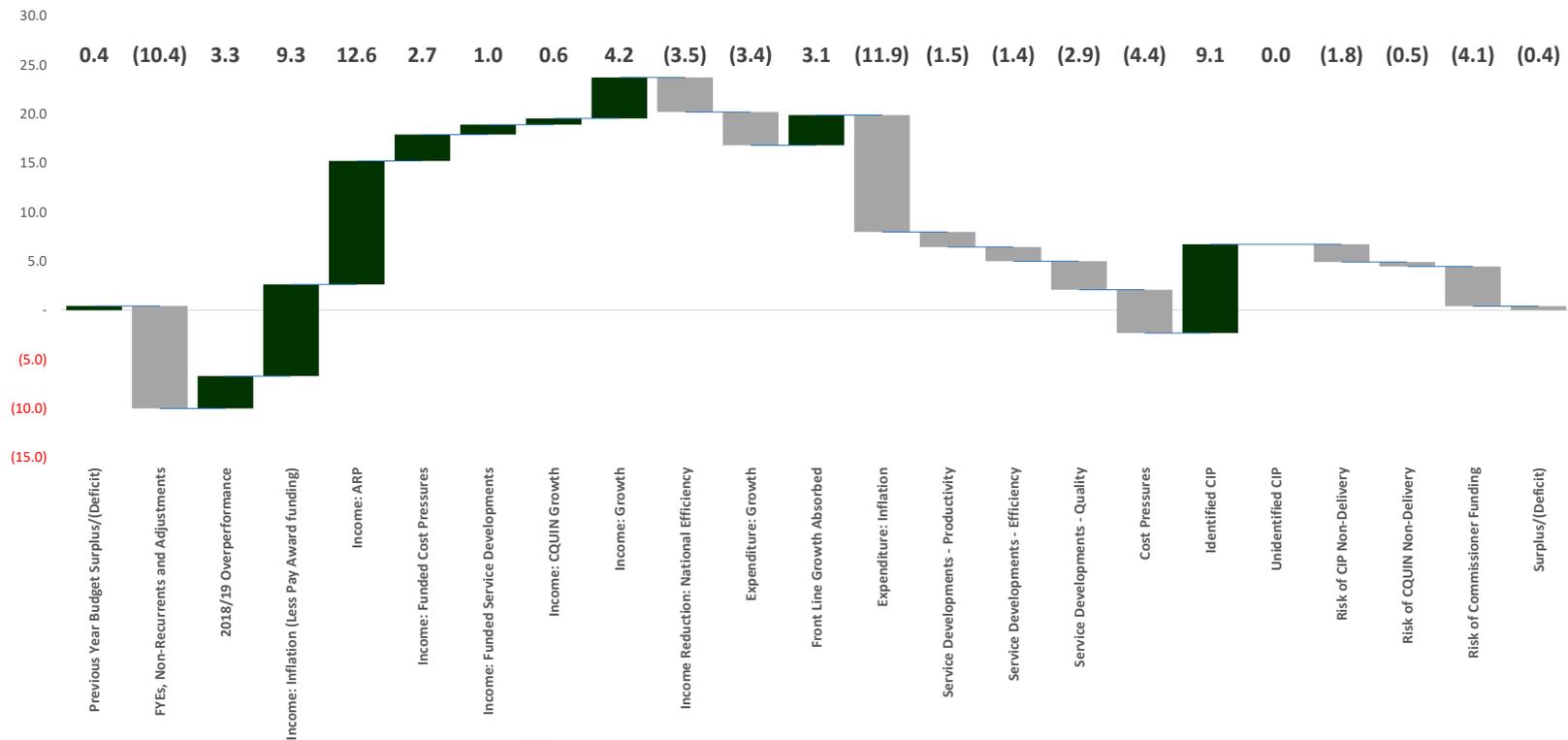
The income and expenditure for integrated and urgent care contracts in North East and South East London have been reflected in the financial plan in accordance with the values outlined in the contract and the documents used to win the bids.

Income	2018/19 (£m)	2019/20 (£m)	Notes
Emergency Service & Urgent Care Contract (ESUC) "999"	328.5	371.43	Subject to negotiation. As per LAS proposal 13 Mar.
North East London Integrated Urgent Care Service (IUC) "NEL 111"	8.6	9.1	As per Tender
South East London Integrated Urgent Care Service (IUC) "SEL 111"	8.3	9.0	As per Tender
Heathrow Service Provision	1.17	1.17	Assumed Flat
Items previously funded by DHSC and NHSE	16.7	-	These have transferred to ESUC
Other Income	18.4	13.1	Including non-patient care income, apprentices income, STF funding
Total	381.7	403.8	

10.2 Finance side of the business plan – detail

Our business plan is based upon the growing patient volumes and inflationary cost pressures we anticipate, along with us undertaking interventions to improve our operational productivity and cost efficiency. Following the introduction of the new ARP response standards, we have found that we need to put out more ambulances to meet these more demanding standards. We plan, in 2019/20, to put out more ambulance hours than ever – in addition to improving our productivity – in order to meet the nationally mandated performance standards.

Our plan is summarised in the bridge below between our 2018/19 and 2019/20 budgets:



The table below details how the corporate and operational budgets have been established and their delegation by Directorate. Income for some services is devolved to directorate level and therefore the central income in the attached table is lower than that on the face of the SOCI which shows income and expenditure on a gross basis.

Directorate	18/19 Budget Expenditure	Budget adjustments	2019/20 Base budget	Activity Cost Growth	Pay inflation	111 Full Year Effect	Reserves	2019/20 Base Budget plus inflation and growth and reserves	2019/20 Cost Pressures	2019/20 Service Development funding	2019/20 CIP	2019/20 Total Budget Expenditure
Central Corporate	20.8	0.5	21.3	0.0	0.0	0.0	0.0	21.3	0.0	0.0	-1.6	19.7
Central Income	0.1	0.0	0.1	0.0	0.0	0.0	3.4	3.5	0.0	0.0	0.0	3.5
Chairman & Non-Executives	0.2	0.0	0.2	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.2
Chief Executive	3.1	-0.1	3.0	0.0	0.1	0.0	0.0	3.1	0.0	0.0	0.0	3.1
Corporate Governance	5.8	-0.2	5.6	0.0	0.0	0.0	0.0	5.6	0.3	0.0	0.0	5.9
Finance	3.7	0.0	3.7	0.0	0.1	0.0	0.0	3.8	0.0	0.0	-0.2	3.6
Fleet & Logistics	39.4	-1.1	38.2	0.1	0.3	0.0	0.0	38.6	0.8	1.5	-1.4	39.5
Im&T	14.9	0.1	15.0	0.0	0.3	0.0	0.0	15.3	2.2	0.7	-0.5	17.6
Medical	20.3	0.8	21.1	0.0	0.7	0.0	0.0	21.8	0.0	1.0	0.0	22.8
Operations	239.2	6.1	245.3	0.3	8.5	4.7	0.0	258.8	0.6	1.1	-4.4	256.0
People & Culture	9.3	-0.1	9.2	0.0	0.2	0.0	0.0	9.4	0.0	0.7	0.0	10.0
Performance	1.2	0.0	1.2	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	1.3
Quality & Assurance	5.9	0.3	6.2	0.0	0.2	0.0	0.0	6.4	0.4	0.2	-0.2	6.8
Strategic Assets & Property	10.9	0.1	10.9	0.0	0.0	0.0	0.0	11.0	0.2	0.8	-0.7	11.3
Strategy & Communications	2.5	-0.1	2.5	0.0	0.1	0.0	0.0	2.5	0.0	0.0	0.0	2.5
London Ambulance Service Total	377.3	6.3	383.6	0.3	10.5	4.7	3.4	402.5	4.4	5.9	-9.0	403.8

As at 19-Mar, our 999 contact is still subject to negotiation and this may affect the expenditure available to the Trust.

10.3 Assumptions

10.3.1 Growth

We believe that patient demand is going to continue to grow at the rate that we have seen historically, which is the number of incidents the Trust will attend each day growing by 1.2% each year. As 2019/20 will be a leap year, we expect the total number of incident we'll attend grow by 1.5%. This growth is a key assumption in our expectation of the amount of people we'll need to have out on London's roads helping patients.

10.3.2 Inflation

Inflation is a key driver of our costs.

10.3.2.1 Pay

The agenda for change pay deal announced in June 2018, results in all Agenda for Change staff getting a 6.5% pay rise over the next three years. We factor this into our business plan.

10.3.2.2 Non-Pay

Our other costs, such as fuel, maintaining vehicles and drugs are all rising, and we factor the cost of these in, based on planning guidance from NHSI.

10.3.2.3 Income

Based on the NHSI planning guidance, we'll receive an increase in our income from the London Clinical Commissioning Groups to pay for these pay and non-pay inflationary pressures. Our plan allows us to manage the difference between the income we receive to pay for inflation and the actual cost to us of that inflation.

The assumptions are summarised below:

	2019/20 (Year 1)	2020/21 (Year 2)	2021/22 (Year 3)	2022/23 (Year 4)	2023/24 (Year 5)
Pay Inflation	3.9%	3.0%	3.0%	3.0%	3.0%
Non-Pay inflation	1.5%	2.0%	2.0%	2.0%	2.0%
Tariff Inflator	3.7%	2.7%	2.7%	2.7%	2.7%
Baseline Activity Growth	1.5%	0.80%	1.2%	1.2%	1.5%
National required Cost Efficiency	1.1%	1.1%	1.1%	1.1%	1.1%
Target CIP*	£9.0m	£8.0m	£8.0m	£8.0m	£8.0m
Cost Efficiency Identified	£9.0m	£5.3m	£0.9m	£0.0m	£0.0m
Productivity Benefits Identified	£4.2m	£4.4m	£4.8m	£0.0m	£0.0m

10.3.3 Cost Pressures

The Trust has identified £3.8m of cost pressures for 2019/20. These are unavoidable costs to ensure the Trust meets its contractual obligations and regulatory and safety standards. The specific pressures are outlined below.

Pressure	Description	Total – 2019/20 (£)
Level 3 safeguarding	Provision of Level 3 safeguarding training to front line staff to enable them to complete Safeguarding referrals directly to the Local Authority.	350,000
IMT Cyber Security	Establishment of a specific cyber security team to ensure the Trust meets Cyber Essentials and implement specific cyber security projects to mitigate the risk / threat of cyber-attacks.	474,000
GDPR Compliance	Establishment of an information governance team to ensure the Trust is GDPR compliant.	150,000
EPRR Command and Control	Provision of additional training for the emergency preparedness, resilience and response team to ensure they meet new regulatory standards.	1,100,000
WRES - Equality and Diversity training	Provision of cultural and inclusivity training for all staff.	377,000
IMT Licensing and infrastructure	Inflationary pressures and new technology requirements to maintain the infrastructure to run an ambulance service.	1,901,000
Total		4,352,000

10.3.4 Service Development

Over the next three years, we plan to improve the service we offer to patients, improve how we look after our people and improve our operational productivity to deliver this service within the resources of the NHS. The cost of making these changes – some tactical and some long term – are all included in our plan. These developments are summarised in the Appendix I.

10.3.5 ARP Funding

<To be updated when ARP agreement made with Commissioners>

10.4 Statement of financial position

Statement of Financial Position details assets and liabilities of the Trust and how these are financed.

<To be updated when our Income and Expenditure position is finalised>

Statement of Financial Position (SOFP)	18/19 £'000	19/20 £'000
Non-current assets		
Intangible assets	1,906	2,392
Property, plant and equipment: on-SoFP IFRIC 12 assets	162,938	173,704
Total non-current assets	164,844	176,096
Current assets		
Inventories	3,158	2,832
Trade and other receivables: due from NHS and DHSC group bodies	11,776	4,900
Trade and other receivables: Due from non-NHS/DHSC group bodies	8,321	17,979
Other current assets		
Cash and cash equivalents: GBS/NLF	8,306	18,566
Cash and cash equivalents: commercial / in hand / other	7	7
Total current assets	31,568	44,284
Current liabilities		
Trade and other payables: capital	(37,503)	(2,150)
Trade and other payables: non-capital		(37,090)
Provisions	(1,178)	(3,445)
Other liabilities: deferred income including contract liabilities		(100)
Total current liabilities	(38,681)	(42,785)
Total assets less current liabilities	157,731	177,595
Non-current liabilities		
Borrowings	(107)	(107)
Provisions	(8,328)	(8,274)
Total non-current liabilities	(8,435)	(8,381)
Total net assets employed	149,296	169,214
Financed by		
Public dividend capital	59,356	63,543
Revaluation reserve	54,142	58,083
Other reserves	(419)	(419)
Income and expenditure reserve	36,217	48,007
Total taxpayers' and others' equity	149,296	169,214

10.5 Cash flow

The cash flow plan sets out the impact of the Trust activities on the cash available to the Trust. Principle movements in the cash position are as follows:

Statement of Cash Flow (SOCF)	Plan 18/19 £'000	Plan 19/20 £'000
Cash flows from operating activities		
Operating surplus/(deficit)	2,597	4,547
Non-cash income and expense:		
Depreciation and amortisation	15,520	16,630
(Increase)/decrease in trade and other receivables	(247)	5,595
(Increase)/decrease in inventories	0	0
Increase/(decrease) in trade and other payables	(1,700)	2,609
Increase/(decrease) in provisions	(2,443)	(3,708)
Net cash generated from / (used in) operations	13,727	25,673
Interest received	67	118
Purchase of intangible assets	(21,734)	0
Purchase of property, plant and equipment and investment property		(22,000)
Proceeds from sales of property, plant and equipment and investment property	0	0
Net cash generated from/(used in) investing activities	(21,667)	(21,882)
Cash flows from financing activities		
Public dividend capital received		
PDC dividend (paid)/refunded	(4,200)	(4,656)
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	(4,200)	(4,656)
Increase/(decrease) in cash and cash equivalents	(12,140)	(865)
Cash and cash equivalents at start of period	20,453	19,437
Restated cash and cash equivalents at start of period	20,453	19,437
Cash and cash equivalents at end of period	8,313	18,572
Cash balance per SOFP	8,313	18,573

10.6 Capital plan

Throughout the extensive business planning process each Directorate has identified capital requirements for the next five years. These have been assessed and prioritised by the Executive Leadership to establish the capital plan outlined below. This includes investment in:

- **The LAS estate:** We will continue to invest in the estate we have to ensure it is fit for purpose and maximises corporate and operational efficiency. We will make improvements to our Headquarters enabling us to rationalise our corporate service estate.
- **The LAS fleet of vehicles:** We will continue our vehicle replacement programme, completing the conversion of 112 DCAs in 2019/20. We will upgrade our entire fleet, in line with the model ambulance specification and installing driver safety and security systems to improve safety of our people, our patients and our assets.
- **LAS technology and systems:** We will continue to invest in new technologies, both physical hardware and new software and systems. This will ensure our staff can work productively and flexibly as required and enable our operational teams to have more support to provide better assessments on scene, increasing their ability to safely avoid conveyances to Emergency Departments.
- **Operational productivity and clinical quality:** We will invest in new products and services to improve operational productivity and quality. These include new paramedics and advanced life support bags, enhancing the security of our drug rooms and stores, purchasing new defibrillators / life-packs and a new asset management to improve the tracking and management of medical items and consumables.

Additionally, the available capital is outlined below. This includes the Trust's internally generated capital plus known additional capital income.

The Trust is over-committed on its capital plan in 2019/20 recognising that not all capital projects will proceed as planned and there will be delays / reductions in some capital expenditure. The capital plan will be reviewed and assessed throughout the year to ensure it is targeted towards the Trust's biggest priorities.

Capital Plan	2019/20
Estates	4,126
Fleet	9,322
IM&T	385
Operational Quality and Productivity	7,736
Total	21,569

Funding Plan	2019/20
Carry Forward	-
Internally Generated	15,500
National Grants	700
Provider Sustainability Fund	4,000
Total Capital Expenditure	20,200

10.7 Cost Improvement Programme

For 2019/20, our efficiency plan is outlined in the schemes below.

Project	Type of Expenditure / Income	Recurrent or Non-Recurrent	Directorate	Status	Efficiency Programme Area	Risk Rating	Plan £'000	QIA Req'd	QIA Status
Workforce productivity (overtime and incentives)	Pay (WTE reductions)	Recurrent	Operations	Plans in progress	Workforce (other)	High	3,894	Yes	In progress
Headcount reduction	Pay (WTE reductions)	Recurrent	Various	Plans in progress	Workforce (other)	Medium	306	Yes	In progress
Estates relocations and consolidation	Non-pay	Recurrent	Property	Plans in progress	Estates and Facilities	High	206	Yes	In progress
Soft Facilities Management	Non-pay	Recurrent	Property	Plans in progress	Estates and Facilities	Medium	315	Yes	In progress
Asset Management	Non-pay	Recurrent	Fleet & Logistics	Plans in progress	Procurement	Low	50	Yes	In progress
Procurement Fleet	Non-pay	Recurrent	Fleet & Logistics	Plans in progress	Fleet	Medium	248	Yes	In progress
Drugs, Medicines and Equipment	Non-pay	Recurrent	Medical / Fleet & Logistics	Plans in progress	Procurement	Low	341	Yes	In progress
Effective Fleet Management	Non-pay	Recurrent	Fleet & Logistics	Plans in progress	Fleet	Low	463	Yes	In progress
Driver Safety Systems	Non-pay	Recurrent	Fleet & Logistics	Plans in progress	Fleet	Medium	250	Yes	In progress
Clinical Education Standards Transformation	Pay (WTE reductions)	Recurrent	Medical	Plans in progress	Workforce (other)	Medium	286	Yes	In progress
Procurement - Influencible Spend	Non-pay	Recurrent	Finance	Plans in progress	Corporate and Admin	Low	1,023	Yes	In progress
ESR Transformation	Non-pay	Recurrent	People & Culture	Plans in progress	Corporate and Admin	Low	23	No	In progress

Project	Type of Expenditure / Income	Recurrent or Non-Recurrent	Directorate	Status	Efficiency Programme Area	Risk Rating	Plan £'000	QIA Req'd	QIA Status
Corporate efficiency	Pay (WTE reductions)	Recurrent	Various	Plans in progress	Workforce (other)	Low	1,458	Yes	In progress
Commercial Income	Income (Other operating income)	Non-recurrent	Various	Plans in progress	Other Savings Plans	High	250	No	In progress
Productivity Improvement						High	3,000		
Total							12,113		

Risk to Delivery:

Low	No anticipated risk arising from QIA. No risk of non-delivery
Medium	Minimal actual or anticipated risk arising from QIA and/or medium risk of non-delivery
High	Actual or anticipated risk arising from QIA and/or high risk of non-delivery

10.8 Operational Workforce

The workforce plan has been produced as part of the Trust's business planning process, and is derived from the business planning model that forecasts the resources required to meet ARP performance targets, given the planned productivity changes and assumed growth in demand.

This section explains the key changes in the Trust's overall WTE plan and then shows how frontline operational resources for our 111 and 999 services are aligned in terms of budget, people and activity plans. The WTE plan is based on the substantive WTE's required to meet the operational plan. However, in practice, this does not necessarily translate directly to the internal workforce plan for recruitment purposes, as Operations will use a range of options for deployment e.g. overtime, use of PAS/VAS in certain circumstances.

Planned efficiencies in 2019/20 will deliver the equivalent of 55 WTE ambulance staff. With improved recruitment and retention LAS will reduce its current vacancy rate and therefore reliance on overtime, the Trust currently covers c.300 WTE per month through overtime, a significant proportion of which is paid at premium rates. These reductions are key work streams within the Trust's CIP.

	Forecast Out-turn 18/19	Plan 19/20	Plan 19/20	Plan 19/20
	WTE	WTE	WTE Change	% Change
ALL STAFF	5,997.28	6,088.99	91.71	1.53%
Bank	44.21	40.21	(4.00)	(9.05%)
Agency staff (including, Agency, Contract and Locum)	174.05	19.93	(154.12)	(88.55%)
Substantive WTE	5,779.02	6,028.85	249.83	4.32%
Total Substantive Non-Medical -Clinical Staff	4,207.65	4,278.04	70.39	1.67%
Total Substantive Non-Medical- Non-Clinical Staff	1,569.33	1,748.76	179.44	11.43%
Total Substantive Medical and Dental Staff	2.04	2.04	(0.00)	(0.00%)
Registered Nursing, Midwifery and Health visiting staff	31.49	31.49	(0.00)	(0.00%)
All Scientific, Therapeutic and Technical Staff	2.71	2.71	0.00	0.00%
Allied Health Professionals	0.00	0.00	0.00	-
Other Scientific, Therapeutic and Technical Staff	0.00	0.00	0.00	-
Health Care Scientists	2.71	2.71	0.00	0.00%
Qualified Ambulance Service Staff	2,957.33	2,980.32	22.99	0.78%
Support to clinical staff	1,216.12	1,263.52	47.40	3.90%
NHS Infrastructure Support	1,569.33	1,748.76	179.44	11.43%
Any others	0.00	0.00	0.00	-
Total Medical and Dental Staff	2.04	2.04	(0.00)	(0.00%)
Bank	44.21	40.21	(4.00)	(9.05%)
Total Non-Medical -Clinical Staff	44.01	39.99	(4.02)	(9.13%)

	Forecast Out-turn 18/19	Plan 19/20	Plan 19/20	Plan 19/20
Registered Nurses	0.00	0.00	0.00	-
Qualified Scientific, Therapeutic and Technical Staff	0.00	0.00	0.00	-
Qualified Ambulance Staff	44.01	39.99	(4.02)	(9.13%)
Support to clinical staff	0.00	0.00	0.00	-
Total Non-Medical- Non-Clinical Staff	0.20	0.22	0.02	10.00%
Total Medical and Dental Staff	0.00	0.00	0.00	-
Agency staff (including, Agency, Contract and Locum)	174.05	19.93	(154.12)	(88.55%)
Total Non-Medical -Clinical Staff	22.76	11.64	(11.12)	(48.86%)
Registered Nurses	22.76	11.64	(11.12)	(48.86%)
Qualified Scientific, Therapeutic and Technical Staff	0.00	0.00	0.00	-
Qualified Ambulance Staff	0.00	0.00	0.00	-
Support to clinical staff	0.00	0.00	0.00	-
Total Non-Medical- Non-Clinical Staff	151.29	8.29	(143.00)	(94.52%)
Total Medical and Dental Staff	0.00	0.00	0.00	-

10.9 Financial Risks

In addition to the budgets detailed above there are a number of risks to delivery of the Trust financial target. These are detailed below:

Revenue Risks	Impact £'m	Likelihood	Value £'m	Mitigations
Commissioners don't agree to meeting the cost of Growth, ARP or strategic initiatives across the trust	11.2	50%	5.6	<This should be mitigated / conclude before final publication>
The trust is unable to identify and deliver sufficient schemes to meet the CIP target in each year	9.1	20%	1.8	Throughout the business planning process the business planning team has worked extensively with Directorates to identify challenging and achievable CIP schemes. These have been agreed in the budget setting process and will be tracked and monitored throughout the year.
The trust is unable to deliver the required level of productivity to meet demand growth	3.0	25%	0.75	The Trust has identified specific interventions to improve the operational productivity of front line

				services. These align with the five-year strategy, Carter recommendations and commissioner requirements. The Trust has established specific action plans for each area and these will be monitored throughout the year for progress.
The trust is unable to deliver the required operation changes to meet CQUIN targets (c.£4m in 2019/20 and beyond)	4.0	10%	0.4	The Trust have an extensive productivity improvement programme targeting key measures of productivity such as ED conveyance. These will ensure we meet the CQUIN targets as key outcomes for the programme.
IUC cannot be delivered within the level of resource agreed with commissioners (15% overspend across two contracts)	2.7	50%	1.35	Implementation of tighter financial controls
We are unable to get Capital Resource Limit cover for the PSF cash from NHSI	3	25%	1	Ongoing engagement with NHSI.
Implications of the EU exit.	6.2	20%	1.2	Ongoing working group exploring and planning for the implications of the EU exit actively mitigating these risks.
The trust cannot deliver performance standards and incurs financial penalties from 2020/21	Not applicable for 2019/20			
TOTAL			12.1	

11 Strategic Risk and Mitigation

At LAS a rigorous approach to identifying and mitigating risks has been developed and implemented across our organisation. This is summarised in the Trust’s Risk Management and Strategy Policy most recently updated in March 2018 which states:

“The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors. This strategy and policy describes a consistent and integrated approach to the management of all risk across the Trust. The Trust is committed to having a risk management culture that underpins and supports the business of the Trust.”

The Trust Board has set the ‘risk appetite’ for the organisation and remain accountable for ensuring that these thresholds are achieved and managed appropriately. These have been considered through the 2019/20 business planning process.

A central principle has been to ensure that any project associated with the mitigation of risks identified on the Corporate Risk Register and through the Board Assurance Framework (BAF), is prioritised as ‘Must Do’ for 2019/20. The current active risks on the BAF and the associated mitigating actions from the business planning process are below:

BAF RISKS TO BE ADDED FOLLOWING BOARD MEETING

Additionally, other risks to the delivery of 2019/20 business plan were identified. These have been considered and mitigated through the process as explained below.

Risk	Mitigation
The 18/19 base budget has assumed fuel prices remain at £1.22 per litre on average over the year. This is consistent with external forecasts but there is a risk that if fuel price were to rise, the cost of this will need funding from elsewhere in the budget	The business plan is based on external forecasts (fuel price to remain constant / reduce) and contingency is planned into the budget for unforeseen changes in external factors.
The business plan intends to reduce Hospital Handover time from 17 minutes on average to 15 minutes on average. This significantly depends on the ability of hospitals to hand patients over to, presenting a risk that this is not deliverable.	The Trust are working closely with Hospitals in London to improve hospital handover, with stakeholder engagement managers and relevant operations managers exploring solutions. If this is not achieved, further reduction in Handover to Green and other productivity measures will be required.
Business as usual pressures and the threat of other major incidents continue to risk the delivery of business plan and associated projects in 2019/20	The ExCo took the decision to take account of a set number of unplanned Major incidents through the year. This will mean we are resourced appropriately should these incidents occur.
Our projects, closely associated with the pace of National Programmes, may be impacted if	We continue to work closely with national and regional bodies on to ensure we are providing the best services for our patients today and

Risk	Mitigation
the central progress is slower than that anticipated	planning the best service developments for the future. We work closely with these teams to understand expected timescales for delivery and adapt appropriately where necessary.
The significant amount of programme activity (including possible restructure and major fleet and estate modernisation), desired pace for change, along with possibility of a Major Incident, will put significant strain on supporting directorates such as Performance, Corporate Governance, and Communications.	The ExCo Business Planning session allowed all directors to view the draft portfolio of programmes for 19/20 in the round. This included an assessment of the impact of each programme on all directorates. Directors have been asked to consider the overall impact on their area and feedback before plans are finalised.

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12 Governance: How we will assure the delivery of the business plan

12.1 Governance processes

The business plan will be overseen and managed through the Trust's existing governance arrangements as outlined below:

Mechanism	How they will assure the business plan
Trust Board	<p>The Trust Board leads the organisation by setting the strategy, vision, mission, values and culture. They are ultimately responsible for the delivery of the business plan. The Trust Board will:</p> <ul style="list-style-type: none"> • Approve spending on large programmes and capital expenditure • Review progress of the business plan deliverables • Receive updates on strategic priorities
Executive Committee (ExCo)	<p>Our ExCo, which is led by our chief executive, consists of the executive directors who are on the Trust Board and five other directors. The ExCo leads and manages the performance of the Trust within the strategic framework established by the Trust Board. In doing so, they are responsible for:</p> <ul style="list-style-type: none"> • the development and implementation of strategy, operational plans, policies, procedures and budgets • the monitoring of operational and financial performance • the assessment and control of risk • the prioritisation and allocation of resources. <p>ExCo members individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to identify, manage and mitigate risks to successful operation of the Trust.</p>
Portfolio Management Board (PMB)	<p>The PMB is responsible for prioritising the Trust's portfolio of programmes and projects, including the delivery of CIPs and business cases. The PMB will receive reports on key programmes, resolve issues, mitigate risks and escalate where required to ExCo.</p>
Enterprise Portfolio Management Office (ePMO)	<p>The ePMO reports into the PMB via the Chief Quality Officer. Its core function is to provide independent assurance to programmes and projects delivered by the Trust together with providing advice and guidance; methodology; standards and tools. The ePMO will monitor, track and assure all programmes and projects within this business plan. As and when new priorities emerge, they will be required to go through the ePMO led Demand Management process to assist PMB in prioritising these.</p>
Board Assurance Committees	<p>The Trust Board has established the following Committees (all chaired by a non-executive director) to provide it with assurance in relation to the effectiveness of the controls in place to identify, manage and mitigate the risks to the successful operation of the Trust:</p> <ul style="list-style-type: none"> • Quality Assurance Committee - provides the Trust Board with assurance on the provision of a high quality, safe, and effective service • Finance and Investment Committee – focusses on the Trust's financial and investments policies, management and reporting, as well as overseeing its performance reporting framework. • Audit Committee – focuses primarily on the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

Mechanism	How they will assure the business plan
	<ul style="list-style-type: none"> • People and Culture Committee – considers all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks • Logistics and Infrastructure Committee - provides assurance on and oversees strategic development and investment in Fleet, Logistics, Estate and IM&T • Remuneration and Nominations Committee - appoints and, if necessary, dismisses the executive directors, establishes and monitors the level and structure of total reward for executive directors, ensuring transparency, fairness and consistency. <p>After every meeting, each of these Committees provide the Trust Board with a report on how it has fulfilled its duties.</p>

12.2 Board Assurance Committees

The Trust Board has established the following Committees (all chaired by a non-executive director) to provide it with assurance in relation to the effectiveness of the controls in place to identify, manage and mitigate the risks to the successful operation of the Trust:

- **Quality Assurance Committee** - provides the Trust Board with assurance on the provision of a high quality, safe, and effective service
- **Finance and Investment Committee** – focusses on the Trust’s financial and investments policies, management and reporting, as well as overseeing its performance reporting framework.
- **Audit Committee** – focuses primarily on the risks, controls and related assurances that underpin the achievement of the Trust’s objectives.
- **People and Culture Committee** – considers all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks
- **Logistics and Infrastructure Committee** - provides assurance on and oversees strategic development and investment in Fleet, Logistics, Estate and IM&T
- **Remuneration and Nominations Committee** - appoints and, if necessary, dismisses the executive directors, establishes and monitors the level and structure of total reward for executive directors, ensuring transparency, fairness and consistency.

After every meeting, each of these Committees provide the Trust Board with a report on how it has fulfilled its duties.

Clinical Council

The Clinical Council exists to provide assurance to the Executive Leadership Team and Trust Board that the clinical elements of the Trust Strategy and Improvement plan are being implemented effectively and in a timely manner

Corporate Committees

Corporate Committees, such as the Quality Oversight Group, exist to ensure that cross-directorate risks and issues are being managed and mitigated appropriately.

Directorate management

Operations Directorate

The Operations Directorate manages its business through station level meetings, to sector level meetings, which escalate issues up to the Operations Board as necessary.

Corporate Directorates

Corporate Directorates, which are not as large as the Operations Directorate, have team meetings and directorate-wide meetings to manage their risks and business as appropriate.

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Appendix I: Strategic Programmes and Improvement projects

To manage the delivery of the business plan, each service development, cost pressure and efficiency project has been grouped within the four portfolios used by the Portfolio Management Board. Within these portfolios, projects have been grouped into programmes with formal project and programme management support and reporting requirements. Each Programme will include a Programme SRO, a Programme Manager and a Programme Board chaired by the Programme SRO and including all relevant stakeholders to drive and direct the programme.

The progress of the programmes will be reported through to the Portfolio Management Board and through the Chair of the PMB to Executive Committee and the Trust Board. Escalation of key risks and issues will be raised through Programme Management via the Programme Board to the Executive led Portfolio Management Board.

The strategic programmes, their sub-projects (where identified), the SRO and key stakeholders are outlined below:



	Strategic Programmes	Projects / Action	Programme SRO	Key stakeholders
Trust wide strategist Programme	Pioneer services & ED Conveyance	Pioneer Falls Pioneer Maternity Pioneer Mental Health UC Apps Improved ACP usage Training of rotational paramedics Upskill Band 6	Quality	Medical, Operations, Fleet and Logistics
	iCAT	ICAT	Medical	Operations, IM&T, People and Culture, Quality
	Spatial Development	Consolidation of Corporate Estate Rationalisation of CETS training estate Relocation EOC training Rationalisation of operational estate Consolidation of operational teams Security Restructure property team Electrification of fleet	Strategic Assets (Property)	All Directorates
	Drugs, consumables and equipment		Strategic Assets (Fleet and Logistics)	Medical, Operations, IM&T
	Asset Management	End to end tracking and management of medical equipment Tranman deployment		
	Fleet	Replacement of fleet Bunkered fuel Blue light conversion Fleet improvement: Driver safety and security systems Workshop improvements Restructure of fleet maintenance Consolidation of vehicles		
	Ready Set Go	Multi Dose Secure Drug rooms phase 1 & 2 Primary response bags/advanced life support bags		
	Security	Protection of staff Sensitive spaces		
	IM&T Essentials	Avaya 999 upgrade EOC CAD Updates IM&T Cyber MS Office 365		
	New CAD & EPCR	New EOC CAD Connecting clinicians		
ESR	Employee Service Records			
Culture				
Clinical Education Planning & Digitisation	Archiving of paper student records Digitising student records Reduce the footprint			

Appendix II: Summary of Savings and Expenditure

	Cash releasing saving ('000s)			Productivity Saving ('000s)			Revenue cost ('000s)			Capital cost ('000s)		
	19/20	20/21	21/22	19/20	20/21	21/22	19/20	20/21	21/22	19/20	20/21	21/22
Cost pressure	£75	£225	-	-	-	-	£4,424	£2,442	£1,820	£245	-	-
Efficiency	£8,697	£5,285	£753	£660	-	-	£1,447	£687	£1,507	£7,015	£9,098	£7,354
Productivity	£248	£189	-	£2,104	-	-	£1,542	£1,999	£2,469	£7,368	£14,987	£13,158
Quality	£201	£49	-	-	-	-	£2,903	£675	£1,166	£8,267	£4,721	£4,721
TOTAL	£9,221	£5,747	£753	£2,764	-	-	£10,316	£5,803	£6,962	£22,895	£28,806	£25,233

Appendix III: Progress against the delivery of the 2018/19 business plan

Ref	Business Plan Deliverable	SRO	Status	Achieve against Deliverable
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	●	Gap analysis completed, evidence has confirmed we have maintained good rating across all domains. Preparation for CQC will start from April 1st
BP.2	We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards	Paul Woodrow	●	Nov moved to BAU
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.	Trisha Bain	●	Currently 21 APP Urgent Care in post. Cohort 2 & Cohort 3 are undertaking their educational programme. The new Clinical Practice Development Manager for Urgent Care has commenced. The Medical Director, Director of Operations and Director of People and Culture have met and agreed that there will be a further 10 APP UC in 2019-20 and 10 in 2020-21
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	Multiple SRO's	●	Five year strategy complete and published. Enabling strategy for People and Culture has been signed off by Trust Board. IMT & Digital is due for Trust Board sign off in March. Remaining strategies are in progress across the organisation.
BP.5	We will pilot the new 'Pioneer Services' set out in our new strategy	Trisha Bain	●	Mental health pilot – 3mth evaluation completed. Met the target of 90% ED against a BAU of 54%. Discussion with SE / SW providers in relation to the provision of a rotational MH nurse model. All other Pioneering services on track and positive outcomes in terms of improved education, training and knowledge in relation to EoL, Falls. APPs recruited and again positive evidence in relation to ED conveyance.

Ref	Business Plan Deliverable	SRO	Status	Achieve against Deliverable
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	●	Focussed work in high level callers in specific boroughs has shown a reduction in caller numbers. Additional frequent caller manager recruited to permit each sector to have a resource working closely with QGAMs and SEM
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	●	Business case approved for bags, Logistics Services Unit undergoing building modification to be completed this year with roll-out Advanced Life Support, Multi-dose Drug Pack and Primary Response Bag from April.
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	●	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. We have set up a monitoring system of usage and have an unvalidated figure of 95% of users accessing their iPad regularly. Each group station has a super user identified to assist colleagues who are less confident
BP.9	We will complete our recruitment plan to fully establish our front-line and newly enlarged Emergency Operations Centre structures.	Patricia Grealish	●	We are currently refreshing reporting for EOC recruitment trajectories in line with the new organisational structure. The management team are confident that the restructure and planned recruitment and training activities will enable us to reach establishment within Q1 2019/20. Focus is on identifying new training estate for EOC new recruitments and internal upskilling requirements.
BP.10	We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate.	Patricia Grealish	●	In delivery – Whilst planned restructures are complete and implementation (by the end of the financial year) is underway, some minor reorganisations will still be required as a result of decisions taken during the latter part of 2018 (e.g. establishment of an Enterprise Project Management Office). Pre-planning work for the restructure for Strategic Assets and Property is underway with delivery during H1 2019/20.

Ref	Business Plan Deliverable	SRO	Status	Achieve against Deliverable
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		On track. All the new branding is completed and, 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 (through Senior Management Meetings bi-monthly, and through the Visible Leader and Engaging Leader leadership programmes).
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		Complete. 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		Complete. Activities under the WRES Action Plan for 17/18 have now been rolled into the extensive action plan agreed for 18/19 and 19/20. Work has commenced on readying for the new Workforce Disability Equality Standard Action Plan which has been discussed at Equality Committee and People and Culture Committee. Likely to be August 2019.
BP.14	We will continue to implement our Clinical Education Strategy	Fenella Wrigley		Clinical education strategy workshop and alternative care pathway workshops have both been held. This, alongside the workforce planning workshop will enable the clinical education strategy to be completed. The electronic student management system has been approved with IM+T and purchased in this financial year. 2000 student training record boxes have been removed from Education Centres to a safe storage location
BP.15	We will develop and roll-out training and development for all our people across functional and operational teams.	Patricia Grealish		Complete. Leadership development programme in delivery phase and Management Essential programmes also underway. First cohort of visible leaders completed with second and subsequent cohorts planned. Continuous improvement will be built into the leadership development pathway elements as delivery progresses.

Ref	Business Plan Deliverable	SRO	Status	Achieve against Deliverable
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	Angela Flaherty		We are closely engaged with commissioners and STP partners led by our 5 Stakeholder Engagement Managers. We co-chair a system group on ACPs that are working to identify new and improved care pathways. This group is particularly focussed on improving MiDOS use and mapping ACPs across London to identify best practice and where there are issues. The 5 senior sector clinical leads have been appointed who will focus on appropriate referral to alternative pathways. Our new Deputy Medical Director is leading a piece of work to identify best practice in ACP usage from across our operational teams
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		Both NEL and SEL IUC are mobilised and we are engaged with stakeholders across London to achieve our strategic intention of integrating emergency and urgent care
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		The focus continues on improvement of efficiency regarding crew handover and ability to offload patients. Whilst we have seen continued improvement however, it is recognise the system is still relatively fragile and struggles with unplanned peaks in activity
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.	Paul Woodrow		We continue to work closely with other emergency services and partners. Most notably we are contributing to the Collaborative Contact & Response (CCR) programme. This programme has now been established with baseline assessments and scoping completed. Funding of £4.5m has been applied for to assist with the next phase which will include the creating of a service model and capability map as well as a benefits tracking process. We are anticipating notification of award for the next phase by the end of April.
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 £4.3m surplus including £4.0m Provider Sustainability Funding. This represents a £1.8m underlying improvement on the initial control total agreed with NHS Improvement

Ref	Business Plan Deliverable	SRO	Status	Achieve against Deliverable
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 continuing to forecast delivery of the £12.3m CIP programme with 80% 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.	Trisha Bain		The Trust's Accountable Emergency Officer and its Head of Business Continuity have confirmed that all business continuity plans (there are just over 100 individual departmental plans) were reviewed, and updated as necessary, at the end of November 2018. There are no current plans which are not considered to be within tolerable levels of risk. Particular attention has been paid to business continuity plans relating to staffing, fleet and the Emergency Operations Centre (EOC). Further assurance about the Trust's business continuity arrangements was received following a visit from NHS England's Emergency Planning Resilience and Response (EPRR) team on 29 November 2018. This visit formed part of NHS England's EPRR annual assurance review where the Trust's compliance against core EPRR and business continuity standards was assessed. No concerns were raised during the visit about the Trust's internal business continuity plans.
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 11 the Trust has delivered £14.4m against £21.8m. Forecast to spend its full allocation of £21.8mm by the end of March.
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, Q2 & Q3 CQUIN delivered, risk included in financial forecast on Conveyance, Flu, Staff Health & Wellbeing results.



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Business Plan NHSI Operational Narrative 2019/20			
Agenda item:	09(ii)			
Report Author(s):	Murray Keith, Head of Business Planning			
Presented by:	Lorraine Bewes, Director of Finance and Performance			
History:	Business planning update to Informal Board in February 2019			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
This paper provides an update to the Board regarding progress on the development of the Trust's Operational Narrative for NHS Improvement. This includes details of our financial and operational plan for 2019/20 and beyond.				
Recommendation(s):				
The Board is invited to endorse the Operational Narrative, subject to ongoing commissioner negotiations				
Links to Board Assurance Framework (BAF) and key risks:				
Not Applicable				

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



2019/20 Operating Plan Narrative

London Ambulance Service NHS Trust

Building Sustainable & Continuous Improvement for London

DRAFT



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1 Introduction

Purpose

The purpose of this document is to respond to the submission requirements of NHS Improvement (NHSI) to outline the Trust's approach to activity, quality, workforce and financial planning for 2019/20 and how the Trust is taking forward the local health and care systems' Sustainability and Transformation Plans.

The NHSI guidance for these submissions is set out in 'Annex C: NHS Improvement guidance to trusts for operational plans'.

This document is for the consumption of NHS Improvement. A separate annual business plan will be published for the external audience later in April / May. This will align with the plan outlined below and in the activity, finance and workforce returns.

Approach to 2019/20 Business Planning

The Trust has taken a comprehensive approach to business planning for 2019/20, building on the five year strategy published in the summer 2018. The business planning process has set out how the Trust will pursue the delivery of the five year strategy in the next year, in addition to taking into account a number of external drivers for change. These include:

- The Lord Carter report on ambulance service productivity and the need to reduce unwarranted variation
- The intentions of the local health system, including the priorities of London's five STPs and the intentions of London's commissioners
- The increasing demands of the population of London, both in terms of volume and type of response required
- The priorities set out in the NHS long term plan

In producing this plan, the Trust has invested in creating a business planning model that links performance / activity, productivity, workforce and finance. This forecasts the resource required to meet the Ambulance Response Programme response targets, with the planned levels of productivity (e.g. See and Convey to ED, Hear & Treat, Out of Service), and therefore the required resources to meet performance. This model has been used extensively to set out the operational plan, in addition to costing and prioritising service developments and other interventions put forward by the organisation.

As a result of this comprehensive business planning process, we have a detailed plan that sets out the resources required to meet performance in 2019/20, with efficiency, productivity and quality schemes that support the delivery of this plan. This has been agreed by the Trust's Executive Committee and Trust Board, with budgets for 2019/20 agreed by each Director.

<Note, review and update following commissioner settlement agreement>

2 Activity planning

The 2019/20 business plan is based on the Trust's forecast activity and methodology set out below.

2.1 Overview of activity forecasts

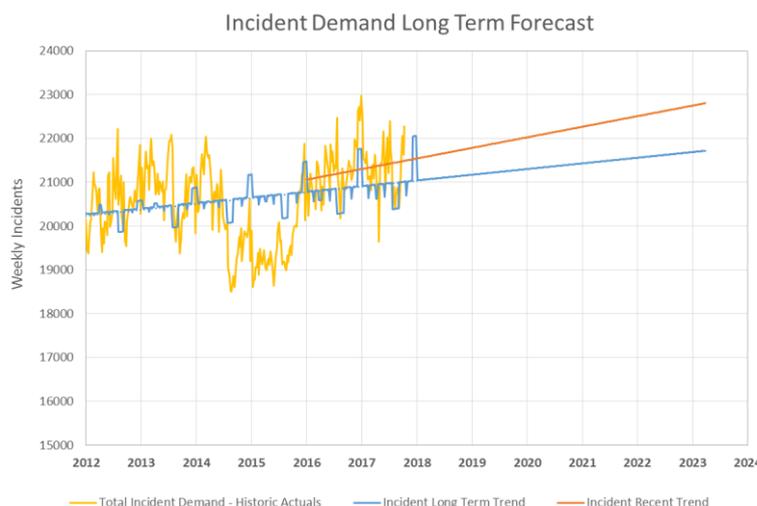
Incident Volume: We expect the number of face to face incidents we attend each day to be 1.2% higher in 2019/20 than the 2018/19 out-turn. Due to the effect of the leap year in February 2020, we expect the total number of face to face incidents the LAS will attend to be c.1.5% higher than the 2018/19 out-turn.

Seasonality: We profile this demand into months for our long term (five year) financial plan, and weeks for our medium term (1 year) operational plans.

Acuity: Our plans are based upon Acuity (i.e. the breakdown of incidents across Categories 1-5) remaining at the levels of 2018/19 outturn.

2.2 Rationale / Methodology

Incident Volume: We have reviewed both long and medium term trends in incident levels, shown below:



The trends of the above graph suggest a steady increase over time in incident volumes. However, the growth rate represented by the blue long-term trend line is dampened by a period of low activity in 2014/15 and 2015/16. The gradient of this blue line represents a growth rate of **c.0.8% per year**. We understand the strong relationship between incident levels (met demand) and the resource we provide to meet this demand. As this reduction in incident volumes coincided with reduced staffing, we believe this this reduction in incident volumes does not represent true patient demand.

Since this period of low incident volumes, we have seen the consistent growth represented by the orange line (**c.1.2% per year**). 2018/19 is turning out to be aligned to this orange line. Further, if the 2014/15 and 2015/16 period is removed, and this trend line is drawn over the remaining data since 2012, a similar projection is created.

In 2016 we undertook a detailed study of population trends in our area of operation and our patient base to understand the demographic pressure. This anticipated growth of **c.2% per year**. Since this study, the growth we have experienced in 2018 and 2019 has been demonstrably below this level.

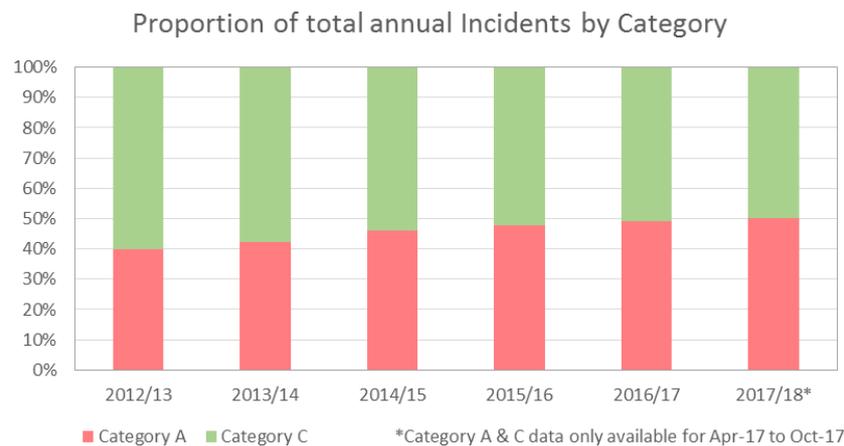
Based on this available information, we believe that the growth rate of daily incident volumes of **1.2% is the most likely**. Internally, we have stress-tested our plan against incident growth of 0.8%

and 2.0% respectively to understand the impact of higher and lower growth on the trust’s financial and operational performance.

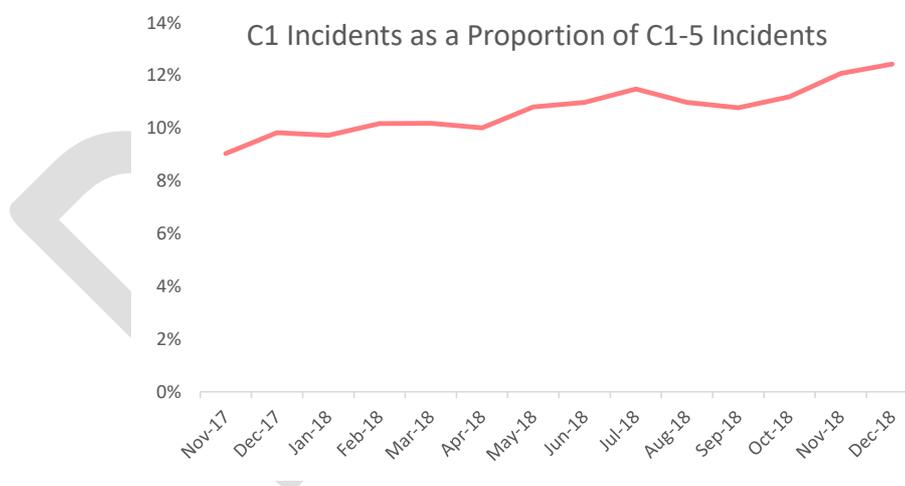
Seasonality: For 2019/20 and beyond we use a 3 year average of the monthly splits of incident volumes, adding an extra $\frac{1}{28}$ th to February for the 2020 leap year.

Acuity: When we implemented ARP (Ambulance Response Programme) on 1st Nov 2017, we moved from measuring incidents in Categories A-C to Categories 1-4 (and later 5). We therefore have a limited data set with which to understand acuity under the ARP categories.

Before ARP, we had seen a steady increase in acuity, as below:



Since the implementation of APR, this increase in acuity has continued to manifest itself as an increase in the proportion of C1 incidents:



However, without sufficient data to understand the seasonal cycle in acuity under the ARP definition, our plans are based on Acuity continuing at 2018/19 out-turn levels. As higher acuity calls are more resource intensive for the Trust, and our commissioning arrangements do not consider the acuity of incidents, this **potential increase in acuity is a key risk to our plan.**

3 Quality planning

3.1 Approach to quality improvement, leadership and governance

Dr Trisha Bain, Chief Quality Officer (CQO) has developed our Trust Quality strategy focussing on improvement and supporting delivery of our vision and objectives. Our definitions of quality are based on the CQC framework drawing on the Francis, Keogh and Berwick reviews and recommendations and Berwick's improvement principles.

The Strategy will be delivered through achieving our quality goals supported by specific targets in our annual Quality Account. The strategy sets out our improvement approach, key enablers and projects required to improve performance. These objectives have quality embedded within them, showing our commitment and reality that quality drives all that we do.

Delivering the strategy will include:

- Building capacity and capability, ensuring the right skills in quality improvement methodology based on NHSI Quality Service Improvement Re-design model (QSIR). 60 staff completed this programme and 15 staff completed Agile programme management techniques training.
- Building the will by setting up learning frameworks, celebrating success, introducing quality Improvement champions in each directorate and sector from those trained in QSIR
- Developing an Enterprise Programme Management Office (ePMO), monitoring and assuring trust-wide programmes and projects, using recognised programme management approaches
- Aligning with strategies particularly, People and Culture, IM&T, clinical and measuring outcomes based on national ambulance Quality Indicators (AQI)
- Applying and monitoring and assuring our patients, staff and the Board with rigorous measurement and quality and efficiency assurance frameworks.

Our assurance and governance frameworks have been reviewed and revised and we have:

- Introduced risk management training supported by a re-designed Datix web system
- Streamlined clinical and quality governance arrangements from frontline to Board
- The Director of Corporate Governance has revised and improved the BAF assurance processes and the workings of all sub-committees to the Board
- Introduced monthly performance management meetings for operational and corporate teams chaired by the Chief Executive
- Newly designed quality and board reporting formats that include SPC charts to ensure we are focused on issues that are based on true change rather than normal variation
- Developed KPIs against each domain, monitored through relevant groups and committees
- Improved feedback loops and visibility to staff on quality reporting and risk. The Quality Oversight Group reports to the Quality Assurance Committee to the Board.

To achieve our rating from good to outstanding we have:

- Conducted a gap analysis across the organisation against each of the CQC domains that includes the new rating of 'Use of Resources'
- Included this in a single overarching QIP plan monitored through our governance committees
- Our key aim is to continue to develop our approach, including systems and processes to ensure they are developed in a sustainable way. The use of rapid improvement methodologies and 'burndown' Agile techniques will be a key factor in realisation of a successful outcome.
- We have maintained a strong focus on our staff survey and are the top ambulance service in terms of response rate and we have identified staff survey champions to take forward the actions so that we have evidence of a response to any improvement areas.

3.2 Summary of Quality Improvement Plan

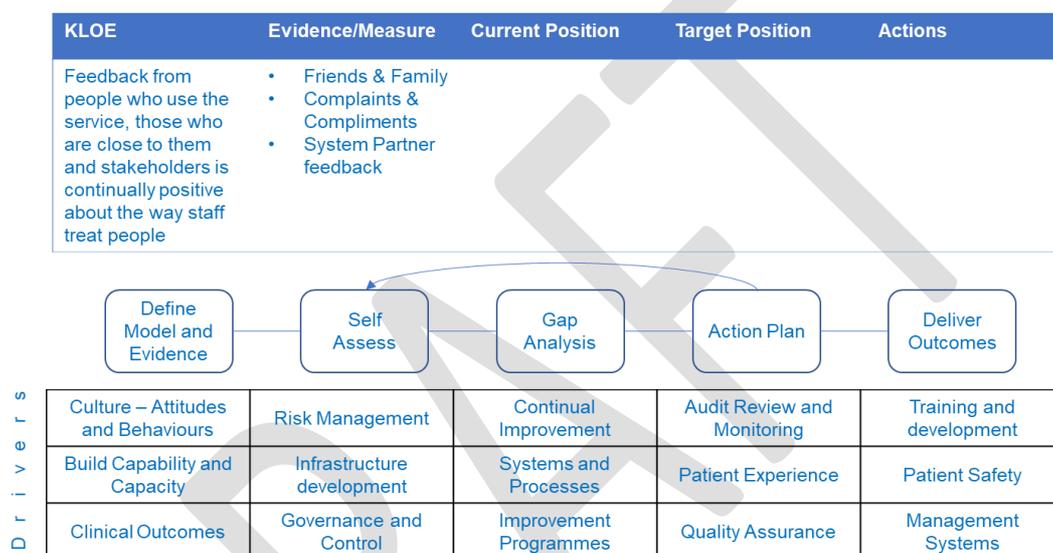
To achieve an overall 'Outstanding' rating we have developed a plan that will focus on demonstrating across all domains:

- Systems and processes are embedded, sustainable, continually improved and recognised as best practice at a national level
- Culture, specifically, attitudes and behaviours embedded as ‘the way LAS do things’ to support outstanding quality performance
- Engagement with our people will have to be upper quartile (top 25% in National staff survey)
- Use of digital technology and systems need to be leading edge, innovative and patient focussed
- Trust performance in its ‘Use of Resources’ will have to be upper decile with no drop off in either quality or patient care and experience
- Engagement with partners and patient to continually improve services will need to be innovative/ground breaking

Approach

The Chief Quality Officer (CQO) already has responsibility for the plan.

Roadmap to ‘Outstanding’



Specific targets for 2019-20 Quality Accounts

The quality account is a regulatory requirement all NHS organisations produced annually. During 2018-19 the priorities set out in the previous annual report have been monitored. Progress is considered alongside all independent reviews of the Trust’s quality standards, via CQC inspections, internal audit plans and the Trust’s own quality assurance mechanisms. We are developing plans for 2019-20, our previous plans are broadly on track to achieve the majority of targets for the 5 goals set for 2018/2019.

Quality priorities for 2019/2020

Based on the projected achievement of all 2018/19 goals, and learning from key quality themes during the year the following priority themes for 2019/20 have been identified:

Quality Focus	Suggested Priority Theme	Suggested Target(s)
Patient safety	Medicines management (source: incidents, serious incidents, KPI performance).	Full compliance against the Gosport gap analysis, measured by percentage completion of the Trust wide medicines management action plan.
	Learning from serious incidents and assurance of SI action effectiveness (source: serious incidents and CQC report).	Evidence that sectors and services (including NHS 111 EOC) hold quarterly learning events (led by QGAMS). Implementation of new SI Assurance and Learning Group, and evidence of effectiveness via reduction in

Quality Focus	Suggested Priority Theme	Suggested Target(s)
		key incident themes (tbc) and robust evidence of action implementation.
	Station security (source: serious incidents and CQC report).	Evidence via KitPrep that audits of compliance against security standards being met 90% time.
Patient Experience	Further develop the Mental Health Pioneer Services	Development of system wide mental health service, to reduce ED conveyance for this cohort of patients (minimum of 10% reduction compared to April 2019).
	Improve End of Life service provision.	Training and education for relevant staff in End of Life care. Increased number of staff trained against April 2019 baseline.
	Implement new Patient and Public Involvement 5 Year Strategy.	Meeting NHSI patient involvement framework KPIs.
Clinical Effectiveness	Handover to green (source: operational performance).	Reducing time for crews to acknowledge readiness for their next call (reduction in time available to respond to the next call against April 2019 baseline).
	Nature of complaints triage.	Reducing number of incidents of this nature against the April 2019 baseline.
	NHS 111 (tbc)	Meeting all contractual targets (tbc).

N.B. Following consultation, final goals and targets will be confirmed. Key performance indicators will be included in the final version of the Quality Account and the business planning document.

The **top 3 risks** to delivering the quality plan are:

- **Competing priorities:** mitigated by ensuring the executive team have prioritised all programmes and project, ensuring they are fully resource and managed
- **Limited expertise in change management and programme management:** the trust have supported the introduction of an ePMO, currently being recruited to and will provide adequate and expert support in change and project management
- **Ensuring quality and corporate governance systems are followed:** the revised framework and increased support within both the quality and corporate governance departments will allow robust monitoring of compliance and identification e.g. risk register updating, serious incident action implementation – against key governance systems and processes

Learning from national investigations and deaths

As part of the strengthening of the risk management process and risk appetite the Director of Corporate Governance has introduced 'horizon scanning' as a regular activity of the Board. This includes identifying key independent reviews. Currently the Director of Corporate Governance and the CQO are working with the Medical Director on a gap analysis of the Gosport Independent Enquiry. The action plan will be monitored via the Quality Oversight Group and up to the Board. The strengthened learning frameworks that include serious incident investigations, bi-annual trust wide learning events and quarterly sector learning events will include national feedback. In addition the trust participates in national ambulance networks for quality and medical directors that share learning through both group meetings and learning portals specifically for serious incidents.

The trust has a mortality review group and process that informs the monthly quality reports and also aggregated learning from incidents, complaints, inquests etc. All serious incidents that includes a death are also reported to the commissioners and the CQC as part of the 72 hour reporting process.

The national early warning score (NEWS2) is fully embedded within the organisation via the medical directorate, senior clinical advisors at sector level and monitoring through the clinical research and audit department. Regular re-contact audits are complete by CARU and identification of issues or concerns are fed into the serious incident group for weekly review. The trust are exploring the use of their iPad technology to enable speedier documentation and reporting of NEWS2.

3.3 Quality Impact Assessment (QIA) Process and CIPS

The QIA promotes systematic exploration of quantitative and qualitative information, helping assess the quality impact of proposed changes to how the Trust carries out its duties and delivers its services. This approach enables staff involved in developing and supporting provision of care to service users to be engaged in assessing potential impacts of service changes on quality and safety.

It is the Trust's policy that the decisions that its directors and managers make, which will impact on the way that the Trust works and delivers its services, shall be subject to a robust process of quality impact assessment (QIA). This assessment is in line with the national NHS policy for Quality Impact Assessment and is carried out as part of the early stages of planning of projects and schemes. Our QIA process aligns with the core quality domains of safety, effectiveness and experience, with an additional requirement to consider wider Trust implications and the impact on staff. It shall be reviewed at key stages through the development and implementation of projects and schemes. The Board shall be assured through direct review of QIA assessments and through the review and challenge of the QIA process carried out under delegated authority by its committees, directors and senior managers.

A QIA shall be undertaken for all planned service change or transformation; changes in the delivery environment; and cost improvement schemes (at project and programme level), to determine if there is a risk that the planned change will have an adverse quality impact on service effectiveness, safety, patient experience and Trust-wide considerations.

During the business planning process, all CIP schemes identified have been supported by Project Initiation Documents and Quality Impact Assessments. These are signed off by the Project Lead and Senior Responsible Officer (SRO, Director Level). The QIAs are then amended as appropriate with final sign-off and approval by the Quality Director and Medical Director. The outputs are monitored and reported through to the Quality Assurance and Quality Oversight Groups. The Director of Finance and Performance is the Senior Responsible Officer for the Trust's efficiency plans and responsible for ensuring this process is followed for all relevant CIP schemes. The Finance and Investment Committee (FIC) has responsibility for oversight of implementing efficiency plans with upwards reporting to the Trust Board by the FIC Chair.

The CIP schemes will be monitored throughout the year, reporting progress and discussing the impact of our plans as they materialise to enable the Trust to respond to any unforeseen risks and issues on quality and performance.

4 Workforce planning

The workforce plan is produced as part of the Trust's business planning process, currently planning for 2019/20 in detail, with a further two years of high level financial plans. In doing so, the workforce plan is subject to review with the CEO and CFO and any new service developments or efficiencies that impact the workforce plan are subject to our quality impact assessment and equality impact assessment.

The workforce plan, along with the other business planning submissions, are reviewed by the Executive Team and will be signed-off by the Trust Board on 26th March 2019.

Monitoring and reporting on the workforce plan

The monitoring and reporting of our workforce plan is overseen by the weekly Operations Resource Group which is represented at an executive and senior leadership level and where progress against the workforce plan is reviewed. A weekly report detailing progress against our workforce plan setting out our recruitment, education and training and operational deployment activity for all frontline and clinical staffing is reviewed at each meeting. The People and Culture Committee is the sub-committee of the Trust Board providing non-executive assurance of our plans.

To produce the workforce plan, we have used Operational Research in Health (ORH), a specialist external consultancy, to produce a high-level simulation model that provides us with an indication of frontline resource requirements and rosters for a typical week in 2019/20 to meet our activity plans to deliver the ARP performance standards. This also includes a recommendation on the number of people required to fill the rosters. Internally, we provide more granular demand-led forecasts (generated from bespoke statistical models) which allows us to understand how to flex our resourcing to maintain an expected level of service on a daily, weekly and monthly basis. This takes into account annual growth rates, seasonal trends, changing demography and patient needs across London, aligning our frontline staffing to geographic and temporal demand.

This is further supported by our integrated business planning model that forecasts the required workforce to meet performance based on our demand forecast and the historic relationship between the resource deployed and the performance we achieve. This is then adjusted for the impact of the planned service developments that will impact the way we respond. In doing so, this ensures our workforce plan is integrated with our activity, finance and performance (both response and quality) plans. To support this, ESR is reconciled to the finance ledger on a regular basis.

The modelling by ORH and outputs of our integrated business planning model underpin our assumptions to negotiate an agreed contract with commissioners, ensuring our plans are affordable and sufficient and deliver to the performance standards of ARP which are intended to ensure our patients receive the right care, first time, all of the time.

4.1 Current workforce challenges

Description of workforce challenge	Impact on workforce	Initiatives in place
Clinical Staffing (Clinical Hub and 111 / IUC services)	Difficulty in recruiting and rostering appropriate clinical staff to establishment levels. Results in over-reliance on agency staffing.	Significant recruitment activity in place for permanent roles. Initiatives in place to reduce agency staff including the introduction of a managed service with Hays, establishing bank rates for GPs and

Description of workforce challenge	Impact on workforce	Initiatives in place
		clarifying and confirming overtime rates for our Advanced Practitioners.
Retention of Emergency Operations Centre call handlers	High turnover especially during the first 6-12 months.	EOC restructure, the introduction of a part time roster and a range of well-being initiatives to support employees and improve attendance and the implementation of professional apprenticeship pathways.
Recruitment and retention of paramedic and non-registered paramedics (TEACs)	Current challenges with training capacity to deliver recruitment targets for registered and non-registered paramedics in 19/20.	Oversees recruitment (Australia, with plans to recruit from Canada). Increase trainee paramedic roles. Improve career paths for paramedics. Plans to explore the use of a Bank for paramedics. 121 retention interviews with international paramedics. Recruitment events and activities that support the LAS Brand and seek to engage London communities in working for or supporting the LAS.

4.2 Current workforce risks

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
Unable to recruit to 111 / IUC services for call handlers	Medium; Increase use of overtime and agency. Increase cost of service provision. Potential impact on performance.	Significant recruitment activity in place for permanent roles. Initiatives in place to reduce agency staff including the introduction of a managed service with Hays, establishing bank rates for GPs and clarifying and confirming overtime	

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress to date
		rates for our Advanced Practitioners.	
Insufficient project management capacity to drive through productivity and quality improvements	High; Lack of progress in implementing productivity and efficiency improvements	Investment in an Enterprise PMO function. Service developments and efficiencies include provision for project management resource when required and not provided from BAU staffing	ePMO established with new processes, reporting requirements and structure. All service developments include project management resource when required.

4.3 Our long term vacancies

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
EPRR – this a nationally delivered course which has a limited capacity and therefore can delay staff from fully undertaking their roles		Potential impact on patient safety	We have raised this as an issue nationally to request more places. We are also creating a pipeline of candidates to ensure so that we can better synchronise start dates with national course dates.
GPs (IUC/111) – due to market forces this is a group who are able to command their own pay rates which creates financial pressures.		Potential impact on patient safety	We have advertised for GP roles and have a number in the pipeline. We have also established bank rates for GPs to ensure we have a flexible resourcing model.

Description of long-term vacancy, including the time this has been a vacancy post	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Advanced Clinician roles (IUC/111)		Potential impact on patient safety	Significant recruitment activity in place for permanent roles. We are also looking at alternate roles to fill our vacancies including pharmacists.

4.4 Commissioner and STP engagement

The workforce plan has been developed taking into account the commissioners plans and intentions, the London STP's plans and the national Long Term Plan for the NHS. Specifically, this is done through regular engagement with the Commissioner through the Strategic Commissioning Board and other ad hoc meetings, and engagement with the STP through our dedicated Stakeholder Engagement Managers (one for each STP) and Partnerships Function. As a pan-London Trust we do not have specific workforce plans with STPs. Our workforce plan is agreed through our contract with the 32 CCGs (Brent CCG as lead commissioner) with plans taking into account recruitment plans across all roles within our organisation.

4.5 Workforce transformation

Our workforce plan incorporates the recruitment of a broader range of healthcare professionals to support the use of alternative care pathways available or in development. This is especially true in our Integrated Urgent & Emergency Care Services (incorporating our 111 contracts) where professional groups include Mental Health Nurses, Midwives, GPs, Pharmacists and Dental Nurses.

In addition to this, we have recruited into the new role of Band 7 Advanced Paramedic Practitioners (APPs) with specific skills and expertise to reduce avoidable conveyances to Emergency Departments. This is supported by further initiatives in 2019/20 to upskill our frontline workforce and reduce avoidable conveyance to ED including:

- Continuing to recruit new APPs in line with the approved business case
- Commence recruitment of new Band 6 Rotational Paramedic Roles who will receive additional training in non-conveyance and be used to staff the new pioneer services.
- Upskilling all registered and trainee paramedics in non-conveyance to ED through the annual core skills refresher programme.
- Restructuring the Clinical Hub to include:
 - Increasing the establishment levels of Clinical Advisors to support the planned increase in Hear and Treat
 - Streamlining the management resource to manage the increase workload, improve performance and support interoperability with the 999s, and 111s and collaboration with external partners (e.g. new pathways).

We have undertaken dynamic workforce modelling and planning to support recruitment of our front line specifically but also other groups across LAS functions. We have developed a workforce model for our frontline sector operations staffing and will be establishing a strategic workforce planning

group to ensure we have the right people with the right skills in the right place at the right time. Our search for talent will include all the diverse roles that will be the future of the LAS clinical offering – no longer just paramedics but other health care professionals who will help us achieve our strategic vision: nurses, midwives, mental health professionals. We will work with our partners to ensure that we establish and maintain safe staffing levels aligned to the agreed operating model of LAS and changing dynamically to meet changing demands as the strategic vision of LAS is developed.

Talent and succession management planning to support the aspirations of our people and assure the service of the LAS.

We will continue with the implementation and expansion of our Professional Apprenticeship Programme during 2019/20.

Additionally, in 2019/20 we will explore the use of a Bank within Ambulance services to reduce expenditure on overtime and agency staffing.

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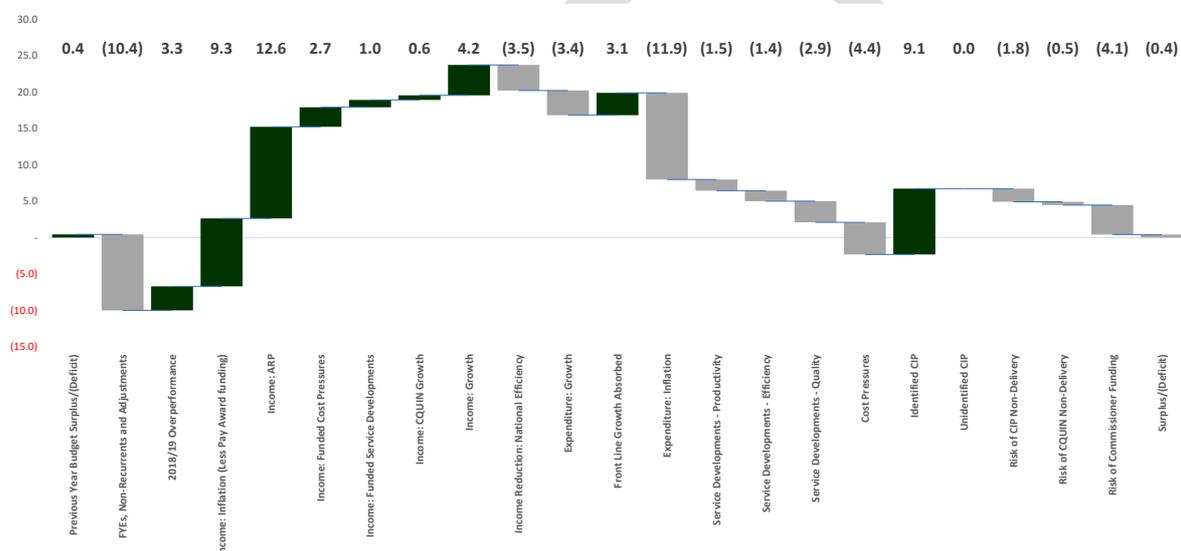
5 Financial planning

The Trust's financial plan is set out in the finance return, providing the full details on the Trust's use of resources for 2019/20.

The financial plan is an output of the Trust's business planning process and integrated business planning model. It is built upon robust financial forecasts, modelling and assumptions agreed by Commissioners (**N.B. still to be agreed with commissioners**) and is consistent with the intent of London's five STPs. It sets out the resources required to meet both the ARP response and quality performance standards (pan-London at a monthly level), align with and develop implementation plans from the Carter report recommendations, improve patient care and implement new service developments that improve the quality of care, productivity and efficiency of the Trust.

5.1 Financial forecasts and modelling

Rigorous forecasts and modelling has been completed for activity, workforce, performance and finance to produce the Trust's financial return. These have been collated into the business planning model that integrates these key priorities. The output of this model, is a clear financial bridge between 2018/19 and 2019/20 outlining all the key movements in the budget – see below.



Note, these are draft figures and will be refined following the agreement of a contract with our commissioners.

This bridge includes the following assumptions that have been agreed with Commissioners:

	2019/20 (Year 1)	2020/21 (Year 2)	2021/22 (Year 3)	2022/23 (Year 4)	2023/24 (Year 5)
Pay Inflation	3.9%	3.0%	3.0%	3.0%	3.0%
Non-Pay inflation	1.5%	2.0%	2.0%	2.0%	2.0%
Tariff Inflatior	3.7%	2.7%	2.7%	2.7%	2.7%
Baseline Activity Growth	1.5%	0.80%	1.2%	1.2%	1.5%
National required Cost Efficiency	1.1%	1.1%	1.1%	1.1%	1.1%
Target CIP*	£8.7m	£8.0m	£8.0m	£8.0m	£8.0m
Cost Efficiency Identified	£9.0m	£5.3m	£0.9m	£0.0m	£0.0m
Productivity Benefits Identified	£4.2m	£4.4m	£4.8m	£0.0m	£0.0m

To continue to meet the requirements of Single Oversight Framework finance metrics, the Trust will continue to deliver public value by meeting all of its financial duties. In particular we will continue to deliver a financial and cash outturn better than our Control Total and continue to secure a Use of Resources rating of 1, the highest possible NHSI rating. In addition, the Trust has made a significant improvement in delivery of its Capital Plan, forecasting delivery of 100%, compared with 94%, 43% and 64% in the previous three years.

Following the detailed study of population trends in 2016 where we anticipated growth of c2.0% we experienced lower levels of growth in 2018/19. Our growth rate of daily incident volumes was therefore adjusted from c2.0% to 1.2%

Additionally in 2019/20 our activity planning assumptions have been adjusted to take account of the effect of the leap year in February 2020. Our modelling and detailed forecasting has increased from c1.2% to c1.5% higher than the 2018/19 out-turn.

5.2 Efficiency savings

Throughout the business planning process, the Trust has completed a complete review of budgets, and a detailed exercise to identify productivity and efficiency improvements for the next three years. The outcome of this is an efficiency plan that is both ambitious and achievable provided the Trust is funded appropriately. The focus has been on improving productivity within Operations (e.g. reducing hospital handover time, increasing jobs per shift, reducing out of service etc.), and increasing the efficiency of our corporate and support functions in line with the recommendations of the Carter Report.

A summary of the savings identified to date (still draft) is provided below:

Project	Type of Expenditure / Income	Status	Efficiency Programme Area	Risk Rating	Plan £'000	QIA Req'd	QIA Status
Workforce productivity (overtime and incentives)	Pay (WTE reductions)	Plans in progress	Workforce (other)	High	3,894	Yes	In progress
Headcount reduction	Pay (WTE reductions)	Plans in progress	Workforce (other)	Medium	306	Yes	In progress

Project	Type of Expenditure / Income	Status	Efficiency Programme Area	Risk Rating	Plan £'000	QIA Req'd	QIA Status
Estates relocations and consolidation	Non-pay	Plans in progress	Estates and Facilities	High	206	Yes	In progress
Soft Facilities Management	Non-pay	Plans in progress	Estates and Facilities	Medium	315	Yes	In progress
Asset Management	Non-pay	Plans in progress	Procurement	Low	50	Yes	In progress
Procurement Fleet	Non-pay	Plans in progress	Fleet	Medium	248	Yes	In progress
Drugs, Medicines and Equipment	Non-pay	Plans in progress	Procurement	Low	341	Yes	In progress
Effective Fleet Management	Non-pay	Plans in progress	Fleet	Low	463	Yes	In progress
Driver Safety Systems	Non-pay	Plans in progress	Fleet	Medium	250	Yes	In progress
Clinical Education Standards Transformation	Pay (WTE reductions)	Plans in progress	Workforce (other)	Medium	286	Yes	In progress
Procurement - Influencible Spend	Non-pay	Plans in progress	Corporate and Admin	Low	1,023	Yes	In progress
ESR Transformation	Non-pay	Plans in progress	Corporate and Admin	Low	23	No	In progress

All of this saving is planned to be recurrent, however, as outlined in the bridge we have included a contingency for non-delivery of CIP to ensure prudence within our financial plan.

In addition to this, we have identified efficiencies for 2020/21 and 2021/22, as the outcome of planned transformation of services and the impact of service developments we are funding in 2019/20. Throughout the next year we will refine these plans and identify further efficiencies to increase productivity and further align ourselves with recommendations of the Carter Report.

Our efficiency plan are supported by following multi-year efficiency plans focussing on increasing productivity:

- Operational productivity
- Effective Fleet management
- Commercial income

Our approach to identifying, quality assuring and monitoring the delivery of efficiency savings is described within the Quality Impact Assessment process

5.3 Agency rules

We will continue to minimise the use of agency staff in line with the Trust Agency policy and within the agency cap set by NHSI. We recognise that agency staff are required at times to short-term engagements, specialist work and vacancy / long term leave cover, and there should be a clear case for doing so, approved by the Director of Finance.

In the past year we have maintained our position within the agency cap and continued to focus on an approach which minimises the Trust requirement. Whilst, we will maintain our approach to minimise spend our agency cap, has increased from £5.99m to £8.89m, in 2019/20. The 2019/20 agency ceiling has been adjusted to accommodate the addition of the new 111 Integrated Urgent Care Services provided by the Trust in North East London and South East London. A complete breakdown of our paybill by substantive, bank and agency is provided below.

	2018/19 pay expenditure ('000)	2019/20 planned pay expenditure ('000)
Substantive	265,445	282,640
Bank	2,668	2,543
Agency	10,203	8,890
Other	1,055	0
Total	279,371	294,073

5.4 Capital planning

The capital plan will be funded through the Trust's own internally generated capital, in addition some additional agreed centrally funded capital for the Trust's digital priorities and a further £4m from the 2018/19 Provider Sustainability Fund pending agreement with the national capital and cash team.

Capital Plan	2019/20
Estates	4,126
Fleet	9,322
IM&T	385
Operational Quality and Productivity	7,736
Total	21,569

Funding Plan	2019/20
Carry Forward	-
Internally Generated	15,500
National Grants	700
Provider Sustainability Fund	4,000
Total Capital Expenditure	20,200

The Trust has agreed to become host provider for the *One London local healthcare records exemplar*. This will involve the management of currently notified capital funding of £7.5m on behalf of the partnership. The Trust will account for and govern this capital resource limit separately from its core capital programme.

Throughout the business planning process, capital expenditure was prioritised alongside all service developments, evaluating each scheme against Board Assurance Framework risks, CQC recommendations, their impact on performance (both response and quality) and their return on investment. This has ensured the highest priority schemes are taken forward. Additionally, for each scheme a quality impact assessment was completed (as outlined in Section 2.0) and an equality impact assessment was completed.

All capital projects are subject to the national and local capital expenditure limits and business cases and / or gating templates will be completed and approved prior to robust procurement procedures.

There are currently no schemes that are above £15m, and therefore required NHSE/I or DHSC approval. For schemes above £1m, a full business case is required for Trust Board approval, and for schemes above £250k a gating template is required for Executive Committee approval.

The Trust recognises that profit on disposal of assets does not count against the achievement against its control total in 2019/20 as per national guidance. We currently have no land / property disposals planned for 2019/20 but are planning our estates consolidation programme and expect to dispose of some land / properties in future years in line with national NHS priorities.

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6 Link to the local sustainability and transformation plans

Through the dedicated Stakeholder Engagement Managers, we are working alongside each STP to understand their priorities and how we will support the STP vision for health and care in London.

The priority areas for our engagement with London's STPs are **ED conveyance, Hospital Handover and IUC / 111 service delivery**.

ED Conveyance

Our most significant contribution to this is through our work to reduce avoidable conveyances to Emergency Departments, reducing pressure on the acute system. Where possible, we will increase hear and treat, increase see and treat, and increase conveyances to other hospitals or health services where required. This will be done through the pioneering ambulance services such as the Advanced Paramedic Practitioners, the Mental Health pioneer and the Falls Pioneer. Additionally, LAS will work with London's five STPs and hospital providers to increase access to and usage of alternative care pathways, reducing pressures on Emergency Departments where possible, and providing better outcomes and experiences for our patients.

Hospital Handover

We are working closely with London's Emergency Departments to reduce handover times when conveyances are required. This will both improve the patient experience and patient outcomes, and enable our crews to get back out on to the road and respond to more incidents within their shifts, further improving response times and quality outcomes.

Integrated Urgent Care and 111 service delivery

The Trust five year strategy sets out the vision to become London's primary integrator of access to urgent & emergency care 'on phone', 'on scene' and 'online', and being the lead provider for urgent and emergency clinical assessment and triage. This will enable us to manage and coordinate the flow of patients through urgent and emergency services, making it as easy as possible to access the help those that need help.

The service will fully integrate services behind 999 and 111 which delivers consistent, safe and efficient care seamlessly accessing pathways ensuring patients receive the most appropriate care, at the earliest stage, to meet their needs whatever entry point they access. Our integrated service will encompass all aspects of urgent and emergency care, coordinated so that the patient's experience is one of the single health service and that there is consistency across London.

7 Membership and elections

Not applicable for London Ambulance Service (not a Foundation Trust)

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Assurance report: **Logistics & Infrastructure Committee** **Date:** **05/02/2019**

Summary report to:	Trust Board	Date of meeting:	26/03/2019
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:

- Cyber security (BAF Risk) - the Committee has asked for a plan to be presented to its next meeting setting out the Trust's direction of travel overall; this should include what is needed to maintain the Trust's current levels of cyber security and what would be required to transform it and any additional significant project resource. This report should be fully costed and include indicative timescales. The Committee felt that further consideration should be given to potential external funding sources for this work.
- The development of the Trust's digital strategy requires further work to ensure that it takes account of comparative data made available by the Carter Report, particularly in relation to control room systems. This should also be considered as part of the Trust's business planning for 2019/20. Consideration will also need to be given to implications of this for the contract extension of the Trust's Computer Aided Dispatch (CAD) system. This will be considered by the Committee in due course.
- The Committee's effectiveness is reduced by often receiving papers late, oral items without supporting papers and the variable quality of performance reporting.

Other matters considered:

- IMT projects, including the upgrade of the CAD.
- Progress in the development of the Electronic Patient Care Record (EPCR) – the business case is on track to be presented to the Board at its meeting in March.
- CAD contract extension – the Trust is exploring an extension of its existing CAD contract.
- Microsoft Licensing – arrangements have been made for the payment of these.
- Lessons learned from the mobilisation of the Trust's 111/IUC service in North East London – indications are that the Trust did not accurately predict the level of resourcing required to launch this service. Whilst this was linked to challenges associated with the

handover from the previous service provider; it indicates that particular attention needs to be paid to this in the launch of the Trust's 111/IUC service in South East London and any future bids.

- National Ambulance Vehicle Specification – the Committee considered the Trust's response to the consultation on this
- Health and Safety Strategy – the Committee noted the updated strategy, which had been approved by the Trust Board at its meeting on 29 January 2019. A few detailed comments were provided.

Key decisions made / actions identified:

- Estates and progress towards the Estates Strategy – the Committee agreed that a plan setting out the issues to be address in this space should be brought to its next meeting.
- The Committee agreed that it should receive a detailed report on the status of all leases held by the Trust.
- Performance reporting on strategic assets and property – the Committee agreed that further information about key performance indicators should be provided ahead of its next meeting.
- Progress on the Trust's Estates and Fleet strategies – the Committee has asked for the plan for the production of both of these strategies.
- The Committee reviewed its Terms of Reference, in particular where responsibility for Health and Safety should sit. It is proposed that consideration be given to a new reporting style on this issue, which allocates specific reporting between the Logistics and Infrastructure Committee, the Quality Assurance Committee and the People and Culture Committee.

Risks:

- The capital plan has been re-prioritised in order to facilitate the purchase of organisational priorities, including kit bags and defibrillators, which may have an impact on the Trust's usage of IT equipment reaching the end of its life. The Committee agreed to have a further report on this at its next meeting.
- Expenditure on telephony (conference calls and mobile data usage) requires greater organisational control. Action is being taken to ensure greater visibility of these costs across the organisation.
- There are indications that controls within the Estates team require strengthening. These relate to oversight of the leases held by the Trust and contracting of suppliers. Work is being undertaken to establish the extent of these issues.

Assurance:

- The Committee has concerns with regard to the effectiveness of internal controls within the Estates team. Until these are resolved the Committee cannot provide assurance to the Board on this issue.
- The performance reporting relating to IMT has provided the Committee with assurance on the day-to-date performance of this function and its projects.
- Further work is required with regard to KPIs and performance reporting of Fleet and Logistics and Estates.



Assurance Audit Committee report:

Date: 11/02/2019

Summary report to:

Trust Board

Date of meeting:

26/03/2019

Presented by: John Jones, Non-Executive Director, Audit Committee Chair

Prepared by: John Jones, Non-Executive Director, Audit Committee Chair

Matters for escalation:

- A report on progress on overdue internal audit recommendations was received. This shows 19 (last meeting 22) items overdue of which 6 (last meeting 6) are high priority. Following discussion the Committee concluded that there was not sufficient assurance that the outstanding recommendations would be implemented by the target dates in the report. The Chief Executive agreed to review these, with the Executive Team and produce a realistic plan to achieve these recommendations within a reasonable timescale.

Other matters considered:

- The latest Board Assurance Framework (BAF), which shows three red risks, was reviewed. These are also subject to monitoring by respective Board Assurance Committees.
- A review of the risk on Cyber Security revealed that a plan was being developed with funding sought (subject to agreement of the funded contract for 2019/20) but full assurance on this would not be provided until 2021. The Board will need to decide if this is acceptable or can be accelerated (will require more funding) or consider if further mitigations can be introduced. This will be monitored by the Logistics and Infrastructure Committee.
- A report on the initial outcomes from a review of the Trust's corporate governance structures was considered. The final report is on the Trust Board agenda for consideration today.
- Single tender waivers for October to December 2018 were reviewed.
- A report on the Losses and Special Payments to 31st 2018 was reviewed by the Committee. Expenditure on vehicle accidents continues at a high level. The Committee received a tabled report from the Director of Strategic Assets and Property analysing the data we have on this subject and proposing a number of recommendations. This report will be considered by the Logistics and Infrastructure Committee at its next meeting.

- An update on the internal Audit plan and Counter Fraud activity to date was presented by Grant Thornton and reviewed by the Committee.
- Four new internal audit studies had been completed –
 - an audit of the Recruitment and Selection Process,
 - an audit of Complaints Handling
 - an audit of the Trust Board Assurance Framework
 - an audit of the Core Financial Systems
- The internal audit team are confident that the plan set for 2018/19 will be completed with scoping agreed for nearly all the remaining audit reviews. The initial plan for 2019/20 was discussed and commented on. This will now be considered by the Executive Team with the final plan coming to the Committee in April for formal approval.
- Activity by the Counter Fraud team was discussed, in particular:
 - completion of the 2018/19 self-review tool
 - feedback following visits to ten ambulance stations
- A report on the annual review of the effectiveness of the internal audit and counter fraud service was considered. The findings have been discussed with Grant Thornton's at a meeting on 24th January 2019 and will be taken forward over the course of the next year.
- An update report on assurance on the General Data Protection Regulation (GDPR) reveals that although some progress has been made we still have some way to go for full assurance. This has not been helped by staff turnover in this area. A revised Information Governance Group has been established and will utilise the Data Security and Protection Toolkit submission for 2018/19 to provide further assurance on the trust position. The draft submission will be subject to independent review.
- The annual review of the Audit Committee effectiveness was considered and concluded that it had met its work plan as set out in the Terms of Reference for the Committee.
- The Committees forward plan was reviewed.

Key decisions made / actions identified:

- The External Audit Plan for the audit of the 2018/19 Annual Accounts was agreed with Ernst and Young. This included key deliverables and an agreement of materiality limits for the accounts review.

Risks:

- The Committee took time consider horizon scanning of any potential new risks which confirmed no new risks being added but asked that consideration be given to assess risks in two areas:
 - Implementation of Carter proposals,
 - Recruitment risk as a result of new proposals to increase paramedic support staff for GPs

Assurance:

- The assurance rating for the internal audit reviews were:
- The audit of the Recruitment and Selection Process was **Significant Assurance** with some improvement required. Five recommendations were made.
- The audit of Complaints Handling was **Partial Assurance** with improvement required. Five recommendations were made.
- The audit of the Trust Board Assurance Framework was **Significant Assurance**. One recommendation was made.
- The audit of the Core Financial systems was **Significant Assurance**. Two recommendations were made.
- Both representatives of the internal (Grant Thornton) and external (Ernst and Young) auditors were present at the meeting.
- A private meeting with both internal and external auditors was held after the formal agenda and no significant issues were raised.



Assurance report: Finance and Investment Committee

Date: 12/03/2019

Summary report to:

Trust Board

Date of meeting:

26/03/2019

Presented by:

Fergus Cass, Non-Executive Director; Finance and Investment Committee Chair

Prepared by:

Fergus Cass, Non-Executive Director; Finance and Investment Committee Chair

Matters for escalation:

- At the end of January (Month 10) there was a cumulative surplus of £3.75m, ahead of the budget of £3.05m. This move from deficit to surplus reflects: seasonal factors; activity levels above contract; and inclusion of £2.60m of anticipated Provider Sustainability Funding (PSF). Additional funding of £4.75m to support delivery of ARP targets has been invoiced to Commissioners but is still under discussion with them. A surplus of £4.30m is forecast for the year 2018/19; this includes PSF totaling £6.70m and is £0.14m below plan. The forecast year-end cash position, at £17.6m, is £3m ahead of plan.
- Agency spending is now forecast at £6.96m, which is above the previous estimate of £5.96m, which in turn was just below the original cap of £5.99m. However, NHSI have confirmed that this breach, which is entirely attributable to the inclusion of the new IUC/111 services, will not trigger a loss of PSF. Agency spending at the NEL IUC/111 is above previous estimates; the excess is being investigated in conjunction with a review of overall administrative support to this service.
- Capital expenditure in the first 10 months was £9.9m, which was £3.4m below plan. The aim is to deliver the full year target of £21.8m: while expenditure on estates and fleet is expected to be on plan, the position relating to IMT spending is being critically reviewed.
- Negotiations with Commissioners regarding 2019/20 are in progress and are subject to mediation. A BAF risk is being proposed in relation to the funding of our five-year strategy. The timetable for final Board approval of the 2019/20 financial plan will need to be updated but provisional targets for resources, expenditure and efficiency will be communicated internally.
- The Board will be updated on planning for a “no-deal” exit from the EU. The Committee was briefed on the main areas that are within the Trust’s responsibility, including fuel, medical devices, consumables, and vehicle parts.

Other matters considered:

- The year's Cost Improvement Programme (CIP) target of £12.3m is expected to be delivered; 80% of the savings will be recurrent.
- Work is proceeding on the procurement strategy, based on analysis of the total procured expenditure by category in 2017/18 and on a review of opportunities for collaborative purchasing. It is anticipated that higher savings targets will result and that the priorities for collaboration will be agreed.
- Remaining actions in the Procurement Maturity Plan were reported as being on track: they relate to use of purchase orders and development of the contract management process. Transitional issues affecting Estates were reviewed and it was noted that a backlog of invoices has been addressed. Expenditure approval processes are being examined by Grant Thornton.
- In addition to the potential impact on suppliers of a "no-deal" exit from the EU, other supply risks were reviewed in the light of the latest information and guidance.
- A progress report on actions in response to the Carter report indicated that relevant projects are proceeding and that opportunities for savings beyond the levels previously indicated are being sought.
- The 2019/20 programme plan is being developed, in a process led by the Enterprise Programme Management Office (EPMO) and involving executive workshops. The process entails reprioritisation of projects, taking into account factors such as the trust's strategy, the Carter report, the links between projects, and the resources required to implement them. A revised timetable of business cases will be prepared.
- The Committee noted progress in implementing new costing systems, as part of a national initiative (Patient Level Information and Costing System - PLICS). Significant steps are expected in 2019/20, including service line reporting and submission of PLICS costing.
- Processes have been clarified relating to determining the position of temporary workers potentially affected by HMRC's anti-avoidance rules (IR35).
- Recently announced changes to the Government Financial Reporting Model (FReM) will be incorporated in the 2018/19 annual accounts. These do not impact our revenue or control total figures.

Key decisions made / actions identified:

- Next steps in relation to negotiations about ARP funding and the 2019/20 finance plan were reviewed and priorities were proposed.
- Factors behind the revision of expected expenditure on agency staff will be identified and reported on.
- Expectations relating to IM&T capital expenditure in 2018/19 are being urgently assessed.

Risks:

- The Committee recommended continued inclusion on the BAF of the risks related to delivery of the control total in 2018/19 and beyond (BAF Risks 52) and a “no-deal” exit from the EU (BAF Risk 53).
- It discussed an emerging risk relating to the Trust’s ability to respond to a changing commissioning environment, especially the developing role of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS).

Assurance:

- The Committee reviewed financial performance to the end of January 2019 (Month 10), the full year forecast for 2018/19, and the risks associated with that forecast. Background information and explanations of variances were provided, including activity levels and the latest expectations relating to CQUIN delivery.
- Cash flow performance and projections were reviewed. At the end of January, the cash balance was £23.7m, which is £3.5m above plan; this reflects positive and negative factors including the underspend on capital and the timing of receipts and payments. Cash flow is forecast to remain positive over the next twelve months and will stay above the agreed £6.5m buffer.



Report to:	Trust Board			
Date of meeting:	26 March 2019			
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:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
<p>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.</p> <p>This report brings together the areas of Quality, Operations, Workforce and Finance.</p> <p>It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.</p> <p>Key messages from all areas are escalated on the front summary pages in the report.</p> <p>It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.</p>				
Recommendation(s):				
<p>The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.</p>				
Links to Board Assurance Framework (BAF) and key risks:				
<p>This report contains an overview of Trust Risks directly linked to the BAF but does not itself raise any risks.</p>				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	<input type="checkbox"/>			
Performance	<input type="checkbox"/>			

Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>
This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>



London Ambulance Service – Integrated Performance Report



Report for discussion with Trust Board members
Analysis based on January 2019 data, unless otherwise stated

Section	Content	Pages
Overview	<ul style="list-style-type: none"> Narrative against Patients, People, Public Value and Partners Summary of business plan delivery 	3
1. Our Patients	<ul style="list-style-type: none"> Trust-Wide Scorecard Response time performance <ul style="list-style-type: none"> Operational Demand Operational Capacity Operational Efficiency Ambulance Quality Indicators and Recontact Rates Business plan delivery 	4 5-8 9 10-11
2. Our People	<ul style="list-style-type: none"> Trust-Wide Scorecard Vacancy Rates, Staff Turnover and Sickness Health and Safety – Adverse Staff Events Additional Workforce Analysis Business plan delivery 	12 13 14 16 17-18
3. Public Value	<ul style="list-style-type: none"> Trust-Wide Scorecard Financial Position <ul style="list-style-type: none"> Income Statement Cashflow Statement Cost Improvement Programmes (CIPS) and Capital Plan Business plan delivery 	19 20-22 23 24

Section	Content	Pages
4. Our Partners	<ul style="list-style-type: none"> Trust-Wide Scorecard CQUINS Call Answering Metrics 111 Service Metrics Business Plan Delivery 	26 27 28 29 30
5. Strategic Themes	<ul style="list-style-type: none"> Overview of progress against the three strategic themes 	32-35

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:

Performance in all national measures has broadly remained stable over time. December 2018 and January 2019 saw the Trust's busiest months on record. Despite this C1 performance in both months remained within the 7 minute national target. The C2 mean performance remains stable, though the YTD position stands just above the national standard. C3 90th centile has been challenged this month and again the YTD position is above the national standard. However, patient safety in these categories has been maintained with long waiting times minimised. ROSC finished 1st out of all the ambulance trusts. We are meeting and on target with all of our Quality priorities and are currently consulting on the 2019/20 priorities.

Achievements since the last board (incl. reference to Business Plan deliverable):

The Trust continues to be within the top three performing Ambulance Services. We are currently best in class for the Category 1 90th Centile measure. We have implemented our post-ARP transformation plan into business as usual, to ensure we can continue to meet national performance and quality standards (BP.2)

The focus continues on improvement of efficiency regarding crew handover and ability to offload patients safely (BP.18)

Provide outstanding care for **our patients**

Sickness rates remain consistent with previous months and we continue to make good progress on our recruitment and training plans across the organisation.

Whilst vacancy rates continue to remain lower than in FY17/18 and we are at our target of 5%, the Trust continues to experience higher than average turnover rates at over 12% predominantly due to Sector Operations. A special task and finish group is underway to review and address this.

- All business plan deliverables on track apart from BP9 in relation to EOC recruitment plan which will be delivered in Q1 19/20.

- Turnover deep dive underway and frontline skills mix meeting planned in March.

Be a first class employer, valuing and developing the skills, diversity and quality of life of **our people**

January's financial performance continues to align with our financial plan for FY18/19 with a strong current cash position for the trust and income whilst still behind contracted levels has increased through high levels of demand.

The majority of business plan deliverables are on track.

- The Trust has improved its outturn by £1.8m enabling access to £4.0m additional PSF funding in 2018/19

- The principal financial risks relate to funding required to deliver ARP performance and management of our agency control cap and potential IT licence cost pressures.

Provide the best possible value for the tax paying **public**, who pay for what we do

Both NEL and SEL call answering within 60 seconds were below 92%, SEL call answering deteriorating to 76.3% and NEL at 69.3%. This was due to a combination of call volumes being above forecast, staff shortages in the contact centres and call balancing between the contracts.

999 call answering also continued to be below 95% in month. During the tail end of January, London experienced freezing temperatures, which increased our call volumes above the normal levels.

Conveyance to ED remained above the contractual trajectory at 62.3% at the end of January 2019. This is 2.2% increase above the trajectory target.

We continue to engage 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.

- Both NEL and SEL IUC are mobilised and we are now focusing to achieve our strategic intention of integrating emergency and urgent care. (BP.17).

- The 5 senior sector clinical leads have been appointed who will focus on appropriate referral to alternative pathways. Our new Deputy Medical Director is leading a project to identify best practice in ACP usage from across our operational teams. (BP.16).

Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London



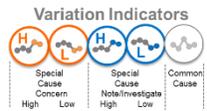
Patients Scorecard

January 2019

Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Current Performance				Trajectory	Benchmarking (Month)		
					Target	Latest Month	Year To Date (From April 2018)	Rolling 12 Months	FY18/19 Trajectory	National Data	Best In Class	Ranking (out of 10)
Category 1 response - Mean	mm:ss	Jan-19	●		07:00	06:20	06:28	06:36	07:00	07:08	06:18	2
Category 1 response - 90th centile	mm:ss	Jan-19	●		15:00	10:30	10:46	10:58	11:18	12:20	10:30	1
Category 2 response - Mean	mm:ss	Jan-19	●		18:00	21:36	19:04	19:42	18:30	22:58	12:11	6
Category 3 response - 90th centile	h:mm:ss	Jan-19	●		2:00:00	2:41:49	2:07:19	2:12:44	2:10:30	2:40:10	1:19:50	5
Category 4 response - 90th centile	h:mm:ss	Jan-19	●		3:00:00	2:51:25	3:03:40	3:12:09	2:14:06	3:16:00	2:05:52	5
ROSC at Hospital	%	Sep-18	●		30.0%	36.5%	36.5%	34.9%	N/A	29.0%	36.5%	1
STEMI call to angiography - Mean	h:mm:ss	Sep-18	●		TBC	02:01	02:04	02:07	N/A	02:08	01:47	4
STEMI call to angiography - 90th centile	h:mm:ss	Sep-18	●		TBC	02:43	02:40	02:47	N/A	02:54	02:29	4
Stroke call to door - Mean	h:mm:ss	Sep-18	●		TBC	01:11	01:10	01:14	N/A	01:13	01:07	5
Stroke call to door - 90th centile	h:mm:ss	Sep-18	●		TBC	01:46	01:45	01:52	N/A	01:51	01:39	5
Re-contact rates in 24 hours (ONLY S&T and H&T)	%	Jan-19	●		7.0%	5.7%	6.6%	6.6%	N/A			
Positive compliments received	Per 1000	Jan-19	●		1.50				N/A			

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

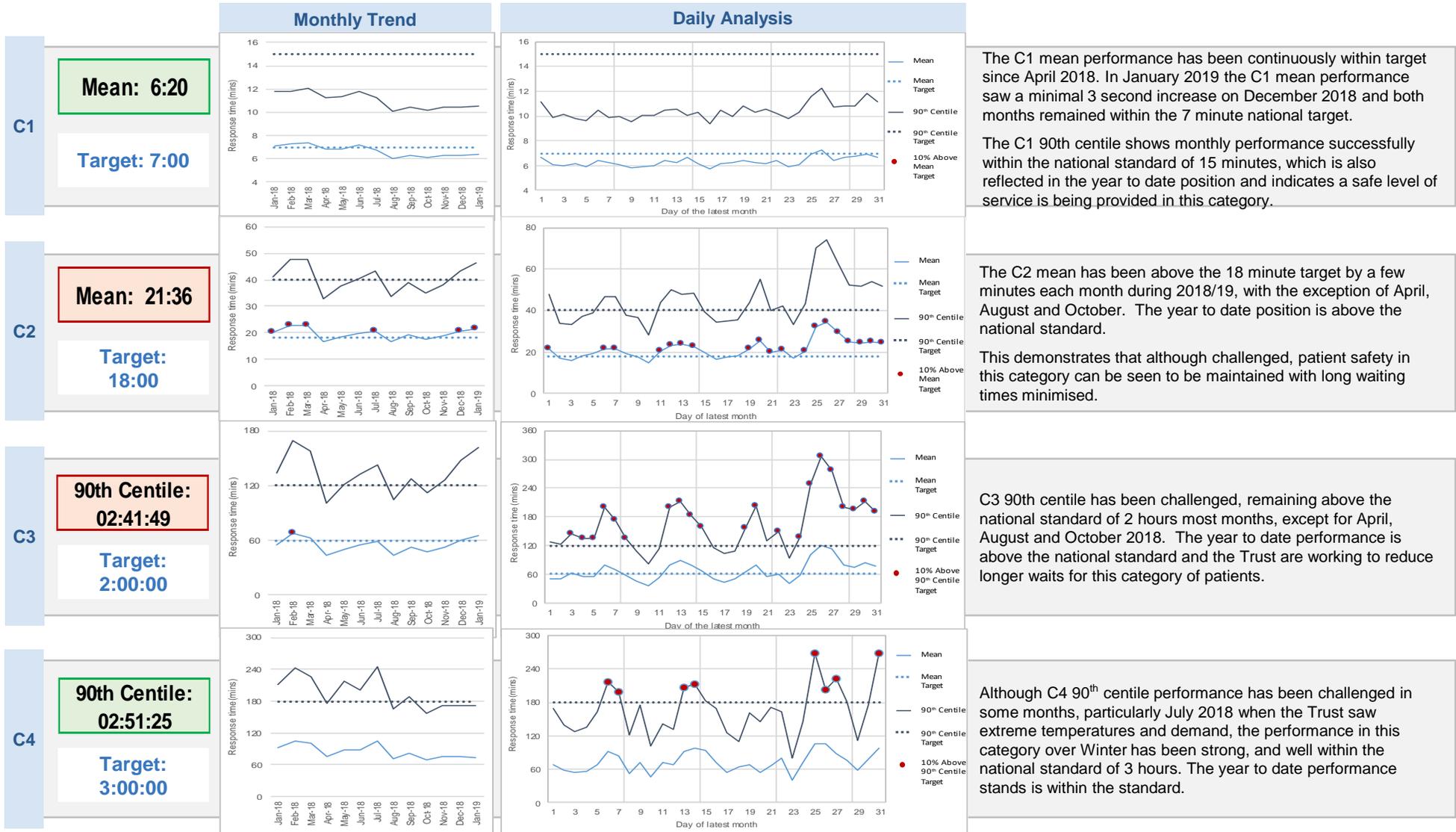
- **G** KPI on or ahead of target
- **A** KPI off target but within agreed threshold
- **R** KPI off target and outside agreed threshold
- KPI not reported / measurement not started



Note: ROSC at Hospital is measured quarterly



The January Category 1 mean returned 6 minutes 20 seconds while the Category 1 90th centile was 10 minutes 30 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 2nd in the Category 1 mean measure and ranked first in the Category 1 90th centile measure when compared to all Ambulance Trusts across England.





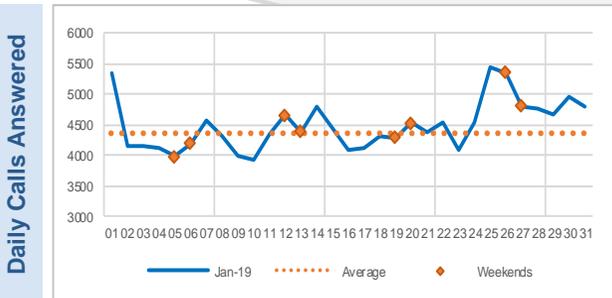
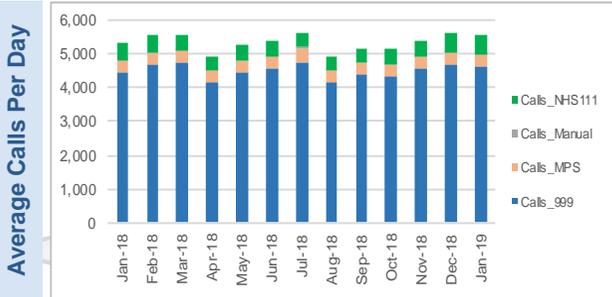
The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

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

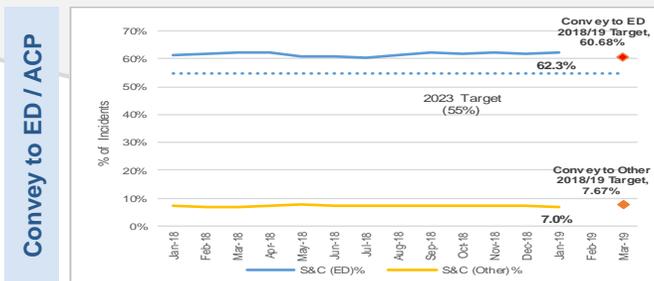
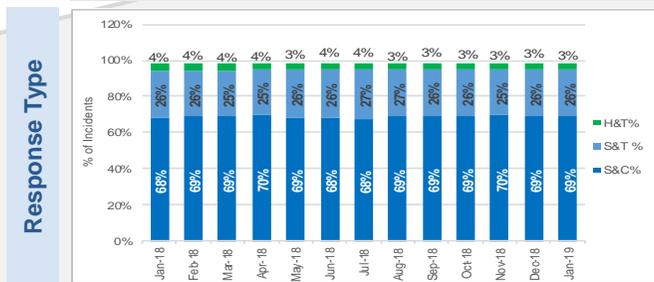
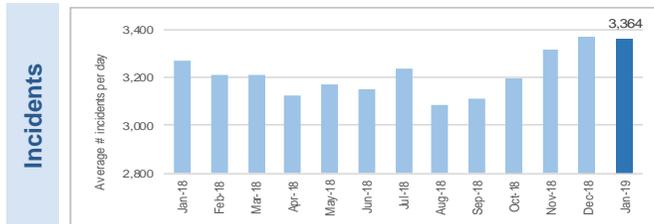
January 2019 saw a similar pattern of 999 calls received into EOC when compared to the December 2018 period. Historically, we normally see an increase in our call demand during the winter period. In comparison to the same month last year we have seen a 0.13% increase in call demand.

During the tail end of January, London experienced freezing temperatures, impacting on our call volumes resulting to higher than normal.



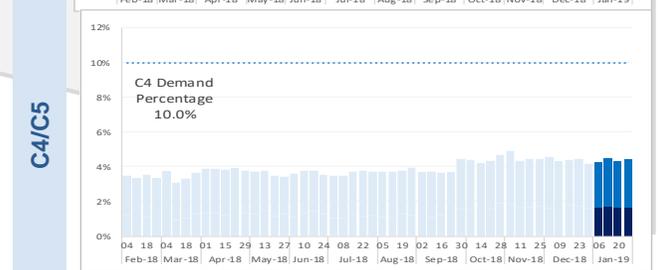
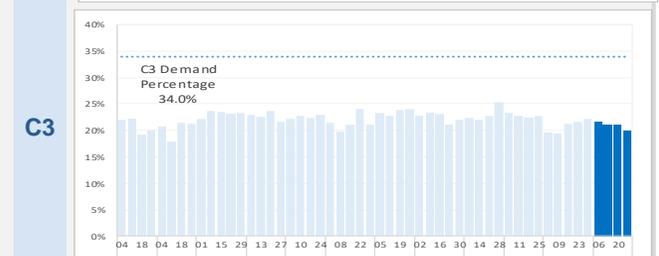
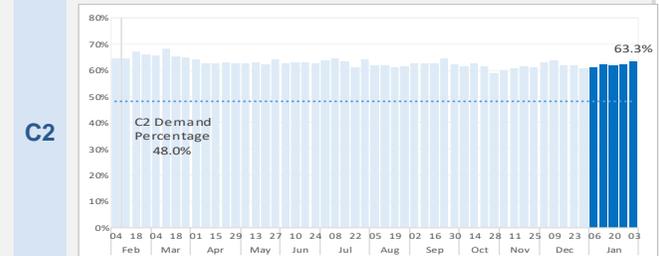
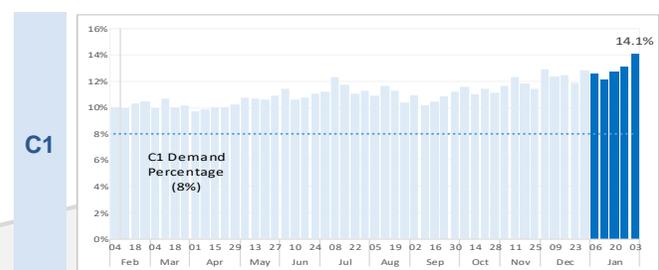
Incidents and Response Type

December 2018 and January 2019 saw the Trust's busiest months on record, with over 100,000 incidents attended in both months. A similar picture is seen with our incident demand this January compared to the same month last year, resulting to a 0.21% increase attributing to the adverse winter weather.



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) **Jan = 62.3%**
 Conveyed to Other (Non ED) Excludes conveyances to units such as Cathlab, HASU, Arrhythmia Centre, etc.

Incident Category (By week)



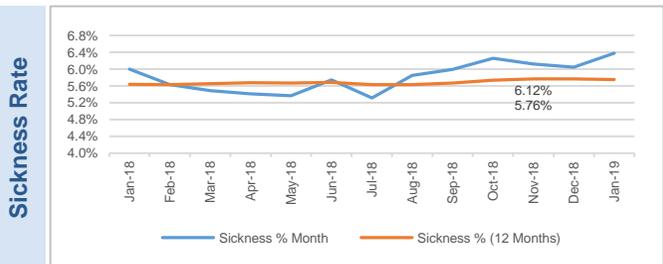
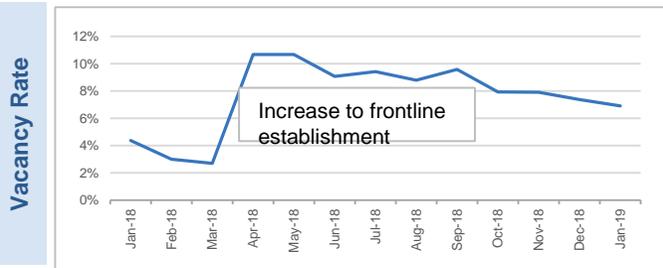


Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

Frontline Operational Staff

The number of filled operational FTE **has increased by 5% since January 2018** and we continue to place considerable effort into our recruitment and retention activity.

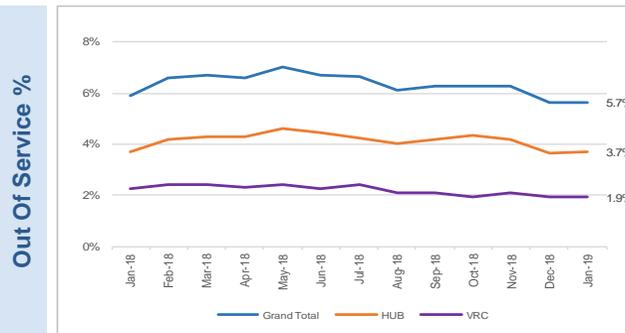
(See Our People section of this report for further detail across the organisation)



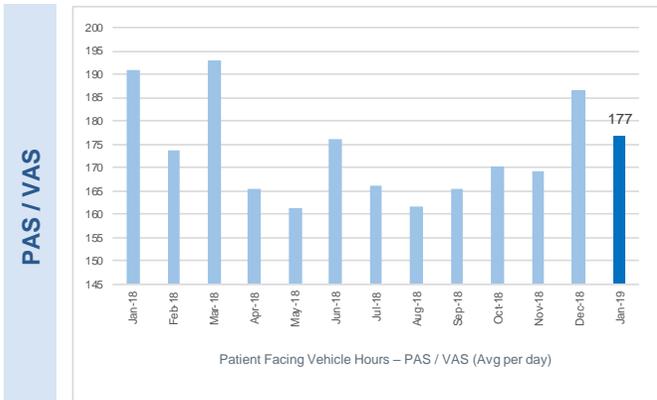
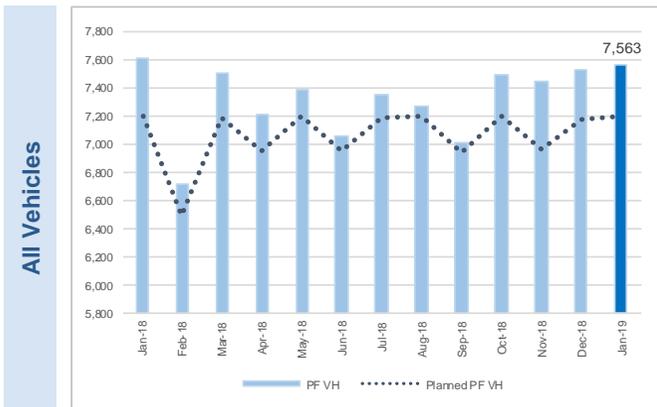
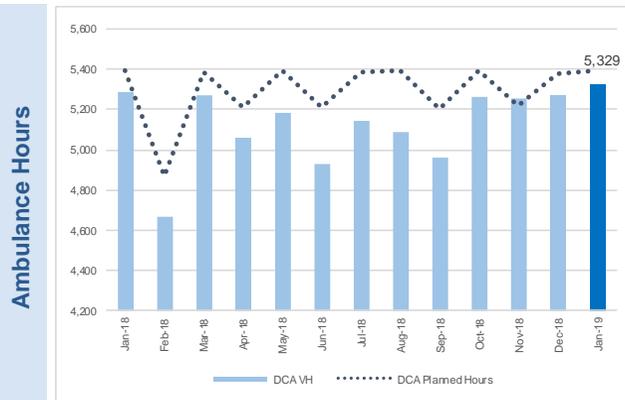
Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate continues to remain under 6%, which is consistent with performance throughout December 2018 and January 2019.

Over the last 12 months the Trust has provided an average of 7,300 patient facing vehicle hours per day. Work is ongoing to align rosters with our ORH demand profile. 5 group stations are anticipated to roll out the new rosters.



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



1. Our Patients

Response Time Performance

Operational Efficiency



We have seen continued improvement in operational efficiency. The average time for the patient handover for the trust ended at 22.3 minutes. This is above standard for the 15 minute target set for patient handover. Patient handover to green for January finished at 13.4 minutes and this measure is seeing improvements week on week. It is recognised that hospital handover delays is a multi-factorial system problem and we need to work together to identify issues at each stage and resolve them. The LAS will continue to work with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance as well as a reduction in the average duration of ambulance handovers.

Arrival at Hospital to Patient Handover

In January we saw a significant increase with our arrival to patient handover over 30 mins; with total time lost exceeding 2900 hours. King Georges and Whipps Cross hospital had the greatest proportion of handovers exceeding 30 minutes at nearly 50%. Northwick Park had the highest number of lost hours over 30 minutes, at 545 hours for the month.

STP	Hospital	Total Conveyances	Handovers	Handovers Exceeding 30 mins	% of Handovers over 30 mins	Total Time Lost Over 30 Mins	Average Arr at Hosp to Patient Handover Time
North Central	Barnet	1,731	1,655	366	22%	110.6	24.5
	North Middlesex	2,930	2,820	514	18%	94.2	19.3
	Royal Free	1,696	1,561	261	17%	65.1	15.3
	University College	1,809	1,715	126	7%	32.9	25.9
	Whittington	1,658	1,597	119	7%	17.6	16.0
North East	Homerton	1,480	1,435	27	2%	3.0	18.5
	King Georges	1,535	1,483	692	47%	96.3	13.6
	New ham	2,173	2,087	478	23%	48.9	29.6
	Princess Royal	1,994	1,845	484	26%	433.4	23.0
	Queens Romford	3,064	2,985	1,067	36%	436.7	18.4
	Royal London	2,248	2,171	158	7%	9.0	24.7
	Whipps Cross	1,919	1,815	847	47%	272.0	23.4
North West	Charing Cross	1,304	1,246	96	8%	12.1	21.2
	Chelsea & West	1,497	1,418	49	3%	7.2	30.8
	Ealing	1,567	1,524	87	6%	28.0	33.1
	Hillingdon	2,014	1,952	244	13%	46.7	15.2
	Northwick Park	3,026	2,923	973	33%	545.0	32.2
	St Marys	2,037	1,938	412	21%	65.7	22.1
	West Middlesex	2,120	2,080	43	2%	4.2	17.5
South East	Kings college	2,314	2,198	497	23%	92.3	22.9
	Lewisham	1,652	1,532	286	19%	128.1	20.6
	Queen Elizabeth II	2,694	2,607	153	6%	80.4	22.5
	St Thomas'	2,551	2,410	128	5%	12.8	17.5
South West	Croydon	2,527	2,437	592	24%	203.2	17.2
	Kingston	1,764	1,727	50	3%	8.7	14.4
	St Georges	2,307	2,230	444	20%	78.7	33.5
	St Helier	1,507	1,444	143	10%	43.6	17.5
TOTAL		55,118	52,835	9,336	18%	2,976	22.3

Maximum handover Value >15 mins per handover

Patient Handover to Green

In January, we saw an overall improvement despite being one of the busiest months on record. Over 2,000 hours were lost due to patient handover to green exceeding the 14 minute threshold.

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	2,651	1,454	55%	168.3	14.9	25.6	6.9
	Edmonton	3,356	1,589	47%	140.1	13.7	22.3	5.3
	Friern Barnet	2,031	925	46%	81.0	13.2	21.7	5.3
North East	Homerton	2,929	1,631	56%	166.5	14.8	24.5	6.1
	New ham	3,922	2,075	53%	223.5	14.6	25.2	6.5
	Romford	3,881	1,952	50%	164.3	13.9	22.0	5.1
North West	Brent	3,775	1,666	44%	162.5	13.2	22.4	5.9
	Fulham	2,327	1,029	44%	85.4	13.2	21.0	5.0
	Hanwell	2,902	1,404	48%	104.2	13.7	20.7	4.5
	Hillingdon	1,582	756	48%	59.0	13.7	21.4	4.7
South East	Westminster	1,359	725	53%	84.8	14.8	24.3	7.0
	Bromley	2,638	1,273	48%	102.1	13.4	21.5	4.8
	Deptford	4,985	2,395	48%	211.2	13.6	22.2	5.3
South West	Greenwich	2,676	1,077	40%	54.2	13.1	17.5	3.0
	Croydon	2,028	1,142	56%	94.7	14.5	22.8	5.0
	New Malden	1,435	676	47%	50.1	13.5	20.3	4.4
Other	St Helier	1,909	929	49%	68.2	13.7	20.6	4.4
	Wimbledon	1,988	975	49%	79.6	13.5	21.8	4.9
	IRO	8	5	63%	3.5	25.1	104.4	42.0
	NETS	1,237	222	18%	20.7	4.9	16.9	5.6
Other	Other	1,557	764	49%	78.3	13.6	23.3	6.1
	Training	1,655	637	38%	65.0	13.3	18.4	6.1
	TOTAL	52,831	25,301	48%	2267.2	13.4	22.2	5.4

Max average breach value Value >7 mins per breach



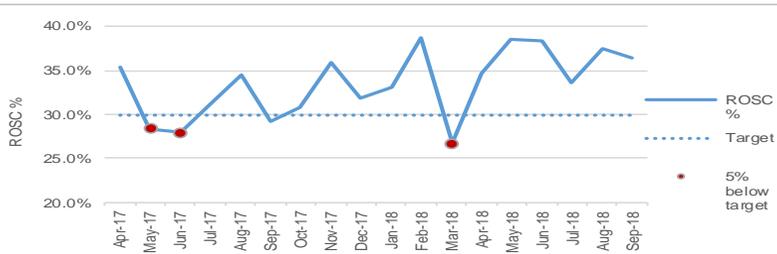
Our Trust-wide scorecard covers 3 of the key Ambulance Quality Indicators: Return of Spontaneous Circulation (ROSC) at Hospital, STEMI call to angiography and Stroke call to door.

The data presented is from September 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 allocated a C1 response receiving an average response of 7 minutes. CPR was commenced on average 1 minute from arrival at the patient with a defibrillator used after a further 2 minutes on average. For STEMI patients, the average response time was 20 minutes, the on-scene time was 39 minutes and the overall call to arrival at hospital time was 75 minutes. For FAST positive stroke patients, the average response time was 22 minutes, the on-scene time was 31 minutes and the overall call to arrival at HASU time was 69 minutes.

ROSC at Hospital

Month: 36.5%

Target: 30%



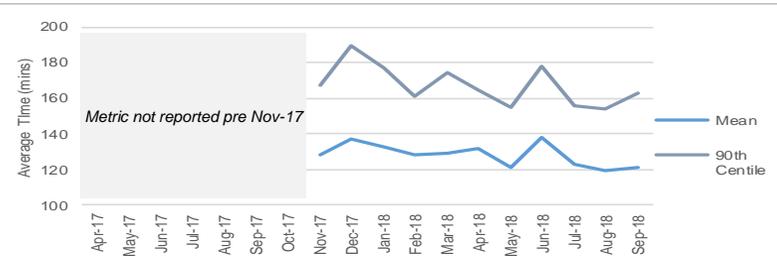
Overall Return of Spontaneous Circulation (ROSC) at Hospital indicator is above the internal target of 30%. The LAS is the top ranking ambulance service this month and performs well above the national average of 29%.

Of note, the Utstein comparator group achieved 70% ROSC, which is well above the national average of 62% and the LAS ranks 1st amongst English ambulance services.

STEMI call to angiography

Mean: 02:01

Target: TBC



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

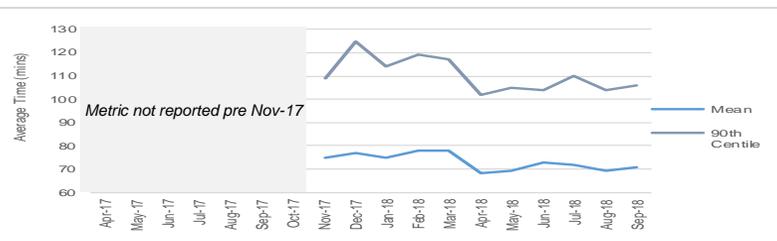
NHS England have republished their figures for call to angiography times for STEMI patients due to data quality issues from information provided by the Myocardial Ischaemia National Audit Project.

The LAS performance was better than the national average for both the mean (2:08) and 90th centiles (2:43 vs 2:54). The LAS ranks 4th for both measures.

Stroke call to door

Mean: 01:11

Target: TBC



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

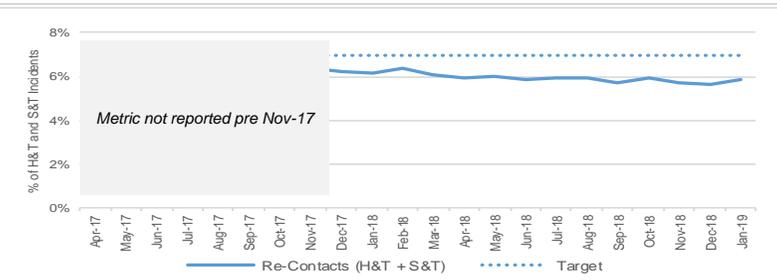
The LAS performance for call to arrival at hospital for suspected stroke patients is below the national average (1:11). The LAS ranked 5th for the mean when compared to other Ambulance Trusts; however it should be noted that there is a difference of 4 minutes between the best performer and the LAS.

The 90th centile is 1:46 and the LAS is below the national average (1:51).

Recontact Rates

Month: 5.9%

Target: 7%



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

Source: Business Intelligence

Note: This measure is not an AQI and is not linked to the CARU ongoing re-contact audit



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		Gap analysis completed, evidence has confirmed we have maintained good rating across all domains. Preparation for CQC will start from April 1 st .
BP.2	We will deliver our post-ARP transformation plan to ensure we can meet national performance and quality standards	Paul Woodrow		Now moved to BAU
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		Currently 21 APP Urgent Care in post. Cohort 2 & Cohort 3 are undertaking their educational programme. The new Clinical Practice Development Manager for Urgent Care has commenced. The Medical Director, Director of Operations and Director of People and Culture have met and agreed that there will be a further 10 APP UC in 2019-20 and 10 in 2020-21
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		Five year strategy complete and published. Enabling strategy for People and Culture has been signed off by Trust Board. IMT & Digital is due for Trust Board sign off in March. Remaining strategies are in progress across the organisation.
BP.5	We will pilot the new 'Pioneer Services' set out in our new strategy	Trisha Bain		Mental health pilot – 3mth evaluation completed. Met the target of 90% ED against a BAU of 54%. Discussion with SE / SW providers in relation to the provision of a rotational MH nurse model. All other Pioneering services on track and positive outcomes in terms of improved education, training and knowledge in relation to EoL, Falls. APPs recruited and again positive evidence in relation to ED conveyance.
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		Focussed work in high level callers in specific boroughs has shown a reduction in caller numbers. Additional frequent caller manager recruited to permit each sector to have a resource working closely with QGAMs and SEM
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		Business case approved for bags, Logistics Services Unit undergoing building modification to be completed this year with roll-out Advanced Life Support, Multi-dose Drug Pack and Primary Response Bag from April.
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		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. We have set up a monitoring system of usage and have an unvalidated figure of 95% of users accessing their iPad regularly. Each group station has a super user identified to assist colleagues who are less confident.



Quarterly Reporting (Latest report as at 6th March, 2019)

- | | |
|-------------------|--|
| SAFE | <ul style="list-style-type: none"> Implementation of Health Assure – now populated by sectors across all domains Hospital Handovers – continued reduction in significant delays & improvement in Handover to Green. Patients with suspected sepsis and NEWS of 7 or more who received Sepsis care bundle reported at 89% compliance. This is the best in the Country Defibrillator downloads has achieved the target of increasing to 20% |
| EFFECTIVE | <ul style="list-style-type: none"> Continued roll out of urgent care APP service improving patient care & reducing conveyance. Funding agreed for next 2 cohorts in 19/20 & 20/21 Rethink! – training review completed & implementation plan submitted following recommendations of review. Volunteer strategy – enhancing Emergency Responder & Community First Responders schemes drafted and to be reviewed by Trust Board in March |
| CARING | <ul style="list-style-type: none"> Whose Shoes? - Mental Health team hosted stakeholder event, 7th Feb at Guy's Hospital. Maternity – 3 practice development midwives in post Patient and Public Involvement – strategy & implementation plan drafted. |
| RESPONSIVE | <ul style="list-style-type: none"> Pioneer Services – Mental Health Car pilot commenced in SE London; See & Treat rate increased for this group of patients Complaints – clearer guidance developed to aid staff in completing statements Resilience - Annual EPRR assurance, Trust assessed as substantially compliant with action plan in progress to address outstanding items |
| WELL LED | <ul style="list-style-type: none"> Statutory and mandatory training compliance currently 89%. ESR transformation programme continues. To date 98% of staff have successfully logged into MyESR. Staff Survey Action Plan – 2018 response rate achieved 65%- top in country for Ambulance services. Equality & Diversity - BME overall workforce is currently at 14.9% and on course to achieve the target of 15% by the end of March 2019 |

		Progress Status			
		Complete	G	A	R
<i>TOTAL</i>	87	39	43	3	2
Safe	15	5	9		1
Effective	21	16	5		
Caring	4	2	2		
Responsive	8	2	6		
Well Led	31	13	17	1	
Use of Resources	8	1	4	2	1

3 actions with an Amber status are off track but recoverable. Two are dependent on the final outcome at the end of the financial year; relating to capital programme delivery and control total targets.

2 actions have a Red status (will not meet the originally defined target). 1 relates to the delivery of CQUINs, the other relates to the implementation of an Asset & Equipment monitoring system, the plan for which will now be reassessed for 2019/20 delivery.

- 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



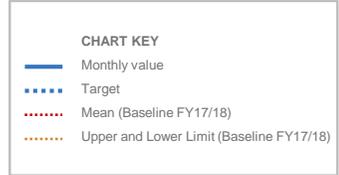
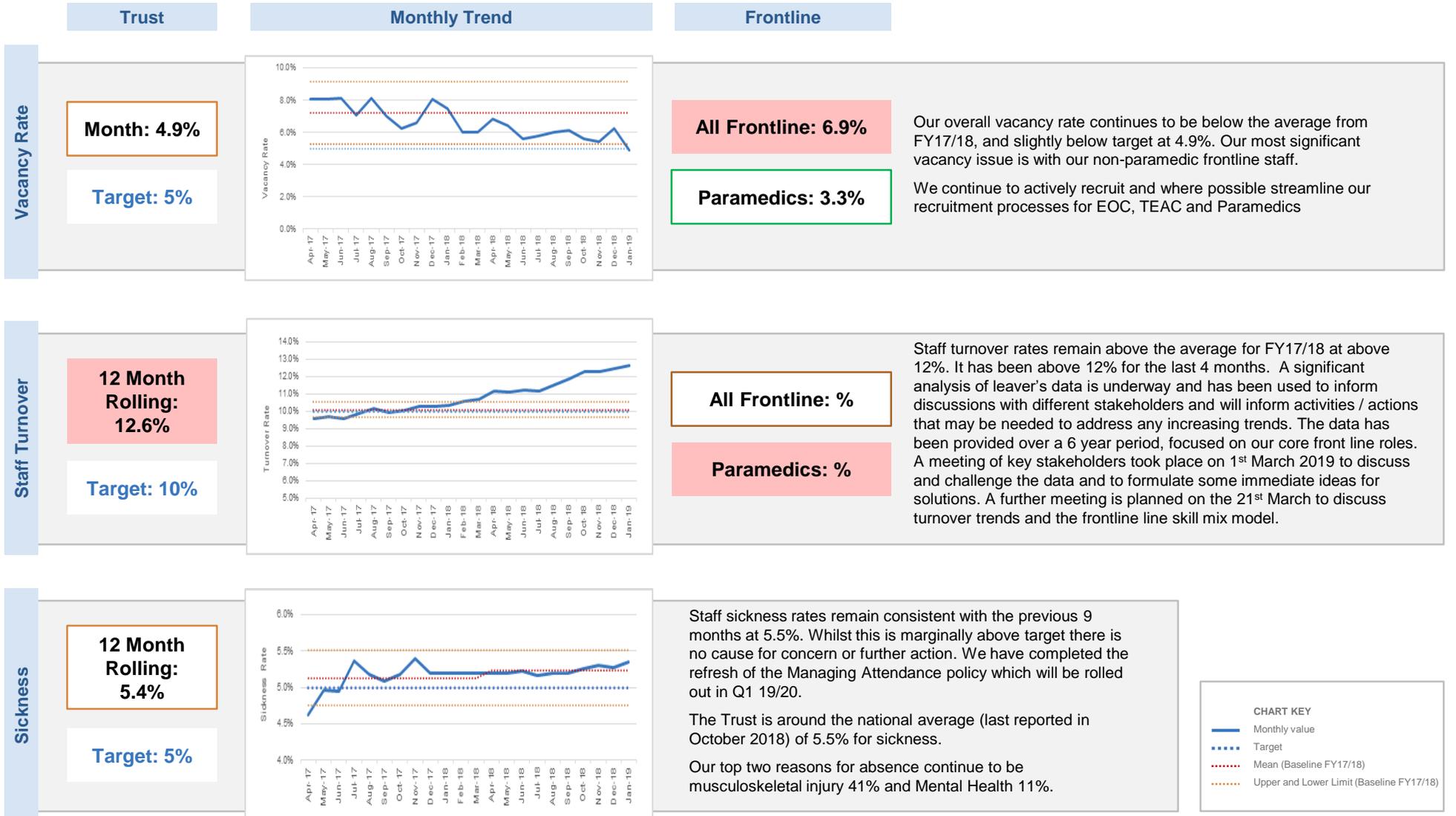
People Scorecard

January 2019

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Current Performance			Trajectory	Benchmarking			
					Target	Latest Month	2018/19 Year To Date Actual	Rolling (12 Month Average)	2018/19 Trajectory	National Data	Best In Class	Ranking (out of 11)
Staff Survey engagement score	Y	Score (Range)			6.2		6.2					
BME Staff Survey engagement score	Y	Score (Range)			6.4		6.1					
Staff survey completion	Y	%			50%		65%					
Staff Sickness levels	M	%	Jan-19		5%	5.5%	5.2%	5.3%				
MSK related staff injuries (staff survey)	Y	%			50%	48.3%						
MSK reduction in moderate harm	M	Count			0.25							
Bullying and Harrassment incidents (decreasing)	Y	%			7.2		7.0					
% of BME Staff	Q	%	Jan-19		15%	14.9%	14.1%	14%				
Statutory & Mandatory Training (85% or above)	M	%	Jan-19		85%	88%	88%	88%				
Staff appraisal compliance (85% or above)	M	%	Jan-19		85%	81%	85%	81%				
Flu vaccination rate (increasing - CQUIN)	M	%	Jan-19		75%	65%						



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 at our target of 5%





Compliance with Health and safety action plan:

Actions arising from the Health and Safety Review have been progressed in line with the action plan; 63/69 actions have been completed (and continue to be embedded) and 6 actions are in progress and on schedule/behind schedule.

Adverse Staff Events

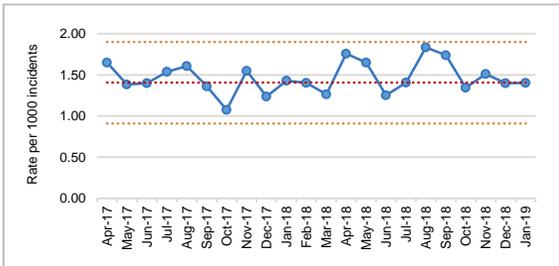
The total number of H&S incidents was 289 resulting in **2.87 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below.

141 (49%) of the H&S related incidents reported during January - 2019 resulted in Low Harm.

3 (1.0%) of the H&S related incidents reported during January - 2019 resulted in Moderate Harm.

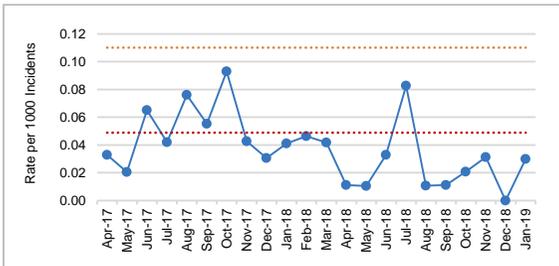
Month: 1.40

Low Harm



Month: 0.03

Moderate



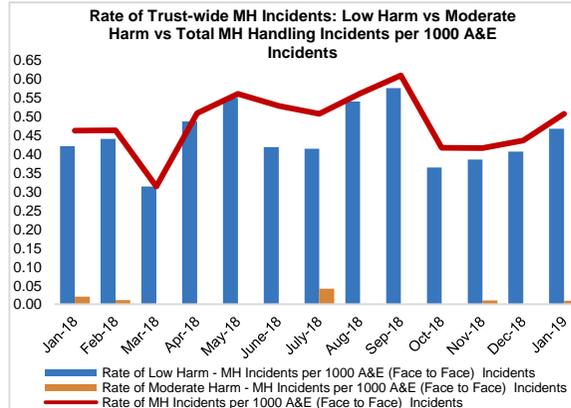
Manual Handling

- Practical manual handling training is on CSR 2019:1 from April-2019.

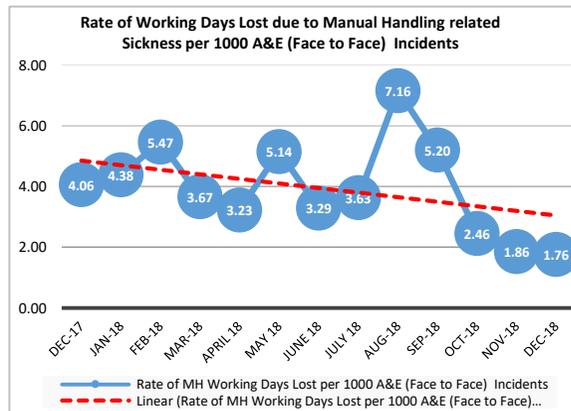
Key Updates:

- There has been a reduction in the incidents reported involving Manger Elks, Track Chairs and Tail lifts as a direct result of new equipment/vehicles being purchased by the Trust along with a redefined maintenance schedule. Monitoring of these incidents continues through various groups.
- The Fire risk assessment programme is due to commence by end of February-2019 and will be undertaken by Trenton Fire Ltd.
- Visits to assess general security issues at ambulance stations is planned to be completed by end of quarter 4.

Manual Handling



Manual Handling Related Sickness





The analysis below looks at 1) H&S Incidents rate & RIDDOR Report Rate per 1000 A&E (face to face) incidents 2) RIDDOR Incidents by Cause and 3) Assaults on Staff :

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Rate of Incidents</p>	<h3 style="text-align: center;">Monthly Trend</h3> <p style="text-align: center;">H&S Incidents & RIDDOR Reports Rate per 1,000 A&E (Face to Face) Incidents</p> <table border="1"> <thead> <tr> <th>Month</th> <th>Rate of incidents per 1000 incs</th> <th>Rate of RIDDOR per 1000 incs</th> </tr> </thead> <tbody> <tr><td>Apr-18</td><td>3.2</td><td>0.2</td></tr> <tr><td>May-18</td><td>3.1</td><td>0.2</td></tr> <tr><td>Jun-18</td><td>2.7</td><td>0.2</td></tr> <tr><td>Jul-18</td><td>2.9</td><td>0.2</td></tr> <tr><td>Aug-18</td><td>3.1</td><td>0.3</td></tr> <tr><td>Sep-18</td><td>3.1</td><td>0.3</td></tr> <tr><td>Oct-18</td><td>2.9</td><td>0.2</td></tr> <tr><td>Nov-18</td><td>2.8</td><td>0.2</td></tr> <tr><td>Dec-18</td><td>2.9</td><td>0.2</td></tr> <tr><td>Jan-19</td><td>2.9</td><td>0.2</td></tr> </tbody> </table>	Month	Rate of incidents per 1000 incs	Rate of RIDDOR per 1000 incs	Apr-18	3.2	0.2	May-18	3.1	0.2	Jun-18	2.7	0.2	Jul-18	2.9	0.2	Aug-18	3.1	0.3	Sep-18	3.1	0.3	Oct-18	2.9	0.2	Nov-18	2.8	0.2	Dec-18	2.9	0.2	Jan-19	2.9	0.2	<p>The graph on the left highlights the YTD rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust.</p> <p>There is no benchmark/comparable data was received from any of the other ambulance Trusts during January 2019.</p>
Month	Rate of incidents per 1000 incs	Rate of RIDDOR per 1000 incs																																	
Apr-18	3.2	0.2																																	
May-18	3.1	0.2																																	
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<p style="writing-mode: vertical-rl; transform: rotate(180deg);">RIDDOR by Cause</p>	<h3 style="text-align: center;">RIDDOR Reportable Incidents by Cause - YTD</h3> <table border="1"> <thead> <tr> <th>Cause</th> <th>Number of Incidents</th> </tr> </thead> <tbody> <tr><td>Manual Handling</td><td>109</td></tr> <tr><td>Slips, Trips and Falls</td><td>40</td></tr> <tr><td>Other</td><td>33</td></tr> </tbody> </table>	Cause	Number of Incidents	Manual Handling	109	Slips, Trips and Falls	40	Other	33	<ul style="list-style-type: none"> Total of 182 RIDDOR incidents reported to the HSE during 2018/19. 15 RIDDOR incidents reported in January 2019. 4 out of the 15 incidents reported outside the 15 days timeframe. The Trust wide RIDDOR reporting time frame (<15 days) compliance in January 2019 was 73%. Manual Handling incidents account for the highest number of RIDDORs reported across the Trust during 2018/19. 																									
Cause	Number of Incidents																																		
Manual Handling	109																																		
Slips, Trips and Falls	40																																		
Other	33																																		
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Assaults</p>	<h3 style="text-align: center;">Assaults on Staff by Patients</h3> <table border="1"> <thead> <tr> <th>Month</th> <th>Number of Assaults</th> </tr> </thead> <tbody> <tr><td>DEC-17</td><td>35</td></tr> <tr><td>JAN-18</td><td>35</td></tr> <tr><td>FEB-18</td><td>35</td></tr> <tr><td>MAR-18</td><td>24</td></tr> <tr><td>APR-18</td><td>35</td></tr> <tr><td>MAY-18</td><td>42</td></tr> <tr><td>JUN-18</td><td>52</td></tr> <tr><td>JUL-18</td><td>35</td></tr> <tr><td>AUG-18</td><td>45</td></tr> <tr><td>SEP-18</td><td>49</td></tr> <tr><td>OCT-18</td><td>44</td></tr> <tr><td>NOV-18</td><td>33</td></tr> <tr><td>DEC-18</td><td>25</td></tr> <tr><td>JAN-19</td><td>39</td></tr> <tr><td>FEB-19</td><td>32</td></tr> </tbody> </table>	Month	Number of Assaults	DEC-17	35	JAN-18	35	FEB-18	35	MAR-18	24	APR-18	35	MAY-18	42	JUN-18	52	JUL-18	35	AUG-18	45	SEP-18	49	OCT-18	44	NOV-18	33	DEC-18	25	JAN-19	39	FEB-19	32	<p>There was a slight decrease in the number of assault on staff by patient related incidents in Jan-2019. The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.</p>	
Month	Number of Assaults																																		
DEC-17	35																																		
JAN-18	35																																		
FEB-18	35																																		
MAR-18	24																																		
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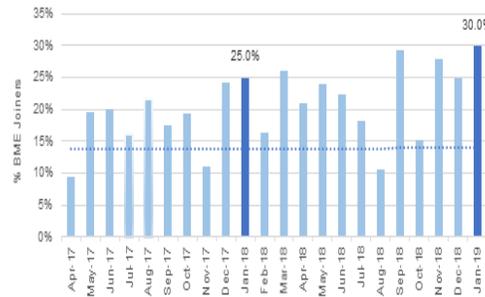
Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

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 January 2019 compared to the current Trust BME profile. This year we have recruited 204 BME staff and 104 BME staff have left.

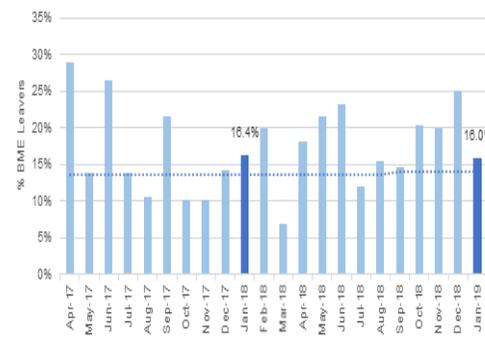
BME Starters



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

First women's breakfast well attended and positive feedback. Next meeting 28 March. The Trust will achieve its target of 15% BME representation by 31 March 2019. Low number of BME candidates moving into and staying in core front line roles. Feedback on female experience through selection process at senior level. Planning underway to agree action.

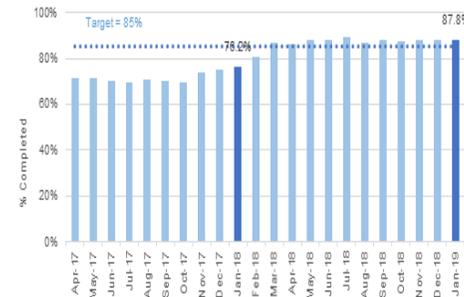
BME Leavers



Statutory and Mandatory Training and Appraisals

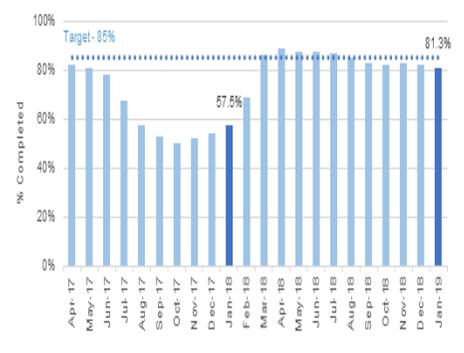
- Trust compliance in Statutory and Mandatory training is **87.8%** and over 136,000 e-learning courses have been completed since go-live. Over 98% of all Trust staff have logged into ESR and over 95% have completed e-learning.
- Appraisal completions at **81.3%** at the end of January.

Statutory & Mandatory



Trust compliance is 88% with Sector Operations at 91% and Corporate 89%. EOC, the subject of the CQC Must Do action, is at 84.94%. CSR2018.1 is 93% and CSR 2018.2 is 66% (trajectory brings this back in line). Information Governance is at 88% for January and will increase alongside CSR completions.

Appraisal Compliance



PDR Appraisals were at 81.3% at the end of January 2019. This is predominantly linked to a number of Corporate staff who have become non-compliant and focus is on Business Partners working with their colleagues to achieve 85% compliance. Weekly reports are provided to Corporate Directors to facilitate the required improvement.



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		We are currently refreshing reporting for EOC recruitment trajectories in line with the new organisational structure. The management team are confident that the restructure and planned recruitment and training activities will enable us to reach establishment within Q1 2019/20. Focus is on identifying new training estate for EOC new recruitments and internal upskilling requirements.
BP.10	We will complete the restructuring and recruitment to our main organisational directorates, changing the way we operate.	Patricia Grealish		In delivery – Whilst planned restructures are complete and implementation (by the end of the financial year) is underway, some minor reorganisations will still be required as a result of decisions taken during the latter part of 2018 (e.g. establishment of an Enterprise Project Management Office). Pre-planning work for the restructure for Strategic Assets and Property is underway with delivery during H1 2019/20
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		On track. All the new branding is completed and, 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 (through Senior Management Meetings bi-monthly, and through the Visible Leader and Engaging Leader leadership programmes).
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		Complete. 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		Complete. Activities under the WRES Action Plan for 17/18 have now been rolled into the extensive action plan agreed for 18/19 and 19/20. Work has commenced on readying for the new Workforce Disability Equality Standard Action Plan which has been discussed at Equality Committee and People and Culture Committee. Likely to be August 2019
BP.14	We will continue to implement our Clinical Education Strategy	Fenella Wrigley		Clinical education strategy workshop and alternative care pathway workshops have both been held. This, alongside the workforce planning workshop will enable the clinical education strategy to be completed
BP.15	We will develop and roll-out training and development for all our people across functional and operational teams.	Patricia Grealish		Complete. Leadership development programme in delivery phase and Management Essential programmes also underway. First cohort of visible leaders completed with second and subsequent cohorts planned. Continuous improvement will be built into the leadership development pathway elements as delivery progresses

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

R Business Plan deliverable significantly off track



BP.9 EOC Narrative

- 2018/19 started with an increased recruitment target of 171 FTE for EMDs.
- Reporting of a year end gap of 35 FTE has reduced following refreshed reporting to reflect restructure, resulting in an improved position of 24 FTE.
- Recruitment trajectories and new entrant training plans are sufficient to bring this to full establishment within Q1 2019/20
- Focus is on identifying new training estate for EOC new recruitments and internal upskilling requirements by December 2019
- 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. Professional apprenticeship pathways are being planned to improve retention but will await the completion of the EOC Restructure.
- Streamlining of our selection process, including re-assessing pass rates and the introduction of online assessments and, streamlining and improvement of pre-employment checking have also assisted in the recruitment activity. A review of this new approach has been provided to the People and Culture Committee and decisions will be made on what elements to build into the ongoing recruitment processes.
- EOC restructure – the consultation process has concluded with the implementation planned from April 2019. It is anticipated that this will improve retention and other management capacity issues and this will be monitored closely.

BP.9 EOC vacancy position as at 31st March 2019

NB. Please note that there are a number of internal moves due to be implemented in April and May which have resulted from the current restructure in EOC. The position shown below reflects the current EOC staffing and presents the staffing position based on the planned internal moves. The internal moves are between the Emergency Call Handler, Call Co-Ordinator and Emergency Resource Dispatcher roles.

As at 31st March 2019

Role	Band	Funded FTE	Staff in Post	Vacancy FTE	Vacancy %
Emergency Call Handler	3	177	116.85	60.15	34.0%
Emergency Call Coordinator	4	111.1	147.06	-35.96	-32.4%
Total		288.1	263.91	24.19	8.4%
Emergency Resource Dispatcher	5	150	150.28	-0.28	-0.2%
Emergency Call Handling Supervisor	5	10	7.00	3.00	30.0%
Performance Manager - Dispatch	6	10	9.52	0.48	4.8%
Performance Manager - Call Handling	6	10	8.43	1.57	15.7%
Watch Manager	7	20	19.49	0.51	2.6%
Total		200	194.73	5.27	2.6%
Grand Total		488.1	458.64	29.46	6.0%



Public Value Scorecard

January 2019

Indicator (KPI Name)	Basis	Data From Month	FY18/19 Target Status	Current Performance						Forecast	Benchmarking		
				FY18/19 Target	Latest Month	Month Plan	2018/19 Year To Date Actual	YTD Plan	Rolling (12 Month Average)	2018/19 Forecast	National Data	Best In Class	Ranking (out of 11)
Control Total (Deficit)/Surplus	£m	Jan-19	●	4.4	2.5	1.6	3.7	3.0		4.3			
CIP Savings achieved	£m	Jan-19	●	12.3	1.4	1.7	9.9	9.6		12.3			
CIP Savings achieved - % Recurrent	£m	Jan-19	●	75%	80%		80%			75%			
Use of resources index/indicator	(n)	Jan-19	●	1	1	1	1	1	2	1			
% of Capital Programme delivered	%	Jan-19	●	100%	6%	9%	45%	61%		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

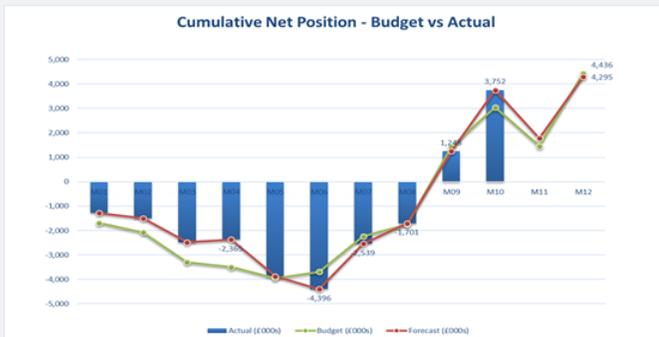


January's financial performance continues to align with our financial plan for FY18/19 with a strong current cash position for the trust and income whilst still behind contracted levels has increased through high levels of demand.

YTD outturn vs budget

YTD: -£4.4m

Budget: -£4.4m



- The Trust is forecast to deliver £4.3m surplus including the additional £4.0m Provider Sustainability Funding. This is £141k adverse to the adjusted control total surplus of £4.4m. The variance to the revised control total relates to a shortfall in the national funding for the agenda for change pay settlement. NHS Improvement have agreed this treatment and have overridden the control total breach for this while national funding discussions continue.
- Main contract activity for month 10 YTD is 1.36% higher than contract, and the variable income in relation to this (£3.3m) 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 £0.5m behind planned income at the end of month 10. The forecast currently assumes the Trust will only achieve £3.3m of the budgeted £4.6m growth. The Trust has included £4.75m income related to the additional costs for the implementation of ARP requested by commissioners which has been invoiced this month.

Financial Position Metrics

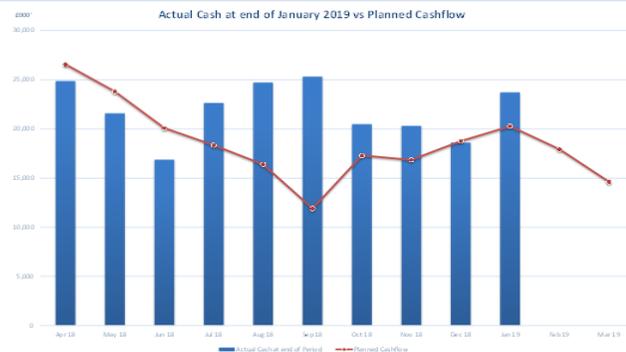
	Month 10 2018-19			YTD Month 10 2018-19			Full Year 2018-19
	Budget	Actual	Variance fav / (adv)	Budget	Actual	Variance fav / (adv)	Budget
Surplus / (Deficits)	1,619	2,504	885	3,045	3,752	707	4,436
EFL				10,036	6,577	3,459	16,288
CRL				13,300	9,886	3,414	17,126
Suppliers paid within 30 days - NHS	95%	95%	0.0%	95%	89%	(6.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	78%	(17.0%)	95%	84%	(11.0%)	95%
EBITDA %	10.5%	10.4%	(0.1%)	6.2%	6.1%	(0.0%)	6.5%
EBITDA	3,532	4,241	709	19,621	19,793	172	24,837
NRAF (net return after financing)				3.14%	3.16%	0.0%	(1.9%)
Liquidity Days				0.01	6.97	6.96	(2.21)
Use of Resources Rating				1.0	1.0	0.0	2.0

- The Trust is £3.4m behind a capital plan of £13.3m 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. The Trust is on course to spend its full capital allocation in 2018/19.
- Non-NHS 78%, NHS 95% performance (volume) for this month, performance is still below 95% target. The fall in Non-NHS performance is due to a large number of overdue invoices being cleared in January 2019.

Cash position

YTD: £23.7m

Plan: £20.2m



- Cash is £23.7m as at 31 January 2019, £3.5m above plan. This is made up of a number of offsetting variances.
- An analysis of the cash position shows that receipts from income are £5.6m above planned due to £4.3m NEL contract income, QBE £1.9m and NHSE £3.3m pay award funding received but not in plan and (£3.9m) unpaid income, there are higher than planned creditor payments of £8.7m due to the recovery to normal payment service by our outsourced accounts provider, NEL set-up and operating costs, higher than planned in year non-pay spend and pay at £1.9m.
- These are being offset by under payments of £7.2m on capital and £1.3m 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 10 – January 2019)

	Month 10 2018-19 £000			YTD Month 10 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	32,496	39,379	6,883	310,302	315,716	5,414	372,033	377,133	5,100
Other Operating Income	1,135	1,289	154	7,290	6,824	(466)	9,663	9,172	(491)
Total Income	33,631	40,668	7,037	317,591	322,539	4,948	381,696	386,305	4,610
Operating Expense									
Pay	(23,605)	(23,710)	(106)	(233,883)	(227,395)	6,488	(280,932)	(270,727)	10,205
Non Pay	(6,495)	(12,717)	(6,222)	(64,088)	(75,351)	(11,264)	(75,926)	(90,896)	(14,969)
Total Operating Expenditure	(30,099)	(36,427)	(6,328)	(297,970)	(302,746)	(4,776)	(356,858)	(361,623)	(4,764)
EBITDA	3,532	4,241	709	19,621	19,793	172	24,837	24,683	(155)
EBITDA margin	10.5%	10.4%	(0.1%)	6.2%	6.1%	(0.0%)	6.5%	6.4%	1.4%
Depreciation & Financing									
Depreciation & Amortisation	(1,565)	(1,331)	234	(13,111)	(12,461)	651	(16,241)	(15,962)	280
PDC Dividend	(350)	(426)	(76)	(3,500)	(3,804)	(304)	(4,200)	(4,656)	(456)
Finance Income	4	16	11	58	130	72	67	138	71
Finance Costs	(2)	(3)	(1)	(22)	(11)	11	(27)	(13)	14
Gains & Losses on Disposals	0	8	8	0	104	104	0	104	104
Total Depreciation & Finance Costs	(1,913)	(1,737)	176	(16,576)	(16,041)	534	(20,401)	(20,388)	14
Net Surplus/(Deficit)	1,619	2,504	885	3,045	3,752	707	4,436	4,295	(141)
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	(0)	32	32	(0)	38	38	(0)
Remove STP funding 2016/17	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance	1,622	2,507	885	3,077	3,784	707	4,474	4,333	(141)
Net margin	4.8%	6.2%	1.3%	1.0%	1.2%	0.2%	1.2%	1.1%	1.8%

Income

- Main contract activity for month 10 YTD is 1.36% higher than contract, and the variable income in relation to this (£3.3m) 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 £0.5m behind planned income at the end of month 10.
- The forecast currently assumes the Trust will only achieve £3.3m of the budgeted £4.6m growth. The Trust is including £4.75m of additional income for ARP implementation which has been invoiced this month.

Operating Expenditure (excl. Depreciation and Financing)

- Pay expenditure is £6.5m lower than plan YTD, due primarily to front line vacancies.
- The underspend on front line pay is partially offset by private ambulance expenditure £3.9m.
- Non-Pay is over by £10.7m YTD due to overspends on consultancy & professional fees (£0.1m), conflict resolution training (£0.3m), Subsistence (£0.6m), Uniforms (£0.3m), Adastra in EOC (£0.2m), Fuel (£0.7m), Medical gases and surgical items (£0.1m).

EBITDA

- The Trust delivered an EBITDA of £19,793k to November which represents EBITDA margin of 6.1%.

Depreciation and Financing

- Overall Financial Charges are £0.6m 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 10 – January 2019)

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Jan-19	Jan-19	
	Actual	Actual	Actual	Actual	Actual	Actual	YTD	YTD	Var
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	22,634	24,715	25,317	20,488	20,304	18,591	30,300	30,300	0
Operating Surplus	(35)	1,067	3,627	2,499	4,720	4,241	19,792	19,277	515
(Increase)/decrease in current assets	1,249	3,045	(5,520)	(3,764)	(7,053)	(628)	(10,562)	771	(11,333)
Increase/(decrease) in current liabilities	1,265	975	(1,537)	1,928	1,034	3,820	5,263	(503)	5,766
Increase/(decrease) in provisions	208	(751)	138	(41)	137	26	(670)	(5,840)	5,170
Net cash inflow/(outflow) from operating activities	2,687	4,336	(3,292)	622	(1,162)	7,459	13,823	13,705	118
Cashflow inflow/(outflow) from operating activities	2,687	4,336	(3,292)	622	(1,162)	7,459	13,823	13,705	118
Returns on investments and servicing finance	15	17	19	14	12	16	130	43	87
Capital Expenditure	(621)	(2,071)	(1,556)	(820)	(563)	(2,343)	(18,850)	(22,104)	3,254
Dividend paid	0	(1,680)	0	0	0	0	(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	(606)	(3,734)	(1,537)	(806)	(551)	(2,327)	(20,400)	(23,741)	3,341
Movement	2,081	602	(4,829)	(184)	(1,713)	5,132	(6,577)	(10,036)	3,459
Closing Cash Balance	24,715	25,317	20,488	20,304	18,591	23,723	23,723	20,264	3,459

Operating Position

- There has been a net outflow of cash to the Trust of (£6.6m), this is £3.5m lower than the planned outflow (£10.0m).
- Cash funds at 31 January stand at £23.7m.
- The operating surplus at £19.8m is £0.5m above plan.

Current Assets

- The movement on current assets is (£10.6m), (£11.3m) lower than planned movement.
- Current assets movement was lower than planned due to receivables (£7.8m), accrued income (£3.1m) and prepayments (£0.4m).

Current Liabilities

- The movement on current liabilities is £5.3m, a £5.8m higher than planned movement.
- Current liabilities movement was lower than planned due to trade and other payables (£2.6m), accruals £7.1m and Deferred income £1.3m.

Provisions

- The movement on provisions is (£0.7m), is a £5.2m lower than planned movement.

Capital Expenditure

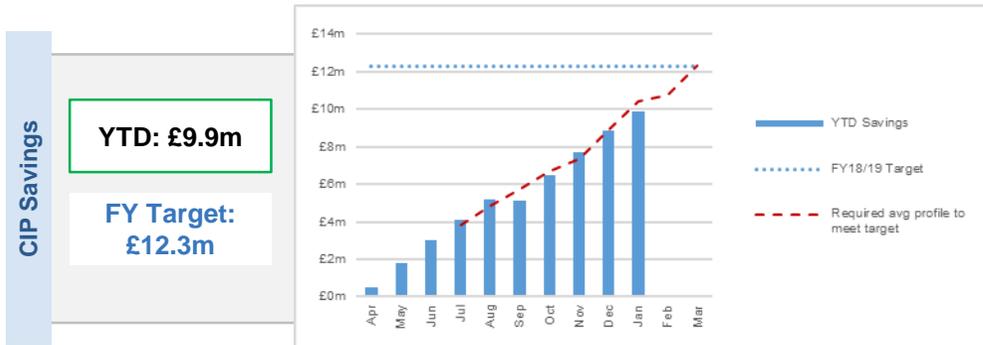
- Capital cash outflow is £18.9m, is a £3.3m below plan.



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 £1.4m and YTD £9.9m both on plan. Delivery of the full year target of £12.3m remains a risk and continues to be closely monitored for the remainder of the year.

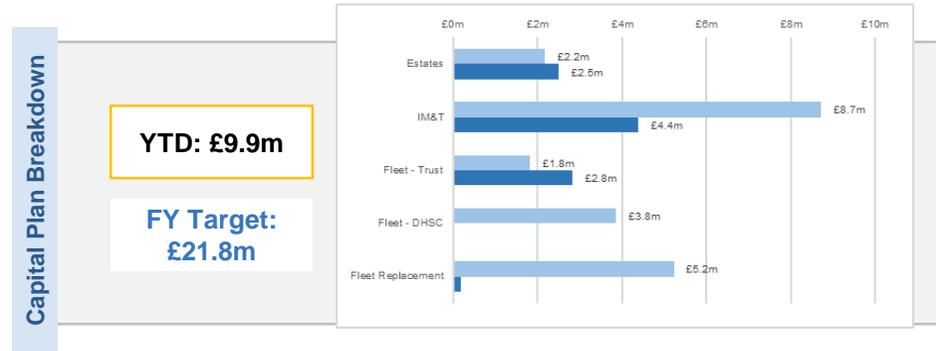


All plans have been created with documentation complete which has led to a switch from development to delivery. The table below summarises the status of the different initiatives (Red = Not delivering, Amber = Off track with mitigation, Green = Delivering)

Red	Amber
<p>Improving planning of annual leave: The proposals are currently with the Trade Unions. No further progress reported. This scheme will not delivery efficiency savings during 18/19.</p>	<p>Addressing EOC Incentive Payments: There continues to be a significant downturn in overtime costs and expenditure following the decision to remove incentive payments from September. The recruitment forecast is now showing an end of year gap of -32 FTEs (previously showing)</p>
<p>Driver Training & Maternity Income Generation: As confirmed these schemes will not delivery during 18/19</p>	<p>Fleet Procurements: This scheme continues to be ragged as AMBER. The sale of PTS and Motorcycles has now delivered savings of £123k as at Month 9 as part of the recovery plan.</p>
<p>Reducing OOS: Further good progress has been made during Jan 19 to reduce lost hours due to out of service across all codes. This reflects the increased focus in the Vehicle Resource Centre and introduction of the pilot Tactical Operations Centre. Over 1,000 hours have been saved when compared to the previous year. This equates to c£100k. This scheme will carry forward to 2019/20 as a non-cash releasing efficiency scheme.</p>	
<p>Improving Attendance: The sickness absence rate for operational staff continues not to show any improvement overall. To be carried forward to 2019/20</p>	
<p>Vehicle Make Ready: The plan to realise savings of £110k (revised target) will not be achieved. No further savings have been identified to meet the shortfall however we anticipate further savings from engineering standards</p>	
<p>Stadia/Staffing Events: Despite significant improvements in control of expenditure and planning, it has been difficult to demonstrate additional income due to reduced events attended generating income during 18/19. The improvements from improved controls over overtime expenditure are evidenced through the overtime/incentives scheme which is over-performing against the CIP Plan.</p>	

Capital Plan

- Capital spend is £9.9m against a budget of £13.3m, £3.4m behind plan.



- The Trust was awarded £3.8m capital funding from the sustainability and transformation partnership ambulance schemes. This is to fund the purchase of additional ambulances.
- The Trust CRL of £15.5m has been confirmed and increased by £3.8m above to £19.3m. In addition the Trust carried forward £1.6m from the last financial year resulting in a total capital plan of £21m
- Orders have been placed for all Estates and Fleet spend. Further work is required to provide assurance that all IM&T capital will be utilised in year.



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 £4.3m surplus including £4.0m Provider Sustainability Funding. This represents a £1.8m underlying improvement on the initial control total agreed with NHS Improvement
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 continuing to forecast delivery of the £12.3m CIP programme with 80% 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 Trust's Accountable Emergency Officer and its Head of Business Continuity have confirmed that all business continuity plans (there are just over 100 individual departmental plans) were reviewed, and updated as necessary, at the end of November 2018. There are no current plans which are not considered to be within tolerable levels of risk. Particular attention has been paid to business continuity plans relating to staffing, fleet and the Emergency Operations Centre (EOC). Further assurance about the Trust's business continuity arrangements was received following a visit from NHS England's Emergency Planning Resilience and Response (EPRR) team on 29 November 2018. This visit formed part of NHS England's EPRR annual assurance review where the Trust's compliance against core EPRR and business continuity standards was assessed. No concerns were raised during the visit about the Trust's internal business continuity plans.
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		The Trust has delivered £14.4m against £21.8m. Forecast to spend its full allocation of £21.8mm by the end of March.
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, Q2 & Q3 CQUIN delivered, risk included in financial forecast on Conveyance, Flu, Staff Health & Wellbeing results.



BP.24 CQUIN Delivery

CQUIN	Q1	Q2	Q3	Q4	Total	Mitigations
HWB1A – Staff Survey				0%	0%	Results have been released nationally and although we have seen general positive improvements, the percentage improvements needed to achieve CQUIN have not been met. A case will be made to commissioners to support partial payment recognising the good work done in year.
HWB1B – Healthy Food				100%	100%	Good progress has been made on engagement with suppliers. Commissioners recognise this and are assured that LAS are focused on promoting healthy food throughout the organisation.
HWB1C – Flu vaccinations				75%	75%	A case will be made to commissioners that vaccinations were not available for 8 weeks which impacted to the ability of LAS to achieve the 75% vaccination rate. A significant improvement has been made from 2017/18 to 2018/19.
CQUIN 12 – Reductions in Conveyance				40%	40%	A plan has been developed and agreed with commissioners as per CQUIN requirement. Unfortunately expected improvements have not been realised. The Contracts team are currently in discussion with commissioners around a partial payment mechanism to allow achievement of some funding for 2018/19.
STP Engagement	24%		37.5	32.5%	95%	Engagement across sectors remains high. Feedback has been received from some STP's as part of the Q3 Review meeting that areas of improvement are required for Q4 to be achieved in full. These are being picked up with leads locally.
Digital	20%	35%	10%	35%	100%	Following delays from NHS Digital commissioners have agreed to amend deliverables to align with work currently on going in the Trust.

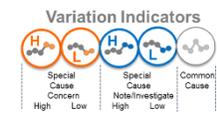


Partners Scorecard

January 2019

Indicator (KPI Name)	Basis	Data From Month	STATUS	Statistical Process Control Icon	Current Performance					Trajectory	Benchmarking (Month)		
					YTD Target	Latest Month	Month Target	2018/19 Year To Date Actual	Rolling (12 Month Average)	2018/19 Trajectory	National Data	Best In Class	Ranking (out of 11)
Conveyance rate to ED (CQUIN)	%	Jan-19	●		60.83%	62.3%	60.2%	61.7%					
STP engagement metric (CQUIN)	£m	Jan-19	●	N/A	2.0	1.2	1.2	2.0					
Digital (CQUIN)	£m	Jan-19	●	N/A	2.1	0.3	0.3	2.1					
Call answering - 999 (less than 5 seconds)	%	Jan-19	●			87.6%	95%	86.7%	84.8%				
Call answering - NHS 111 (less than 60 seconds)	%	Jan-19	●			76.3%	95%		84.6%				

- **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





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 Q3 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	Q9a = 16.0% Q9b = 48.4% Q9c = 46.0%	Q9a = 22.5% Q9b = 52.2% Q9c = 56.1%	£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	<i>Range of targets</i>		£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	68% <i>At 01/03/19</i>	>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	<i>ED Convey = 61.74%</i> <i>H&T = 3.39%</i> <i>S&T = 26 %</i>	ED Convey = 60.68% 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	<i>Range of targets</i>		£3,205k	£2,003k	63%	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	<i>Range of targets</i>		£3,205k	£2,083k	65%	100%
TOTAL					£8,012k	£4,086k	51%	100%

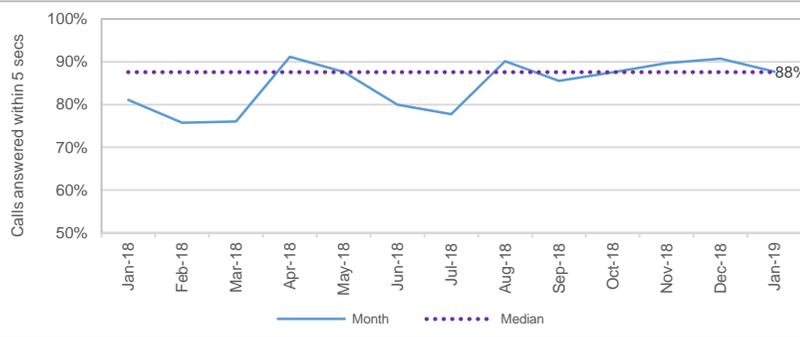


Overall, 999 performance around calls answered within 5 seconds during the winter period has broadly remained unchanged for the last 3 months.

The total call volumes for 111 was above the forecasted volume for the month. Therefore number of staff rostered per shift (based on the forecasted call volumes) struggled to fulfil call answering within 60 seconds. Call balancing between contributed to SELs poor call answering levels. One of the assurances provided to commissioners is to look to recruit more staff to improve the call answering outcomes.

999 Call Answering

Month: 88%



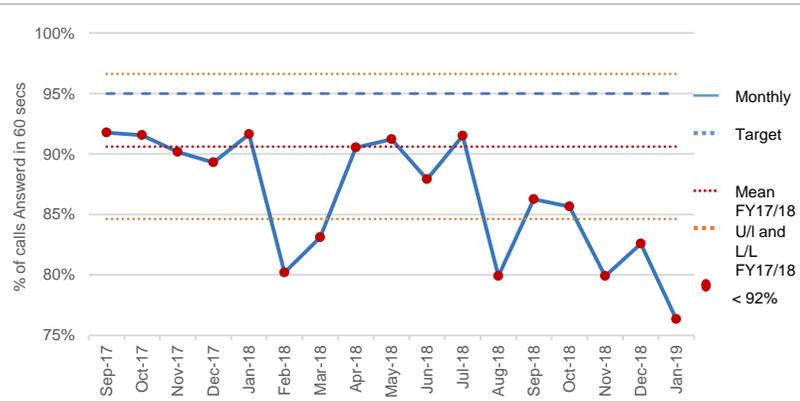
In terms of the Emergency Operations Centres (EOC), 88% of all calls were answered within 5 seconds in January, which was similar to that of December's call answering performance.

The average call answering was in 9 seconds, followed by 17 seconds for 90th centile and 52 seconds for 95th centile. 99th centile finished at 1 mins and 56 seconds.

111 SEL Call Answering

Month: 76.3%

Target: 95%



Demand: SEL answered 36,794 calls in January 2019 compared with 34,941 calls in January 2018 –an increase of 1,853 calls largely due to call balancing. Call balancing from NEL to SEL resulted in 3314 calls included in the total number of calls answered above.

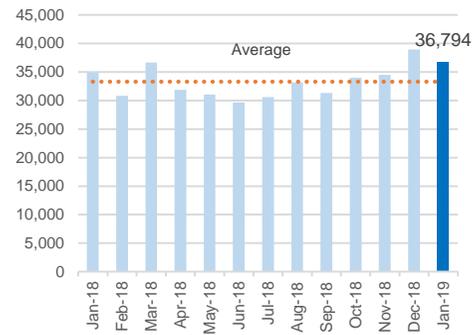
Efficiency: The percentage of calls answered in 60 seconds or less was 76.3% this is a 6.3 percentage points decrease in calls answering performance when compared to December 2018.

On all other days the SLA was under 95% due to staffing challenges, additionally the balancing from NEL to SEL lead to further under performance than would have been seen if SEL had been a standalone service.

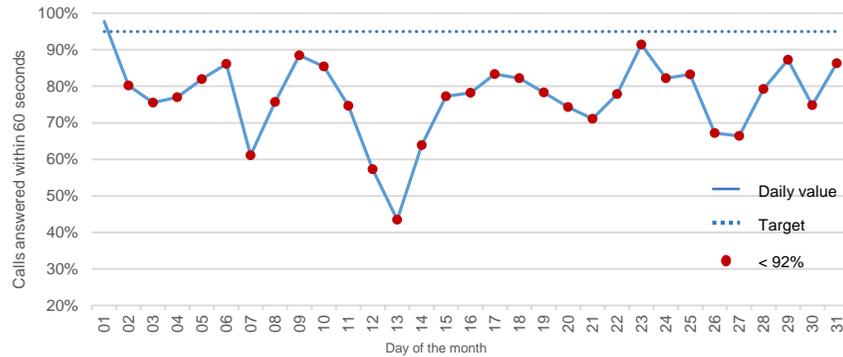


111 South East London

Monthly Calls Answered



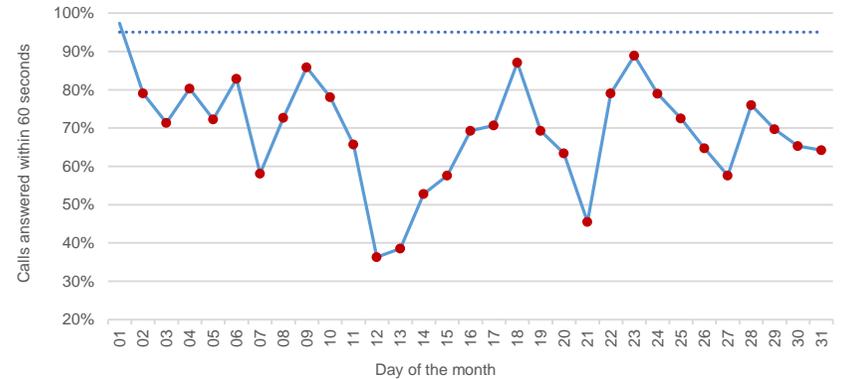
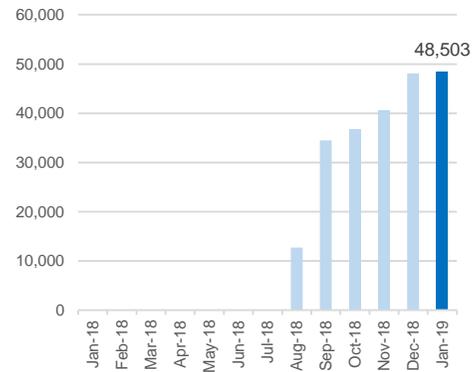
Daily Analysis of Calls Answered within 60 secs



There was a 1,853 increase in answered calls in January 2019 compared to January 2018, which is largely due to 3,314 NEL calls being transferred to SEL.

The 95% target SLA (percentage of calls answered in 60 seconds) was met for 1 day in January with a total of 13 days exceeding 80%. With the exception of 01 January 2019, calls were over demand on the 02, 16, 27, 28, and 30 of the month.

111 North East London



48,503 calls were answered in January, a marginal increase in calls answered when compared to December 2018.

During the month of December 30 out of 31 days failed to achieve the 95.0% or more calls answered with 60 seconds target. Six days of the month saw performance at 80% or above.

Staff training taking place in the centre and staff shortages have had an impact on call answering performance and now a review of the rotas has been escalated by the senior clinical team.



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		We are closely engaged with commissioners and STP partners led by our 5 Stakeholder Engagement Managers. We co-chair a system group on ACPs that are working to identify new and improved care pathways. This group is particularly focussed on improving MiDOS use and mapping ACPs across London to identify best practice and where there are issues. The 5 senior sector clinical leads have been appointed who will focus on appropriate referral to alternative pathways. Our new Deputy Medical Director is leading a piece of work to identify best practice in ACP usage from across our operational teams.
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		Both NEL and SEL IUC are mobilised and we are engaged with stakeholders across London to achieve our strategic intention of integrating emergency and urgent care.
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		The focus continues on improvement of efficiency regarding crew handover and ability to offload patients. Whilst we have seen continued improvement however, it is recognise the system is still relatively fragile and struggles with unplanned peaks in activity.
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		We continue to work closely with other emergency services and partners. Most notably we are contributing to the Collaborative Contact & Response (CCR) programme. This programme has now been established with baseline assessments and scoping completed. Funding of £4.5m has been applied for to assist with the next phase which will include the creating of a service model and capability map as well as a benefits tracking process. We are anticipating notification of award for the next phase by the end of April.

- 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.16 Reducing ED Conveyance

		Jan-19	Year To Date	Year-end Target
See & Convey to Other % (Excl. HASU & Cath Lab)	LAS	7.0%	7.3%	
	Target	-	-	7.7%
ED conveyance % (Excl. HASU & Cath Lab)	LAS	62.3%	61.7%	
	Target	60.2%	60.8%	60.7%

Our organisational strategy commits to an overall ED conveyance reduction of 10% by 2023. In September 2018, Strategic Commissioning Board agreed an ED conveyance reduction of 1%, on a baseline of 61.4%. In order to achieve this, a conveyance reduction action plan was agreed.

Various workshops were held with senior managers in attendance identifying what additional measures could be implemented to help reduce ED conveyance rates. A workshop was held in order to ensure a multidisciplinary approach and identify how this work could be taken forward in a strategic way to achieve best results. The outputs of that workshop were developed into a draft action plan which was then refined through meetings with the Director of Operations, the Medical Director, the Chief Information Officer, the Chief Clinical Information Officer and other senior managers.

Work is still ongoing with Pioneer Services (Mental health, maternity and falls) which also focuses on reducing ED conveyance.

Summary of top themes emerging from ED workshop

- **Improving staff confidence to not convey to ED when appropriate**

There was agreement that work should be undertaken to simplify the policies, procedures, guidelines and bulletins to ensure staff can find the relevant information on conveyance or non-conveyance as easily as possible. It was agreed that a more targeted and broader communications campaign is necessary.

- **Alternative care pathways**

There was acknowledgement that increasing our ability to use non-ED pathways is key to our ambition to reducing ED conveyances.

The workshop focussed largely on direct access to Urgent Care Centres. There was discussion about the wider partnership approach, identifying what pathways we need and influencing system partners to commission differently. The new Head of Partnerships, starting in February will be leading this area of work and would be looking to develop a more effective model.

- **Information and data**

Providing detailed information and consistent use of MiDOS were identified as the key enablers, allowing localised improvements in performance and accurate data capture.

Other themes identified during the ED workshop were around Training Education and Technology. The draft action plan has been developed to include the outputs from the workshop covering allocated actions and owners. The ePMO and the Business Planning team will be taking this forward as part of next year's business plan objectives.



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’. Our strategic themes are:

- Theme 1: Comprehensive urgent and emergency care coordination, access, triage and treatment, with multichannel access for patients
- Theme 2: A world class urgent and emergency response with enhanced treatment at scene and for critically ill patients a faster conveyance to hospital
- Theme 3: Collaborating with NHS, emergency services and London system partners to provide more consistent, efficient and equitable services to Londoners

We are delivering our strategy through: Our strategic programmes, A framework of enabling strategies and improved stakeholder engagement. Progress is detailed on the following slides

Delivering our 5 Year Strategy – Strategic Programmes

Programme

Key Progress & Achievements since last IPR

Priorities for coming months

iCAT London

SEL mobilisation activities have been completed with the exception of the move to Avaya telephony at Southern House.

We went live with In Hours SEL 111 IUC/CAS services on 29 January and with a phased SEL 111 IUC/CAS 24 hours/day service on 26 February as planned.

Service delivery and performance will be monitored by LAS, Commissioners and NHSE during March and patient flows to the CAS will be reviewed to ensure best patient experience and outcome. Full mobilisation is expected at the end of March.

The Avaya telephony platform will be implemented on 27 March. We have initiated a project with Hays to implement Managed Service Programme for the provision of temporary agency resources to support the provision of 111 IUC service for NEL and SEL.

- Completion of the Avaya telephony implementation on 27 March
- Progress the Hays Managed Service project
- Progress iCAT strategy

Pioneer Services

The **Mental Health Pioneer Service** pilot has been running for over three months. Early evaluation shows an average ED conveyance rate of 19% for the mental health car compared to 54% for the BAU response, in line with our strategy modelling. A 3 month pilot evaluation is being written.

The **End of Life staff** survey results has been completed to ascertain a baseline regarding staff confidence levels and training needs. As a result of this survey existing clinical courses have been reviewed and new training material developed and delivered for events such as Clinical Skills Refresher.

Paramedics and associate practitioners (NETS staff) have been recruited (internally) for the **Falls Pioneer Service** pilot starting on 11th March in North West London. Training is being undertaken and vehicle / operational infrastructure put in place.

Confirmation has been received to proceed with recruitment of ten **Urgent Care Advanced Paramedic Practitioners** in 2019/20 and a further ten in 2020/21

- Finalise and distribute the evaluation of the Mental Health service pilot following three months of operation
- Launch of the falls service pilot in North West London on 11th March
- End-of-Life conference for improved collaboration with hospices to be held on 19 March 2019
- Recruitment of APP(UC) Cohort 4 and to fill current vacancies, start in post planned for 9th Sept 2019
- Present business case to commissioners for a 24/7 midwife presence in Control



Programme

Key Progress & Achievements since last IPR

Priorities for coming months

Spatial Development

- The Conference room refurbishment was completed in January 2019 with new furniture and further A/V upgrades due to be undertaken in April 2019
- The third floor HQ refurbishment is in progress and running to programme. Design works are progressing for areas of the first and second floor with works planned to be undertaken later in the year.

- Further works in HQ will provide space for the finance team, which will enable us to vacate Morley Street
- Works to develop the communal areas are to be progressed to provide additional informal meeting spaces
- Upgrades to toilet facilities and provision of a Multifaith room are currently in the design stage

Connecting Clinicians

- Three submissions were received in response to the ePCR tender. These have been reviewed and vendors were invited to a supplier demonstration in February. The commercial process is ongoing.
- Full business case production has continued to progress, including development of the benefits case. Sections have been circulated to key stakeholders for input during the drafting phase. A trust wide benefits workshop was held on 6 February with attendees from across the Trust. The group explored the impacts of ePCR across the trust.
- The scope and approach for the iPad optimisation management process has been defined. Work has started on defining an application evaluation review process which will allow more integrated approach to the deployment of applications on iPads across the Trust. Work has started on the enhancement of the Registration Authority process to support the SCRa project.

- ePCR vendor to be chosen in March 2019. Decision will take into account relevant Trust priorities
- Further workshops to develop ePCR business case and benefits case to be held over the coming months
- SCRa project go live on 15 April
- Full Business Case presented to the May Board
- Approval of benefits case and programme training strategy
- PRF as-is process mapping and ePCR to-be process mapping

Ready, Set, Go (Medicines Management)

- Secure Drug Rooms – We have completed installation of secure drug rooms at 25 stations. This includes CCTV and 'smart' Abloy® CLIQ key system
- Multi Dose Pack – Temporarily on hold due to delayed development of kit Prep
- Primary Response Bags – First delivery of the ALS bags scheduled week commencing 18 Mar19. LSU building works to support rollout in progress and scheduled to complete week commencing end Mar19 . Primary Response Bag agreed / Content agreed. With roll out in 19-20
- Kit Prep – The kit prep audit system has been in use for almost two years with work now focussing on making it mobile. The logistics app has been installed but testing has been restricted due to connectivity issues – schedule to resolve end Mar19

- Completion of final five secure drug rooms as part of phase one of Ready Set Go programme
- Ordering of new drug packs for pilot, dependant on kit prep update, incorporating new packs & processes
- ALS Rollout to commence 8th April in NE sector; Phase 1 at Ilford over a period of 6-8 weeks.
- Roll out kit prep app on iPads to allow staff to select drugs they need as opposed to being hand written
- WiFi implementation at LSU in March 2019



Programme

Key Progress & Achievements since last IPR

Priorities for coming months

Contracting and contractual form

The main work regarding contract preparation has been done as part of the business planning process and has been reported to Finance and Investment Committee in January 2019, including the key business planning outputs that are pertinent to our contract proposal

- Contract proposal was issued on 7th February in response to CCG offer of 31st January.
- Initial gap of £25m has been reduced to £18m. Main area of gap is £12.6m to fund delivery of the national performance standards (ARP)
- Escalation meetings are planned to ensure contract signature by 21st March.
- Final NHS National Standard Contract and CQUIN guidance publications now overdue by two weeks.

- NHS Standard Contract to be signed by 21st March
- Should this not be achieved planning for arbitration would be required
- Contractual requirements requiring operational delivery to be communicated and included in local workplans eg. CQUINs, KPIs, Quality Reporting and Service Development Improvement Plans

Delivering our 5 Year Strategy – Effective Stakeholder Engagement

One of our three strategic themes, as outlined in our 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.

Key strategic level forums attended

- SEL Directors of Strategy & COO forum
- Pan-London ACP and Demand Management Board
- STP A&E Delivery Boards
- London Directors of Strategy Forum
- STP Programme Boards
- SWL Transformation & Delivery Board
- NEL Strategy Directors Meeting

Progress since the last IPR

- Our new Head of Partnerships started with LAS in February 2019
- We have successfully achieved 100% award for Q3 of the STP engagement CQUIN
- Through the CQUIN we have received positive feedback that the STPs are pleased with the engagement that they are receiving, particularly from the ADOs and SEMs
- Detailed 'STP Insight Packs' have been finalised and are now ready for circulation to Trust Board and others who would find them useful.

Key priorities for the coming months

- Working with the Mental Health Trusts we will start to develop a potential partnership model for staffing our Pioneer Service and co-developing service developments as outlined in the NHS long term plan
- Submit Q4 report for the STP engagement CQUIN. Commissioners and STPs have requested that this report includes a 'statement of intent' for engagement in 2019/20 as this CQUIN will no longer exist
- Distribution of STP Insight Packs to Trust Board and ExCo



Enabling Strategies

Strategy	Lead Director	Progress since last IPR	Key progress over coming months
People & Culture Strategy	Patricia Grealish, Director of People & Culture	Following sign-off of the strategy at the end of November 2018 by Trust Board, the document is currently undergoing design work led by the Communications directorate.	Design work scheduled to be completed in March 2019, and the strategy document will then be published on the Pulse.
IM&T, Data & Digital Strategy	Ross Fullerton, Chief Information Officer	The final version of the strategy will be presented to Trust Board for final sign-off on the 26 th March 2019.	Subject to Trust Board sign-off, the strategy will then under-go design work with the Communications Directorate during April 2019, followed by publication on the Pulse.
Clinical Strategy	Fenella Wrigley, Medical Director	Further iterations of the strategy have been discussed with the SRO Fenella Wrigley and the strategy is now in its final draft.	Comments from other Directors to be incorporated and the Clinical Strategy will then be presented to Trust Board on the 26 th March 2019 for consideration
Quality Strategy	Trisha Bain, Chief Quality Officer	During February 2019, the strategy went out for consultation with key stakeholders.	The final version of the strategy will be presented to Trust Board for sign-off on 26 th March 2019 along with the annual Quality accounts.
Estates Strategy	Benita Mehra, Director of Strategic Assets & Property	Draft strategy has been written	tbd
Volunteering Strategy	Fenella Wrigley, Medical Director	The strategy has been drafted and discussed with the SRO Fenella Wrigley.	The next steps are to circulate the strategy for further comments to key stakeholders and it is planned to be presented to Trust Board in May 2019.
Patient and Public Involvement Strategy	Trisha Bain, Chief Quality Officer	The strategy has been drafted and awaiting the findings of the stakeholder engagement analysis work being led by Judy Hague.	Judy Hague has been commissioned to undertake a stakeholder engagement analysis and the findings of this will feed into further iterations of the strategy development.
Training & Education Strategy	Patricia Grealish, Director of People & Culture	An initial Training and Education strategic framework document has been produced.	Further internal stakeholder engagement is planned, which will feed into the strategy and identify key actions and deliverables.
Commercial Strategy	Lorraine Bewes, Director of Finance	Development of this strategy is pending the appointment of the recently advertised 'Head of Commercial' post in March 2019.	Awaiting appointment of Head of Commercial. Once appointed and in post, a workshop will be arranged to develop the direction and content of the strategy.



Report to:	Trust Board			
Date of meeting:	26 March 2019			
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:	None			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
This paper provides the Board with an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR).				
Recommendation(s):				
The Board is asked to consider this report.				
Links to Board Assurance Framework (BAF) and key risks:				
This paper sets out the content of the BAF and the CRR.				

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

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 52 There is a risk that the Trust will not deliver the required financial targets through an inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	
2	BAF Risk 53 There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	
3	BAF Risk 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.	Ross Fullerton, Chief Information Officer	Logistics and Infrastructure Committee	
Proposed new BAF Risk				
4	BAF Risk 54 There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.	Paul Woodrow Director of Operations	Quality Assurance Committee	
5	BAF Risk 55 The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.	Lorraine Bewes, Director of Finance and Performance	Finance and Investment Committee	

Risk discussions in February and March

Board Assurance Committees

Logistics and Infrastructure Committee

1. At its meeting on 5 February 2019 the Logistics and Infrastructure Committee discussed the fact that cyber security was a risk on the Trust's Board Assurance Framework, and asked about plans to reduce the rating of this risk. A full gap analysis, together with costed plans to achieve both Cyber Essentials Plus and ISO 27001 was requested for consideration by the Committee. Ross Fullerton was asked to provide the Logistics and Infrastructure Committee with a gap analysis and fully costed plan to achieve Cyber Essentials and ISO 27001.

Audit Committee

2. At its meeting on 11 February 2019, the Audit Committee considered the content of the BAF, following discussion of this at the Board meeting on 29 January 2019. The Committee gave particular consideration to horizon scanning in relation to potential future risks. Further information about this discussion can be found in the attached BAF.

Finance and Investment Committee

3. At its meeting on 12 March 2019, the Finance and Investment Committee considered the ongoing appropriateness of BAF Risk 52. It was proposed that this should be re-articulated as follows:

“There is a risk that the Trust will not deliver the required financial targets through an inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.”

4. In light of the implications of current system contracting requirements, the Committee also agreed to propose the following risk for addition to the BAF:

“The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.”

People and Culture Committee

5. The People and Culture Committee met on 13 March 2019. The output of the horizon scanning discussion at that meeting can be found in the attached BAF.

Quality Assurance Committee

6. At its meeting on 19 March 2019, the Quality Assurance Committee supported the proposal that the following risk be added to the BAF:

There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.

Risks removed from the BAF since the last Board meeting

- **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 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.
 - **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
7. At the Trust Board meeting on 29 January 2019, Board members agreed that BAF Risk 47 would be de-escalated from the BAF in light of recommendations from the People and Culture Committee that sufficient evidence had been received to support this. BAF Risk 51, pertaining to procurement, was agreed for de-escalated following discussions at the Logistics and Infrastructure Committee. The Board also approved to de-escalate BAF risk 50, subject to the successful completion of work to replace the Trust's current UPS capacity.

Risks added to the BAF since the last Board meeting

8. As approved by the Board at its meeting on 29 January 2019, one new risk has been added to the BAF since the last Trust Board meeting:
- **BAF Risk 53**
There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust. (Finance and Investment Committee)
9. It is proposed that the following additional risks should be added to the BAF:
- **BAF Risk 54**
There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy (Quality Assurance Committee)
 - **BAF Risk 55**
The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.

Horizon scanning

10. The Board is also asked to review the outputs of horizon scanning discussions (set out in the attached BAF) and consider whether any further risks should be explored.

Corporate Risk Register

Highly-rated CRR risks not included on the BAF

11. The following five 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 budding 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 844 – Risk of time slippage due to Wi-Fi issues at Logistics Support unit at Deptford which may let to the KitPrep project timescales not being met if not properly managed.
- 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 826 – The data warehouse developers are an integral part of the IM&T and BI structure. The Trust has lost one permanent developer, with another leaving at the end of September 2018, leaving one developer who has been tasked to concentrate on writing the logic for re-categorisation for ARP. With the Trust not having a number of permanent data warehouse developers in post this will have a significant impact on the work and pace undertaken by the BI team, and the Performance Directorate.

12. An oral update on these risks will be provided at the Board meeting.

Frances Field
Risk and Audit Manager

		Rare	Unlikelv	Possible	Likely	Almost Certain
IMPACT	Catastrophic			45		
	Major			54	52 53	
	Moderate					
	Minor					
	Negligible					

In order of severity:

BAF Risk 52

There is a risk that the Trust will not deliver the required financial targets through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.

BAF Risk 45

A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period.

BAF Risk 53

There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust.

Risk proposed for addition:

BAF Risk 54

There is a risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.

BAF Risk 55

The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.

LIKELIHOOD

Risk Severity



- High Risk (15-25)
- Significant Risk (8-12)
- Moderate Risk (4-6)
- Low Risk (1-3)

Key

- Net risk rating
- Gross risk rating = net risk rating

Risk Appetite Statement

The London Ambulance Service NHS Trust (LAS) recognises that its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its patients, people, public and partners. As such, LAS will not accept risks that materially provide a negative impact on the quality/outcomes of the care it provides.

However, LAS has a greater appetite to take considered risks in terms of their impact on organisational issues. As such, LAS has a greater appetite to pursue Financial/Value for Money and Reputational risks and has a high risk appetite for innovation (clinical and financial) in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Key Risk Categories – risk appetite and risk tolerance scores

Risk Category	Link to 4 Ps in LAS strategy	Risk Appetite	Risk Appetite Score
Quality/ Outcomes	Patients	LAS has a LOW risk appetite for risks that may compromise the delivery of outcomes for patients.	6-10
Reputation	Partners Public	LAS has a MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	12-16
Innovation (clinical & financial)	Partners Our People	LAS has a HIGH risk appetite for innovation that does not compromise quality of care.	20-25
Financial/VFM	Partners Public	LAS has a MODERATE risk appetite for financial/VFM risks which may ensure the achievement of the organisation's strategy whilst ensuring that the risk of financial loss is minimised and statutory requirements are complied with.	12-16
Compliance/ Regulatory	Partners Our People	LAS has a LOW risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	6-10

Board Assurance Committees - Horizon Scanning (February & March 2019)

Audit Committee

1. At its meeting on 11 February 2019, the Audit Committee considered the content of the BAF, following discussion of this at the Board meeting on 29 January 2019. The Committee gave particular consideration to horizon scanning in relation to potential future risks. In this discussion the following risks were identified for further consideration by the ExCo:
 - 1.1. The potential opportunities/risks associated with delivery of the Carter Report.
 - 1.2. The potential risks associated with changes to the GP contract and the implications that this might have for the recruitment and retention of paramedics.
 - 1.3. The risk that STPs may not prioritise the funding required by the Trust to deliver its strategic priorities.
 - 1.4. Possible risks associated with the implementation of changes to the national specification for ambulances.

Logistics and Infrastructure Committee

2. At its meeting on 5 February 2019 the Logistics and Infrastructure Committee discussed the fact that cyber security was a risk on the Trust's Board Assurance Framework, and asked about plans to reduce the rating of this risk. A full gap analysis, together with costed plans to achieve both Cyber Essentials Plus and ISO 27001 was requested for consideration by the Committee. Ross Fullerton was asked to provide the Logistics and Infrastructure Committee with a gap analysis and fully costed plan to achieve Cyber Essentials and ISO 27001.

Finance and Investment Committee

3. An additional BAF risk relating to the deliverability of the preferred LAS strategy due to the scale of investment and resource required and current system contracting arrangements has been proposed following discussion at the Finance and Investment Committee meeting on 12 March 2019.

People and Culture Committee

4. The People and Culture Committee at its meeting on 13 March 2019 identified the following potential risks for further consideration by the ExCo:
 - 4.1. The workforce implications of the NHS Long Term Plan.
 - 4.2. Risks associated with the current level of vacancies and turnover within the Operations directorate.

Quality Assurance Committee

5. The Quality Assurance Committee met on 19 March 2019 and agreed the proposal of an additional BAF risk relating to the risk that the Trust will not be able to meet KPI's within its 111/IUC contracts as a result of challenged specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy. Consideration was also given to the workforce risks identified by the People and Culture Committee.

Horizon scanning discussions with Directors

6. Formal horizon scanning risk discussions with Directors took place early in March, giving them an opportunity to focus on matters of concern to them which could have an impact on the organisation in the future.
7. The Risk and Audit Manager met with each Executive Committee member and assembled the feedback into a themed summary of the key areas, which they felt posed the biggest risks to the organisation achieving its objectives. From this the following key outline areas of risk were identified:
 - a. There is a risk that we will not maintain our rating of good in our next CQC inspection due to the current nature of concerns being raised, in relation to the impact of re-structures across the Trust and the timescales in which to improve the position.
 - b. There is a risk to reaching our rating of outstanding aim in April 2020 due to our current infrastructure shortfall and ability to support day to day delivery of our specific quality plans, alongside the drive to implement our strategic aims.
 - c. There is a risk that we will not maintain good CQC rating due to the financial support to roll out secure drug rooms which have led to substantial delay to the requirements outlined in the previous CQC report.
 - d. There is a risk that our substantive workforce numbers will be affected by the changing landscape of NHS, enabling other working opportunity for paramedics to be employed which will add pressure on our workforce. (Need to have a flexible recruiting model, to compete in a highly competitive market of delivering clinical services by having a solution to deliver flexible employment solutions.)
 - e. There is a risk that without a Trust-wide robust structure for strategic workforce planning, we will not be able to build a sustainable workforce model.
 - f. There is a risk that we will not keep up with wider sector transformational change in care delivery, including digital technology and regulatory requirements, which may impact our ability to deliver our strategy.
 - g. There is a risk that commissioners do not adequately fund the ARP operational model. This will make the delivery of response time standards for Cat 2 and Cat 3 patients challenging.
 - h. There is a risk that the organisation's progress to deliver efficiencies identified in reducing our estate footprint and optimising our triage systems (CAD), will be held back due to people's resistance to change resulting in industrial disputes. (Needs to be well planned to get the buy in of all stakeholders internal and external to understand the rationale for change.)
 - i. There is a risk that if we do not establish a clear organisational structure to drive culture change which will enable the organisation to develop (e.g. roll out our visible re-engaging leader programmes), we will not achieve the desired cultural change to deliver our strategy.
 - j. There is a risk that if we don't work effectively with our STP's to address any conflicts early, as a result of changes in commissioners' arrangements, tariff and personnel changes, this may work against the organisation delivering its strategy.
8. Work is being undertaken to assess and quantify these risks.

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
1.	53 There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust.	<ul style="list-style-type: none"> • EU Exit task and finish group to undertake a risk assessment of the consignment stock of fleet parts and provide a plan going forward. • Requirement of stocking including fuel, tyres etc., and the need to provide assurance and identify prudent measures to reduce consumption during the period. • It was agreed that a procurement action plan, complete with a schedule would be shared with the Committee to provide further assurance. • Discussions with the military should be undertaken to establish support if required in the event of political unrest.
1, 4	54 There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy.	<ul style="list-style-type: none"> • Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. • Agile approach to the mitigation of risks. • Seeking additional stakeholder support from the wider urgent care system in London. • Phased approach to implementation of SEL based on learning identified during the NEL mobilisation. • Additional capacity and capability engaged to assist in the delivery of the improvement plan. • Further collaborative opportunities being explored with identified potential partners

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

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.	<ul style="list-style-type: none"> • Further case being presented for additional funding (renegotiation) based on increased incident demand. • Chief Executive-led review meetings to assure on agency recovery plan • NHSI is providing support for our request to the National Agency Committee for an agency cap waiver.
22	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	<ul style="list-style-type: none"> • Deliver Phase 2 (18/19) of the cyber programme • Actively monitor the action plan of mitigations identified by audits quarterly: Next Quarter LIC Feb 19 • Develop and obtain funding for 19/20 cyber programme • Initiate 19/20 cyber programme • Delivery 19/20 cyber programme • Define rolling cyber exercise plan including relevant partners

BAF Risk no. 52 There is a risk that the Trust will not achieve the required financial targets through the inability to secure additional funding required from commissioners in 2018/19 and beyond to fund the delivery of national performance standards.			
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: March 2019		
Change since last review:	Additional control added (7)		
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
		16	16
			8
Existing Controls		Positive Assurance of Controls	
<ol style="list-style-type: none"> 1. Commitment from Commissioners during 2018/19 contracting round to consider funding the costs of the impact of new national performance standards. 2. Business case for commissioners in collaboration with Operations, BI, Contracting and Finance. 3. Business case shared with Commissioners for discussion at CPM Meeting. 4. Executive Committee paper on IT licences to be decided upon. Funding was agreed and is factored into the financial forecast. 5. Implemented managed services solution for both SE and NE 111 services. 6. Agency reporting embedded in CEO monthly performance review meetings 7. Central agency committee have confirmed increase of £2.9m to 19/20 agency cap and NHSI has confirmed that 18/19 month 10 forecast of £1m adverse vs existing cap will not count as a trigger for loss of in year STF funding. <p>Gaps in Controls</p> <p>Paper presented to STP Accountable Officers for approval of funding.(not approved)</p>		<ol style="list-style-type: none"> 1. Working group established between Operations, BI, Finance and Contracting to develop business case for commissioners. 2. Business case presented for additional funding currently requiring renegotiation, to reinforce original commitment to fund ARP. However incident demand has increased which provides partial mitigation (see month 9 finance report). 3. Approved IT server licence option, which is reflected in financial forecast. 	
Further Actions		Responsible Person/s	Due Date
1. Further case being presented for additional funding (renegotiation) based on increased incident demand.		Lorraine Bewes, Director of Finance and Performance	March 2019
2. Directors of Finance and People & Culture to ensure allocation of agency budget to Director level and robust monthly tracking in place through performance reviews.		Lorraine Bewes, Director of Finance and Performance / Patricia Grealish, Director of People and Culture	Ongoing
Signed: Lorraine Bewes			

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
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Date risk opened: 01/06/2017	Date risk expected to be removed from the BAF: ongoing
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Change since last review:	
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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
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<ol style="list-style-type: none"> Existing defences have mitigated threats to-date; these include various technical and procedural elements Mitigation of a number of necessary cyber mitigations which were identified by PA Consulting's Independent CAD review The Introduction of a professional cyber team as a managed service from Nov 17 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) Undertaking of several further audits and tests to identify additional mitigations (added to the Cyber action plan). 18/19 Programme of planned improvements initiated. Internal discovery tool implemented. IM&T focussed Cyber un-announced exercise delivered in August 2018. <p>Gaps in Controls Gaps in Controls are documented in the action plans and the Programme. The most significant residual themes relate to</p> <ul style="list-style-type: none"> Network share security Currency of critical security updates, patching and versions (particularly challenging in the CAD environment) User authentication and SQL weaknesses <p>Weaknesses related to potential DDoS and intrusion/malware attacks</p>	<ol style="list-style-type: none"> Cyber Reports to Information Governance Group of cyber-related incidents each quarter Undertaking 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). CareCert notifications performance measured and reported as part of the IM&T's KPIs (reported to IM&T SMT and ExCo monthly) Reporting of action plan progress at LI&C and Board <p>Gaps in Assurance</p> <ul style="list-style-type: none"> NHSE have asked all Trusts to provide a plan to achieve additional 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.
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Further Actions	Responsible Person/s	Due Date
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<ol style="list-style-type: none"> Deliver Phase 2 (18/19) of the cyber programme Actively monitor the action plan of mitigations identified by audits quarterly: Next Quarter LIC Feb 19 Develop and obtain funding for 19/20 cyber programme Initiate 19/20 cyber programme Delivery 19/20 cyber programme Define rolling cyber exercise plan including relevant partners 	Vic Wynn, Head of IM&T Strategy Security & Architecture Vic Wynn, Head of IM&T Strategy Security & Architecture	16/05/2019 28/02/2019 30/03/2019 30/04/2019 31/03/2020 01/03/2019
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Signed: Ross Fullerton

BAF Risk no. 53 There is a risk that the Trust may not be prepared for potential disruption following the UK's exit from the EU, which may negatively impact on the delivery of services and financial position of the Trust.

Risk Classification: Finance	Risk Owner: Lorraine Bewes	Scrutinising Committee: Finance & Investment Committee			
Date risk opened: 17 January 2019	Date risk expected to be removed from the BAF: End of September 2019 (Latest)				
Change since last review:	Additional assurance provided (5)				
Underlying Cause/Source of Risk: The Trust has carried out a comprehensive review of its preparedness for a departure from the European Union on a worst case basis and has considered risks to supply chain, business continuity and emergency preparedness, workforce, drugs and other more general risks including regulatory risks taking into account all of its services including 999 / 111 / IUC.		Gross Rating	Current/Net Rating	Target Rating	
		16	16	8	
Existing Controls		Positive Assurance of Controls			
<ol style="list-style-type: none"> The Trust has conducted its assessment of the risks faced by the Trust in the event of a worst case departure from the EU on 29 March 2019, in line with the framework mandated by the Department of Health and Social Care. The Trust's standing orders allow for urgent decisions to be taken when necessary. The Trust has business continuity plans in place which are being tested in the context of hypothetical EU exit scenarios. The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a UK depot. Four key suppliers would hold 3 months' worth of stock on UK soil. <p>Gap in controls</p> <p>The Trust is the only ambulance service that relies almost entirely on pump fuel and would therefore be particularly exposed during a fuel shortage. The Trust cannot change the configuration of its fuel supply and is reliant on the national priority list for the provision of fuel in the event of a shortage.</p>		<ol style="list-style-type: none"> Exit from the EU to be a standing item on the Executive Committee agenda going forward. A focus group is in place which is meeting fortnightly providing feedback to the Executive Committee on the actions being taken to manage any risks identified with standing reports on logistics, fleet parts and fuel, procurement, drugs supplies including Frimley Park, communications and EPRR and Business Continuity. The Trust has identified a Director to be the Senior Officer responsible for the Trust's preparedness for the UK's exit from the EU. The Trust has been advised they are considered a priority service by the government for the supply of fuel in the event of a shortage. IUC/111 clinicians in the CAS are receiving increased requests for longer prescriptions which is being mitigated through a medicines bulletin being sent to staff. 			
6. Further Actions		Responsible Person/s		Due Date	
<ol style="list-style-type: none"> EU Exit task and finish group to undertake a risk assessment of the consignment stock of fleet parts and provide a plan going forward. Requirement of stocking including fuel, tyres etc., and the need to provide assurance and identify prudent measures to reduce consumption during the period. 		<ol style="list-style-type: none"> Justin Wand, Deputy Director of Fleet and Logistics Steve Perks, Head of Fleet and Estates 		<p>Report to ExCo 13 March and TB 26 March 19</p>	

3. It was agreed that a procurement action plan, complete with a schedule would be shared with the ExCo to provide further assurance.	3. Richard Deakins, Head of Procurement	Report to ExCo 13 March and TB 26 March 19 Report to ExCo 27 March
Signed: Lorraine Bewes		

Risks proposed for addition to the BAF:

BAF Risk no. 54 There is a risk that the Trust will not be able to meet KPI's within our 111/IUC contracts as a result of challenged specialist resource requirements and performance which may result in us not fully delivering our strategy			
Risk Classification: Operational / Corporate	Risk Owner: Paul Woodrow	Scrutinising Committee: Quality Assurance Committee	
Date risk opened: 05/03/2019	Date risk expected to be removed from the BAF:		
Change since last review:			
Underlying Cause/Source of Risk: Ability to recruit and retain advanced clinical medical staff such as GPs.	Gross Rating	Current/Net Rating	Target Rating
	16	12	8
Existing Controls	Positive Assurance of Controls		
<ol style="list-style-type: none"> 1. Daily monitoring of metrics including safety. 2. Clinical escalation plan developed and implemented 3. Executive oversight – direct reports meetings. 4. Thematic review of incidents and complaints weekly reflected in monthly quality report. 5. Improvement plan developed and being delivered using agile techniques. 6. Revised forecast and planning modelling to improve resource productivity and capacity particularly at weekends. 7. Scrutiny through both internal and external committees, QOG, QAG, CQRG. <p>Gaps in Controls</p>			
Further Actions	Responsible Person/s		Due Date
<ol style="list-style-type: none"> 1. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. 2. Agile approach to the mitigation of risks. 3. Seeking additional stakeholder support from the wider urgent care system in London. 4. Phased approach to implementation of SEL based on learning identified during the NEL mobilisation. 5. Additional capacity and capability engaged to assist in the delivery of the improvement plan. 6. Further collaborative opportunities being explored with identified potential partners 			
Signed: Paul Woodrow			

BAF Risk no. 55 The preferred LAS strategy may not be deliverable within the Trust's timeframe due to the scale of investment and resource required and current system contracting arrangements.

Risk Classification:	Risk Owner:	Scrutinising Committee:		
Date risk opened:	Date risk expected to be removed from the BAF:			
Change since last review:				
Underlying Cause/Source of Risk:		Gross Rating	Current/Net Rating	Target Rating
Existing Controls	Positive Assurance of Controls			
Gaps in Controls				
Further Actions	Responsible Person/s		Due Date	
Signed:				

Corporate Risk Register - March 2019

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)	Sector / Department
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	03/01/2019	25	High	BT and two IM&T engineers provide status reports into the ongoing problem with suggested solutions.	4	Moderate	Fleet and Logistics
826	The data warehouse developers are an integral part of the IM&T and BI structure. The Trust has lost one permanent developer, with another leaving at the end of September 2018, leaving one developer who has been tasked to concentrate on writing the logic for re-categorisation for ARP. With the Trust not having a number of permanent data warehouse developers in post this will have a significant impact on the work and pace undertaken by the BI team, and the Performance Directorate.	01/08/2018	20	High	Data warehouse developers are managed within the IM&T Directorate, therefore the risk and controls fall to them. The impact will be felt through the organisation, including the BI team.	John Downard	14/03/2019	20	High	IM&T to mitigate this risk. JD - A new Snr BI Developer has started 2/1/19 and is undergoing induction/knowledge transfer. A 2nd vacancy is on hold for this FY.	8	Significant	IM&T
706	EOC Training have limitations on space and building facilities which may impact ability to deliver training and current lease is due to expire in December 2019 and new space has not yet been identified. 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	14/02/2019	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	Estates
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	28/02/2019	16	High	Inspection of cabinet in situ	1	Low	NHS111



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Serious Incidents Management			
Agenda item:	13			
Report Author(s):	Gail Webster, Senior Quality Governance Manager			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
<p>The Quality Assurance Committee (QAC) has received a Serious Incident (SI) update report for February 2019 providing an overview of SIs declared and closed in January 2019.</p> <p>This report provides anonymised synopses of individual, closed SIs referred to in the update report.</p>				
Recommendation(s):				
The Board is asked to review the report				
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	<input checked="" type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>

Ensuring staff are valued, respected and engaged	<input type="checkbox"/>
Partners are supported to deliver change in London	<input type="checkbox"/>
Efficiency and sustainability will drive us	<input type="checkbox"/>



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Serious Incidents Update			
Agenda item:	13			
Report Author(s):	Gail Webster, Senior Quality Governance Manager			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
<p>The Quality Oversight Group (QOG) has received a Serious Incident (SI) update report for February 2019 providing an overview of SIs declared and closed in January 2019.</p> <p>This report provides anonymised synopses of individual, closed SIs referred to in the update report.</p>				
Recommendation(s):				
The Trust Board is asked to review the report				
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	<input checked="" type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>

This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input type="checkbox"/>
Partners are supported to deliver change in London	<input type="checkbox"/>
Efficiency and sustainability will drive us	<input type="checkbox"/>

Serious Incident Update

February 2019

Completed investigations

1. During January 2019, 5 completed Serious Incident (SI) Root Cause Analysis (RCA) reports were submitted to the Clinical Commissioning Group (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. All reports which were due in January 2019 were submitted within the 60 working day deadline.

Serious Incident closures

3. There were 6 SI investigation reports approved and closed by the CCG during January 2019. The Executive Summaries of these reports are provided in a separate report.
4. These 6 investigations generated 37 actions which are detailed in the table below. Of these:-
 - 11 have been completed and closed.
 - 22 are ongoing and are within the assigned target completion date.
 - 4 actions have breached the assigned deadline. These are being followed up through relevant managers to prioritise completion.

StEIS & Datix Number	Incident type	Sector	Number of actions and completion Red indicates overdue action	Date for completion	Date submitted to CCG
2018/15 334 18424	Communication, care & consent	South West Sector	Revisit management of breech birth JRCALC 2017 and LAS Maternity Policy 2017.	Completed	13/09/2018
			Provide targeted education and support for the attending staff.	Completed	
			Undertake a full case review with the Practice Leads for Pre-hospital maternity care identifying the potential human factors that influenced this episode of care.	Completed	
			Local training sessions for staff focussed on breech presentation and the appropriate methods of management that can be applied.	Completed	
			Undertake an open and supportive de-brief with staff to understand the contributory factors and identify any training needs.	Completed	
			Staff involved must attend a two day maternity placement within a labour ward/birth centre environment.	31/12/2018	
			Provide staff with an easy to use / intuitive tool to aid in the event of a breech presentation.	Completed	
			Write and publish a case study on the management of new born thermoregulation and how to optimise temperature for sharing across the organisation	31/12/2018	
			Maternity Emergencies update training for all clinical staff	Completed	
2018/21 743 20106	Dispatch & call	EOC	Emergency Medical Dispatcher (EMD) A's line manager will complete their implemented action plan and ensure completion of all required practice changes to meet compliance objectives.	31/03/2019	29/11/2018
			EMD B must complete a formal feedback and reflection session on this call and implement the required practice changes. The outcome of the session must be documented.	Completed	
			Schedule all EMDs to attend and record their completion of current Core Skills Refresher (CSR) training and infographic training on NOC ineffective breathing.	31/03/2019	
			Training Department must review current model for notification of line management of failure to attend training and effectively implement any changes and monitor compliance.	31/03/2019	
			Develop a mechanism for effective communication to all EMDs on the need to establish whether a patient with cancer is on chemotherapy.	31/03/2019	
			Liaison between Human Resources and Heads of Departments to review return to work programmes for staff to ensure that they encompass all aspects of staff roles and that these are documented.	31/03/2019	
			Continue with the implemented recruitment plan for EOC.	Ongoing	
			Review procedure for completion of Duty of Candour ensure that this is completed within required deadlines.	31/03/2019	
2018/20 079 20010	Dispatch & call	EOC	Immediate feedback meeting with EMD B to discuss non-compliances and identify changes in practice required and actions to implement these.	Completed	09/11/2018
			EMD B to attend a further feedback session on this call with Emergency Operations Centre (EOC) QA Manager and complete a formal documented reflection with an action plan for change of practice to address the issues identified.	31/03/2019	
			EMD B to reread Medical Priority Dispatch System and Nature of Call protocols and confirm to their line manager that they have read and understood this.	31/03/2019	

			EOC QA Manager to implement a monitoring plan of EMD B's calls with feedback sessions and action plan development with EMD B.		
			EMD B's line manager to review Quality Assurance Key Performance Indicators and monitor implementation of actions to address issues identified.	31/03/2019	
			Complete the parallel Human Resources investigation and implement the actions arising from this.	31/03/2019	
2018/24 073 20926	Clinical treatment (EXCEPT medication related)	Medical Directorate	Paramedic A and Emergency Ambulance Crew (EAC) A must attend a reflective session with a CTL which must be documented with the required changes in practice and how these will be achieved.	Completed	31/12/2018
			Paramedic A and EAC A must attend CSR 2018.3 and confirmation of this must be provided to a Clinical Team Leader (CTL).	31/03/2019	
			Paramedic A and EAC A must attend a Trust workshop on comprehensive record keeping and provide evidence of this to CTL.	31/03/2019	
			Implementation of a Clinical Performance Indicator Audit feedback plan with documentation of this and monitoring to ensure that this is delivered 6 monthly.	31/03/2019	
			Publication of a case study of this incident in the next Insight magazine.	31/03/2019	
			EMD to attend a feedback and reflective session with a QA Manager.	Completed	
2018/23 769 21022	Clinical treatment (EXCEPT medication related)	North East Sector	Face to face review of Patient Report Form (PRF) against expected practice, using examples of good practice.	28/02/2019	28/12/2018
			Reflective Account - Written work to be undertaken how the incident will influence future practice.	31/01/2019	
			Clinical Team Leader to allocate time – clinician to undertake module, evidence of successful completion to be uploaded to Datix Actions module.	28/02/2019	
			Both Trainee EAC A and B must undertake reflective practice - Written work to be undertaken how the incident will influence future practice.	31/01/2019	
			CTL to allocate time – clinician to undertake module, evidence of successful completion to be uploaded to Datix Actions module.	28/02/2019	
2018/24 559 21392	Dispatch & call	EOC	CTM A must complete a formal documented.	28/02/2019	09/01/2019
			EMD A must complete a formal feedback and reflection session on this call and implement the required practice changes. The outcome of the session must be documented.	31/03/2019	
			On return to work EMD A must complete a formal documented return to work programme to cover all issues relevant to their role	31/03/2019	
			CTM A must complete a formal documented.	31/03/2019	

SI Activity by Month

5. During January 2019, 11 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust compared to the previous 2 years. The overall total for the same periods in 2017 and 2018 is 94 and 87 respectively so there has been no increase in the number of SIs in 2018.

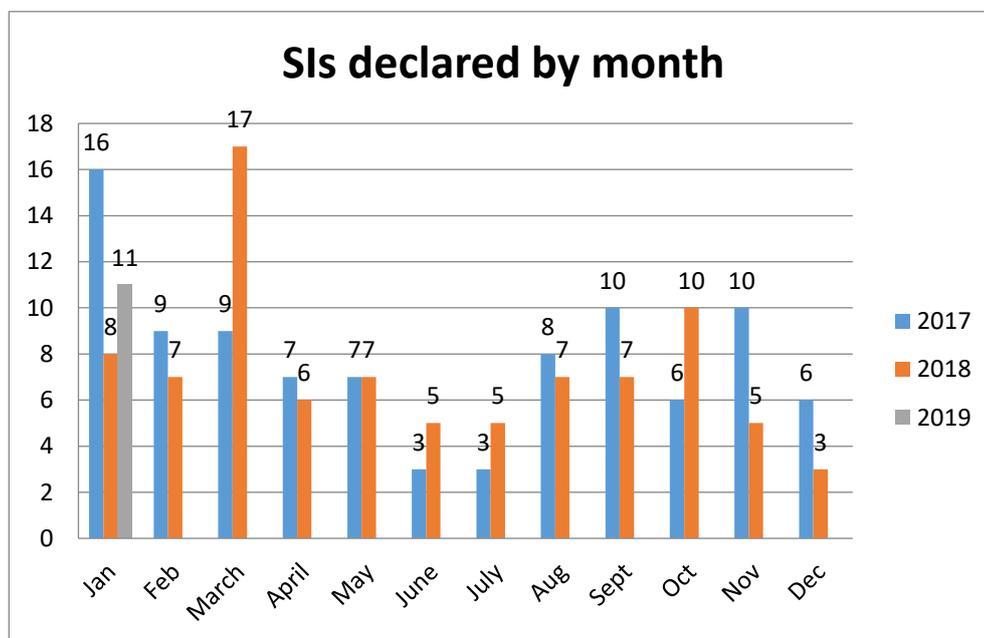


Fig. 1: Serious Incidents Declared/Month

CCG Feedback – January 2019

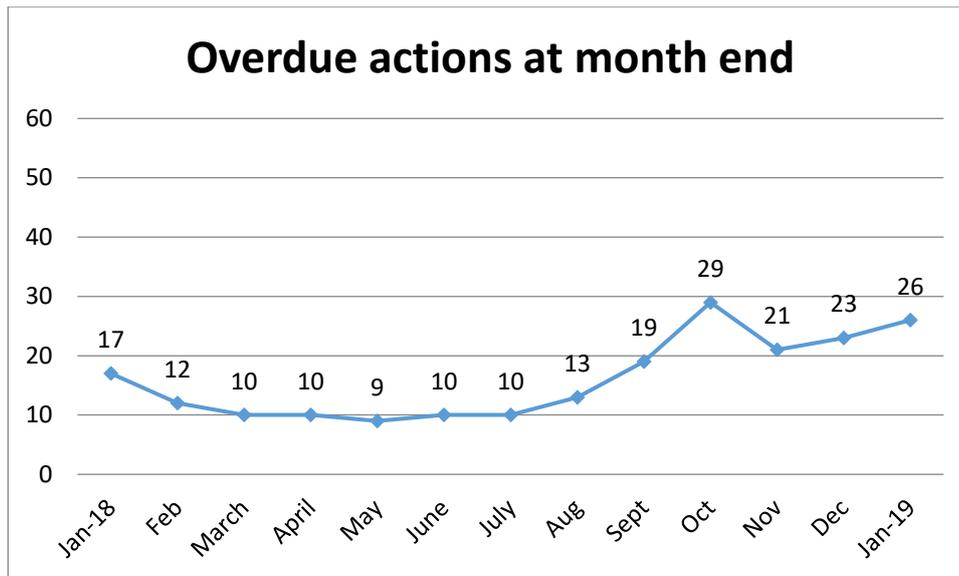
6. The CCG provides feedback on their review of all SI reports and submitted by the LAS. The Quality, Governance & Assurance Team analyse the themes in order to continually improve the quality of investigations, reports and actions.
7. The CCG raised the issue of the trend relating to failure to identify ineffective breathing at pre-triage. Since the implementation of Nature of Call (NOC) serial actions have been taken to minimise the risk of error however while there has been a reduction in occurrence, it does still occur. A targeted thematic review of these incidents has been commissioned which is being led by the Head of 999 Quality and Continuous Improvement in order to address this more effectively. It will be completed by May 2019.
8. Many SIs require actions with individual staff involved in the incidents to support them to learn and implement practice changes in order to improve quality of care and patient safety. The Trust also recognises the importance of organisational learning and sharing of lessons. There has therefore been an increase in the use of case studies on SIs, articles in the insight magazine etc. In addition the Learning From Experience Group has been disbanded and a new SI Learning Assurance Group had its first meeting in January 2019. One of the main objectives of this Group is to ensure that the actions generated from recommendations from SI investigations are effectively implemented and embedded and the learning is shared across the Trust. They will provide assurance to the SIG.

SI Category Themes – January 2019

9. A trend analysis of SIs is published quarterly, which provides meaningful information for Trust wide prioritisation, learning and risk management in the last quarter. The next thematic report will be published in April 2019.
10. The 6 SIs closed in January 2019 will be incorporated into the quarterly report but the main issue from each was:-
 - Poor communication from the crew on scene back to EOC and Clinical Hub on an imminent home birth which was an undiagnosed breech so all the appropriate support could not be provided.
 - Failure to identify ineffective breathing at NOC with a delay in obtaining the correct Category (Cat) 1 priority for the call.
 - Ineffective breathing was not identified in a caller who was the patient who then became unresponsive. Incorrect triage obtaining a Cat 2 instead of Cat 1.
 - Ineffective breathing was identified at NOC and a Cat 1 priority was obtained, however this was then downgraded when the ineffective breathing was not transferred through to the triage and the call was downgraded to a Cat 2.
 - An elderly patient on anticoagulants fell, had capacity and declined conveyance to hospital. The crew did not fully explain the risks to the patient and did not use all the options available to persuade them to go to hospital. 4 days later there was re-contact and the patient had a cerebral haemorrhage. The crew had underestimated the risks as the patient did not appear to have serious injuries at the time.
 - Inadequate safety netting for a patient with dementia who had fluctuating capacity and declined conveyance to hospital with possible urinary tract infection. 3 days later there was recontact and the patient had severe sepsis.
11. The Executive Summaries of these reports are provided in Appendix 1 and actions in Section 2.

Overall SI Action Compliance

12. At the end of January 2019 there were 26 SI actions overdue which is significantly higher than the target of <10 (see Fig 2 below).
13. The remedial action implemented in November 2018 was named individuals from the Quality, Governance and Assurance Team took responsibility to follow up personally with the action owners and to escalate to the Deputy Director for Quality, Governance & Assurance where no headway was being made. This did have some impact with a significant reduction in overdue actions over December 2019.
14. There were a large number of actions which were assigned a completion date of the end of December 2018, this proved a challenge with seasonal operational pressures and resulted in an increase of overdue SI actions entering January 2019.
15. A regular status report is provided and there is focus at all levels of the organisation on completion of actions.



Actions & Assurance

16. There is a focus on the follow up of SI action completion to reduce the number of overdue actions to below the target of 10. The Quality, Governance and Assurance Team will continue to monitor and escalate to the relevant senior managers to address these and achieve the set KPI of <10.
17. The Serious Incident Learning and Assurance Group is now in place with the inaugural meeting having taken place in January 2019 where the terms of reference with the eventual aim of increasing Trust wide learning were approved and adopted.
18. 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 Trisha Bain
Chief Quality Officer



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Proposed approach to 2018/19 Annual Report and Accounts			
Agenda item:	14			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	Presentation to ExCo on 13 March 2019			
Status:	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
<p>This report provides information about the approvals processes (and associated timetable) to be followed in the production of the 2018/19 Annual Report and Accounts. It also presents the proposed outline of the Annual Report and the Annual Governance Statement for approval.</p>				
Recommendation(s):				
<p>The Board is asked to:</p> <ul style="list-style-type: none">Note the approvals process for the 2018/19 Annual Report and Accounts (and associated timetable); andConfirm that it is content with the proposed approach to drafting the Annual Report and Annual Governance Statement.				
Links to Board Assurance Framework (BAF) and key risks:				
<p>The Annual Report and Accounts provide information about the organisation's assurances arrangements.</p>				

Please indicate which Board Assurance Framework (BAF) risk it relates to:	
Clinical and Quality	<input type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input checked="" type="checkbox"/>

Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

Proposed Approach to 2018/19 Annual Report and Accounts

1. This report provides information about the approvals processes (and associated timetable) to be followed in the production of the 2018/19 Annual Report and Accounts. It also presents the proposed outline of the Annual Report and the Annual Governance Statement for approval.

2018/19 Annual Report and Accounts production timetable

2. The table below sets out the approval processes for the production of the 2018/19 Annual Report and Accounts:

Wednesday 10 April 2019	Executive Committee to review draft papers for Audit Committee meeting on 18/04/19
Thursday 11 April 2019	Papers for Audit Committee meeting on 18/04/19 to be circulated to Committee members
Thursday 18 April 2019	Audit Committee to review draft Annual Accounts and AGS
Wednesday 24 April 2019	Submission of draft Annual Report and Accounts (inc AGS) to NHS Improvement
Thursday 09 May 2019	Papers for Audit Committee meeting on 16/05/19 to be circulated to Committee members
Thursday 16 May 2019	Audit Committee to review draft Annual Accounts and AGS together with update on external audit findings to date and Head of Internal Audit Opinion
Friday 17 May 2019	Papers for Audit Committee meeting on 23/05/19 to be circulated to Committee members (dispensation being sought from the Chair of the Committee to circulate late)
Thursday 23 May 2019	Audit Committee to review and recommend Annual Report and Accounts (inc AGS) to the Board in light of ISA 260 Report from external auditors
	Board to approve tabled Annual Report and Accounts (inc AGS)
	CEO and Finance Director to sign Annual Report and Accounts (inc AGS)
	Annual Report and Accounts (inc AGS) to be submitted to NHS Improvement

3. Board members are asked to note this timetable.

2018/19 Annual Report – outline content

4. The proposed outline content for the 2018/19 Annual Report is set out below. Attached as an appendix is a more detailed content plan showing links to national reporting requirements.

Section	Summary of content
Chairman’s foreword	TBC – focus on culture
Chief executive’s foreword	Focus on reflection as new CEO, performance summary, leadership priorities and new strategy.
About us <ul style="list-style-type: none"> • Services we provide • Vision, purpose and values • Performance summary 	<p>Overview of services provided and some key facts and figures. High level performance summary linking to more detail in later sections of report.</p> <p>Reference to being taken out of Special Measures and agreement of Trust Strategy</p>
Our patients <ul style="list-style-type: none"> • Introduction • Who we care for • Improving services • Patient and public engagement • Friends and family test scores 	<p>Overview of different types of patients cared for across critical and urgent care.</p> <p>A summary of key improvement projects helping to improve quality/experience: pioneer services.</p> <p>Brief update on patient forum and community events linking to more detail in Quality Account.</p>
Our people <ul style="list-style-type: none"> • Introduction • Diversity and equality • Recruiting new people • Retaining and developing our people • Recognising our people • Volunteers • Staff survey • Freedom to speak up 	<p>Overview of staff facts and figures including actions and progress on diversity, recruitment and retention, freedom to speak up.</p> <p>Summary of key internal and external awards recognising staff during the year.</p> <p>Thanks to volunteer responders with updated figures on number of incidents supported in the year.</p> <p>High level summary of staff survey results with link to more detail in Quality Account and full results available online.</p> <p>Reference to adoption of Freedom to Speak Up Strategy.</p>
Public value <ul style="list-style-type: none"> • Carter • Long Term Plan 	Key system-wide developments that have an impact on the operations of the trust.
Our partners <ul style="list-style-type: none"> • Introduction • STPs • Blue light partners • Strategic alliance with SCAS 	Summary of key partnerships the trust is involved in.
Quality and performance <ul style="list-style-type: none"> • Introduction • Quality matters • 999 and 111 performance • Financial performance • Sustainability • Challenges and risks • Anti-bribery/anti-slavery 	<p>Quality: summary of quality work taken from Quality Account and providing link to full document on trust website.</p> <p>Performance: Performance split into two periods Apr-Oct on old KPIs and Nov-Mar on ARP. High level summary of key figures linking to full financial statements later in report.</p> <p>Additional statutory statements on sustainability, risk, etc</p>
Our Strategy	How we have delivered in 18/19 and a look forward to 19/20

5. Board members are asked to confirm that they are content with the proposed outline content for the 2018/19 Annual Report

Annual Quality Account

6. In order to avoid duplication between the content of the Annual Report and the Annual Quality Account, it is proposed that duplication, readers are referred to the Annual Quality Account for further information about:
 - Statement of Duty of Candour;
 - Clinical incidents; and
 - Clinical audit.
7. Board members are asked to confirm that they are content with this proposed approach to avoid duplication between the Annual Report and the Annual Quality Account.

2018/19 Annual Governance Statement – outline content

8. A model Annual Governance Statement (AGS) has been provided by NHS Improvement (NHSI) (see Annex); this should be adapted and expanded to reflect the particular circumstance of each NHS trust. NHS Improvement does not prescribe which issues should be considered to be significant control issues. NHS trusts should ensure that a consistent definition of what constitutes significance is applied from year to year. Guidance on examples of factors to consider in determining whether an issue is significant is provided by NHSI and set out below.
9. In applying this model format, the trust must note the requirement that the conclusion section must either:
 - clearly state that no significant internal control issues have been identified or
 - specifically list the significant internal control issues which have been identified in the body of the AGS.
10. In addition the AGS should include:
 - a) Disclosure of any serious incidents relating to information governance including data loss or confidentiality breach. As a minimum this should include details of any incidents classified as Level 2 in the Information Governance Incident Reporting Tool. For these cases the trust should also disclose whether these cases have been reported to the Information Commissioner's Office (ICO) and detail any action taken by the ICO. If disclosure would be prejudicial to any ongoing investigations or disciplinary or regulatory proceedings, details may be omitted.
 - b) Information on the Board's committee structure, changes in personnel of executives and non-executives, the Board's performance, including its assessment of its own effectiveness and that the required standards are achieved.
 - c) A statement on how the NHS trust assures the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data.
 - d) **New for 2018/19:** A description of the key ways in which the trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. Describe how your trust complies with the 'Developing Workforce Safeguards'4 recommendations.

- e) **New for 2018/19:** A statement that the trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS'5 guidance.

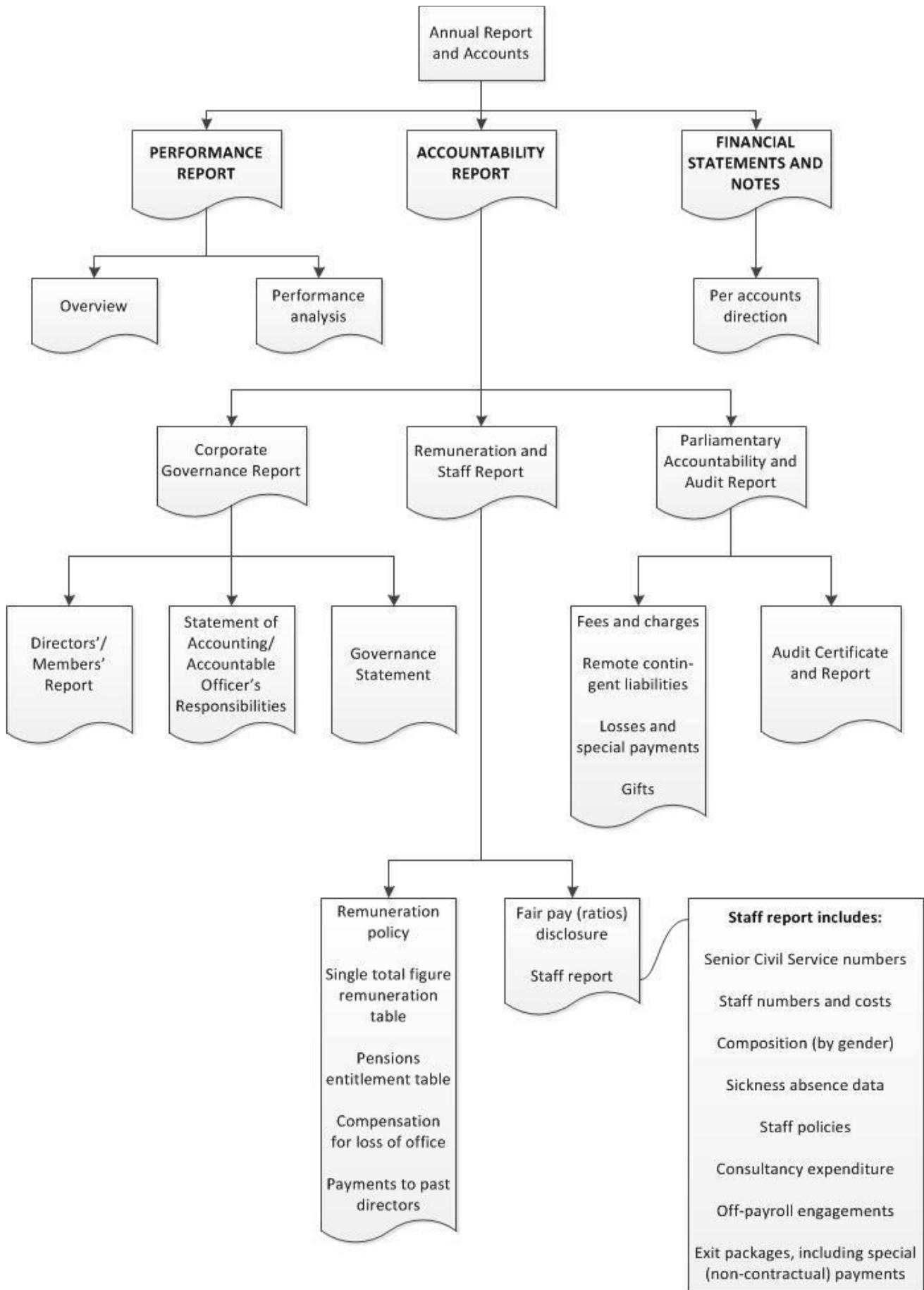
11. Determining significant internal control issues. The following list gives examples of factors to consider when determining whether an internal control issue is significant. This list is not intended to be exhaustive.

- Might the issue prejudice achievement of priorities?
- Could the issue undermine the integrity or reputation of the NHS?
- What view does the Audit Committee take on this point?
- What advice has internal or external audit given?
- Could delivery of the standards expected of the Accountable Officer be at risk?
- Has the issue made it harder to resist fraud or other misuse of resources?
- Did the issue divert resources from another significant aspect of the business?
- Could the issue have a material impact on the accounts?
- Might national or data security or integrity be put at risk?

12. Board members are asked to note the outline content of the 2018/19 Annual Governance Statement.

Philippa Harding
Director of Corporate Governance

DH Group Accounting Manual 2018/19 – the structure of an annual report and accounts (Chapt 3, Annex 1, pg. 52))



no.	section	sub-section	Section summary	Manual of Accounts section	Manual of Accounts specific wording
1	Foreword - chair		To be confirmed – focus on culture	NA	
2	Foreword - CEO		Focus on reflection as new CEO, performance summary, leadership priorities and new strategy.	overview - ceo performance statement	a statement from the chief executive providing their perspective on the performance of the organisation over the period
3	About us	Intro	Overview of services provided and some key facts and figures. High level performance summary linking to more detail in later sections of report. Reference to being taken out of Special Measures and agreement of Trust Strategy	overview - introduction	a short summary explaining the purpose of the overview section
3.1		Services		overview - statement of purpose	statement of the purpose and activities of the organisation, including a brief description of the business model and environment, organisational structure, objectives and strategies
3.2		Vision purpose and values		overview - statement of purpose	
3.3		Performance summary		overview - performance summary	Minimum requirement includes "a performance summary". No specific guidance on what needs to be within this beyond "the overview should be enough for the lay user to have no need to look further into the rest of the ARA unless they were interested in further detail."
4	Our patients	Intro	Overview of different types of patients cared for across critical and urgent care.	supports delivering requirements of overview and performance analysis	no specific wording requirements
4.1		Who we care for	A summary of key improvement projects helping to improve quality/experience: pioneer services.		
4.2		Improving services			
4.3		Patient and public engagement			
4.4		Friend and Family Test	Brief update on patient forum and community events linking to more detail in Quality Account.		
5	Our people	Intro	Overview of staff facts and figures including actions and progress on diversity, recruitment and retention, freedom to speak up.	supports delivering requirements of overview and performance analysis.	no specific wording requirements
5.1		Diversity and equality	Summary of key internal and external awards recognising staff during the year.	Section provides link to "staff report" content in Governance section.	
5.2		Recruiting new people			
5.3		Retaining and developing our people	Thanks to volunteer responders with updated figures on number of incidents supported in the year.		
5.4		Recognising our people			

no.	section	sub-section	Section summary	Manual of Accounts section	Manual of Accounts specific wording	
5.5		Volunteers	High level summary of staff survey results with link to more detail in Quality Account and full results available online. Reference to adoption of Freedom to Speak Up Strategy			
5.6		Staff survey results				
5.7		Freedom to speak up				
6	Public value	Carter Long Term Plan	Key system-wide developments that have an impact on the operations of the trust.	supports delivering requirements of overview and performance analysis	no specific wording requirements	
7	Our partners	Intro	Summary of key partnerships the trust is involved in.	supports delivering requirements of overview and performance analysis	no specific wording requirements	
7.1		STPs				
7.2		Blue light partners				
7.3		Strategic alliance with SCAS				
8		Quality and performance				Intro
8.01	Quality matters		One page summary of quality work taken from Quality Account and providing link to full document on trust website.	Performance report - performance analysis		
8.02	Performance, 999		Performance split into two periods Apr-Oct on old KPIs and Nov-Mar on ARP			
8.03	Performance, 111					
8.04	Financial performance		High level summary of key figures linking to full financial statements later in report.	Overview - going concern statement Performance analysis	An explanation of the adoption of the going concern basis (see paragraphs 4.11-4.16 below) where this might be called into doubt (for example, by the issue of a report under Section 30 of the Local Audit and Accountability Act 2014/17 for a CCG or an NHS provider). NB: given surplus position no need to include a "going concern" statement this year. This analysis is required to utilise a wide range of data including key financial information from the financial statements section of the accounts.	
8.05	Sustainability		The trust's work on environmental issues	Performance analysis	Information on environmental matters, including the impact of the entity's business on the environment. Entities must also comply Compliance with mandatory sustainability reporting requirements ¹	
8.06		Continuing challenges and risks	High level summary of key risks facing the organisation and linking to risks listed in annual governance statement.	overview - key issues and risks Performance analysis	the key issues and risks that could affect the entity in delivering its objectives Narrative to explain the link between KPIs, risk and uncertainty.	

2018/19 annual report content plan and national requirements

8.07		Anti-bribery/anti-slavery		Performance analysis	Non-financial information, including social matters, respect for human rights, anti-corruption and anti-bribery matters.
9	Our strategy		One page summary of developing strategy and core themes with link to full strategy on website.	NA	How we have delivered in 18/19 and a look forward to 19/20
10	Annual Governance Statements		Content provided by Governance	Accountability report	
11	Financial statements		Content provided by Finance	Financial statements	

Model annual governance statement

[The wording which is not in square brackets in this pro forma AGS should be replicated in every AGS. The words in square brackets should be amended and expanded as appropriate to the body in question.]

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of [insert name of provider] NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in [insert name of provider] NHS Trust for the year ended 31 March 20xx and up to the date of approval of the annual report and accounts.

Capacity to handle risk

[Describe the key ways in which:

- leadership is given to the risk management process; and
- staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Include comment on guidance provided to them and ways in which you seek to learn from good practice.]

The risk and control framework

[Describe the key elements of the risk management strategy, including the way in which risk (or change in risk) is identified, evaluated, and controlled. Include mention of how risk appetites are determined. Explicitly describe the key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance

with CQC registration requirements. Explicitly include how risks to data security are being managed and controlled as part of this process. Include a brief description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed. Work performed to assess whether services are well-led under NHS Improvement's well-led framework will assist with this assessment and the trust should refer to well-led reviews as appropriate.]

[Include a description of the principal risks to compliance with the NHS provider licence^{6, 7} condition 4 and actions identified to mitigate these risks, particularly in relation to:

- the effectiveness of governance structures,
- the responsibilities of directors and subcommittees;
- reporting lines and accountabilities between the board, its subcommittees and the executive team;
- the submission of timely and accurate information to assess risks to compliance with the conditions of the licence; and
- the degree and rigour of oversight the board has over the trust's performance.]

[Describe key ways in which risk management is embedded in the activity of the organisation. For example, set out the ways in which equality impact assessments are integrated into core trust business or how incident reporting is openly encouraged and handled across the trust.]

[New for 2018/19] [Describe the key ways in which the trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. Describe how your trust complies with the 'Developing Workforce Safeguards'⁸ recommendations.]

The trust [is fully /is not fully] compliant with the registration requirements of the Care Quality Commission.

⁶ <https://www.gov.uk/government/publications/the-nhs-provider-licence>

⁷ While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance. We aim to treat all providers in comparable circumstances similarly unless there is sound reason not to. We therefore base our oversight, using the Single Oversight Framework, of all NHS trusts and NHS foundation trusts on the conditions of the NHS provider licence.

⁸ <https://improvement.nhs.uk/resources/developing-workforce-safeguards/>

[New for 2018/19] The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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

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

[Updated for 2018/19] The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

[Describe the key process that has been applied to ensure that resources are used economically, efficiently and effectively, including some comment on the role of the board, internal audit and any other review or assurance mechanisms.]

Information governance

[Describe any serious incidents relating to information governance including data loss or confidentiality breach. As a minimum this should include details of any incidents classified as Level 2 in the Information Governance Incident Reporting Tool. For these cases the trust should also disclose whether these cases have been reported to the Information Commissioner's Office (ICO) and detail any action taken by the ICO.]

Annual Quality Account

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

[Brief description of steps which have been put in place to assure the board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data]

In particular this should explain how the trust assures the quality and accuracy of elective waiting time data, and the risks to the quality and accuracy of this data]

Review of effectiveness

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

[Describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the role and conclusions of:

- the board
- the audit committee
- if relevant, the risk/ clinical governance/ quality committee/risk managers/risk improvement manager
- clinical audit
- internal audit and
- other explicit review/assurance mechanisms.

Include an outline of the actions taken, or proposed to deal with any significant internal control issues and gaps in control, if applicable.]

Conclusion

[state either that no significant internal control issues have been identified or make specific reference to those significant internal control issues which have been identified in the body of the AGS above]

Signed.....

Chief Executive

Date: xx May 20xx



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Gender Pay Gap Report			
Agenda item:	15			
Report Author(s):	Chris Randall, Head of Workforce Analytics			
Presented by:	Patricia Grealish, Director of People and Culture			
History:	Presented at Equalities and Diversity Meeting in March 2019			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
Any organisation that has 250 or more employees is now obliged to publish and report specific figures about gender pay. This report uses the snapshot date of 31 March 2018 and must be publicly reported by 30 March 2019. A gender pay gap is the difference between the average earnings of men and women across an organisation, expressed relative to men's earnings.				
Recommendations:				
The Board is requested to review and discuss the content of the report.				
Links to Board Assurance Framework (BAF) and key risks:				
N/A				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	<input type="checkbox"/>			
Performance	<input type="checkbox"/>			
Financial	<input type="checkbox"/>			
Workforce	<input type="checkbox"/>			
Governance and Well-led	<input type="checkbox"/>			
Reputation	<input type="checkbox"/>			
Other	<input type="checkbox"/>			
This report supports the achievement of the following Business Plan Workstreams:				
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>			
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>			
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>			
Efficiency and sustainability will drive us	<input type="checkbox"/>			



NHS

London Ambulance Service
NHS Trust

Gender Pay Report

As at 31st March 2018



1. Background

Any organisation that has 250 or more employees is now obliged to publish and report specific figures about gender pay. The first report uses the snapshot date of 31 March 2018 and must be publicly reported by 30 March 2019. A gender pay gap is the difference between the average earnings of men and women across an organisation, expressed relative to men's earnings.

2. Our commitment to Equality of Opportunity and Inclusion

At the Trust we are committed to promoting equality of opportunity and diversity to enhance our inclusion work. The Trust has committed to ensure that equality, diversity and human rights are embedded in all areas of our employment, planning and service delivery. We strive to provide excellence in all we do and recognise the value that Inclusion brings. We are committed to ensuring that all our employees are treated with dignity and respect and given equal opportunity and encouragement to progress and develop within the organisation.

We strongly believe that equality, diversity and inclusivity in all its forms delivers greater impact in the work we do and enhances the services we deliver to Londoners. Our commitment to the principles of Equality, Diversity and Inclusion informs all of our work with our people.

I confirm this gender pay report is accurate and reflects a snapshot of our organisation on 31st March 2018. Our figures show that while the London Ambulance Service is doing well at most levels, it needs to close the gender pay gap at the higher levels of the organisation. We are working hard to address these challenges, and we have set up a working group to investigate this data, better understand the gap in bonus payments and to recommend improvements.

We already have a range of family-friendly policies and our maternity policy is being revised. We are training our staff to help them guard against unconscious bias against women, particularly for the higher level posts, as female under-representation at higher levels is driving the gender pay gap within the Trust. We will do all we can to discover and remove the barriers which stop women moving into senior posts.



Patricia Grealish

Director of People and Culture

3. What is the Gender Pay Gap ?

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

4. The difference between the gender pay gap and equal pay

The gender pay gap differs from equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

5. What does the Gender Pay Audit cover ?

The audit focuses on comparing the pay of female and male employees and shows the difference in earnings. It provides information on the following:

- The mean gender pay gap in hourly pay
- The median gender pay gap in hourly pay
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of males and females receiving a bonus payment
- The proportion of males and females in each quartile pay band

6. Gender profile at the Trust

1. As at 31st March 2018, we had 5,354 staff in post at the Trust.
2. Our gender profile is 44% female and 56% male, similar to the previous year (44%/56%)
3. Tables 1 to 2 provide further breakdown of this data by agenda for change banding. Table 1 shows the gender split for each pay band (reading across). Table 2 shows the distribution of each gender by pay band (reading down).

Table 1: % gender by Agenda for Change band

	Female	Male
Band 2	57%	43%
Band 3	54%	46%
Band 4	42%	58%
Band 5	47%	53%
Band 6	43%	57%
Band 7	37%	63%
Band 8a	43%	57%
Band 8b	25%	75%
Band 8c	45%	55%
Band 8d	37%	63%
Non Afc (Directors)	66%	34%
Total	44%	56%

Table 2: % gender by banded categories

	Female	Male
Band 2	34.4%	32.4%
Band 3		
Band 4		
Band 5		
Band 6	62.7%	63.8%
Band 7		
Band 8a		
Band 8b	2.6%	3.7%
Band 8c		
Band 8d		
Non Afc (Directors)	0.3%	0.1%
Total	100%	100%

7. Our gender pay audit data

7.1 The mean and median gender pay gap

The mean gender pay gap adds together the hourly pay rates of all male and female pay and divides this by the respective number of male or female employees. The gap is calculated by taking the difference between the male and female averages and dividing that by the mean hourly rate for males.

The median arranges the hourly rates from highest to lowest and finds the point in the middle of that range.

For the purposes of this calculation we include basic pay, allowances, pay for leave and shift premium pay. This does not include overtime or bonus (incentive) payments.

Gender	Mean Hourly Rate	Median Hourly Rate
Male	19.32	19.47
Female	18.41	18.66
Difference	0.91	0.81
Pay Gap %	4.70	4.16

Mean Gender Pay Gap	Median Gender Pay Gap
4.7%	4.2%

7.2 The mean and median bonus gender pay gap

The mean bonus gender pay gap adds together bonus payments for all male and female pay and divides this by the respective number of male or female employees. The gap is calculated by taking the difference between the male and female averages and dividing that by the mean bonus payment for males.

The median arranges the bonus payments from highest to lowest and finds the point in the middle of that range.

For the purposes of this calculation we only include incentive payments which are those which relate to locally agreed incentive payments which are outside of Agenda for Change and are communicated via our internal bulletins.

Overtime is excluded from this calculation.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£1,979.35	£1,112.00
Female	£1,426.20	£745.00
Difference	£553.14	£367.00
Pay Gap %	27.95	33.00

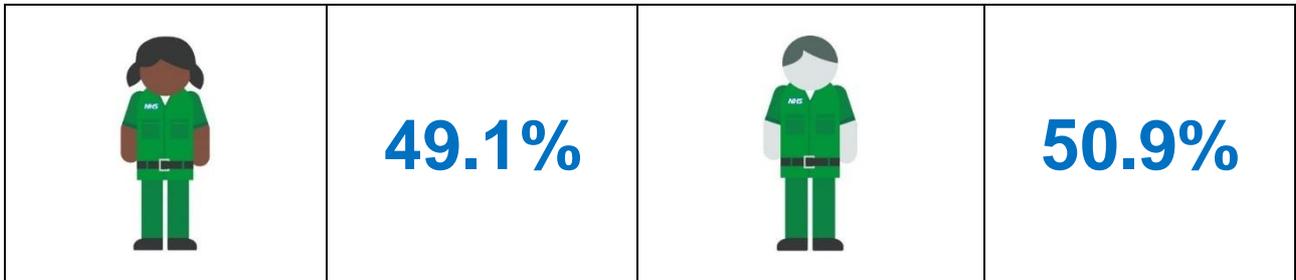
Mean Bonus Gender Pay Gap	Median Bonus Gender Pay Gap
27.95%	33.00%

Proportion of males receiving a bonus payment	Proportion of females receiving a bonus payment
66.18%	62.76%

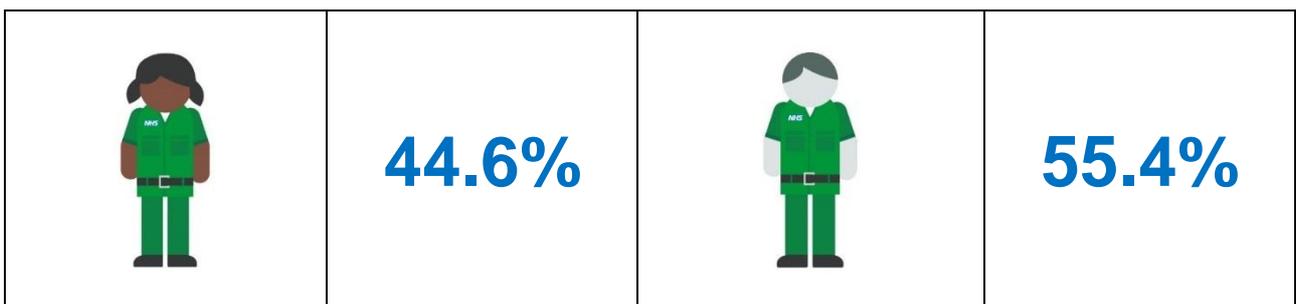
7.3 Proportion of males and females in each pay quartile

This data ranks all of our employees from lowest to highest paid, dividing this into four equal parts or quartiles and calculating the percentage of men and women in each of the quartiles.

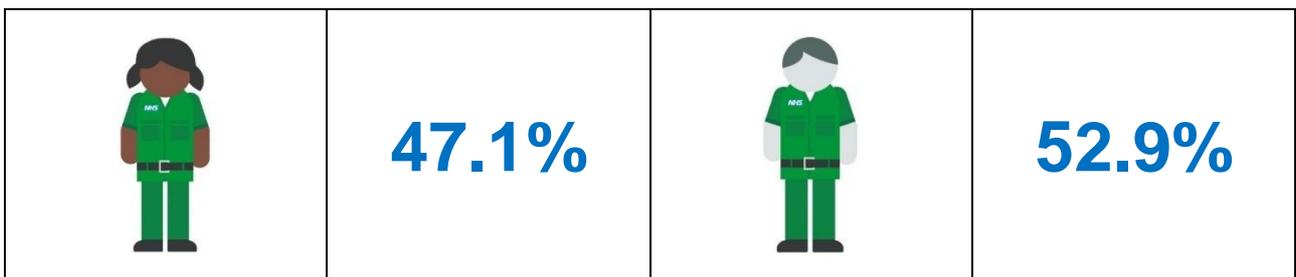
Lower Pay Quartile



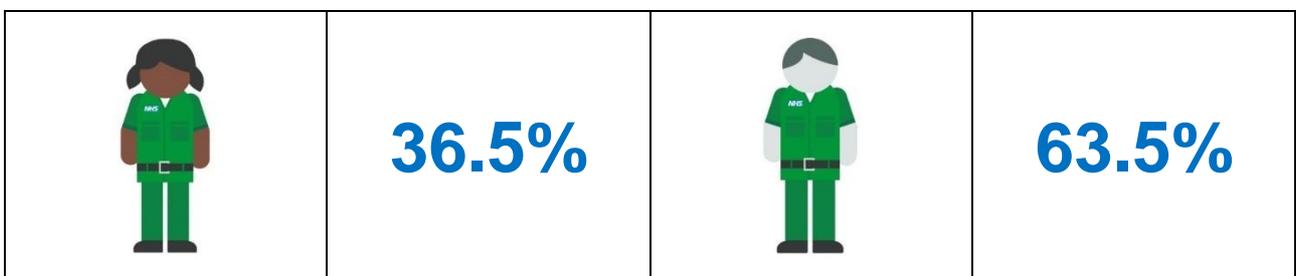
Lower Middle Quartile



Upper Middle Pay Quartile



Upper Pay Quartile



8. Gender Pay Gap Reporting Narrative

- a. There are moderate differences on average pay and the proportions of males and females who receive bonuses. We employ 490 more male employees than female employees and therefore this will account for some of the variance. The gap between females and males receiving bonuses has reduced from 5.7% to 3.4%. Compared with 2016/17, the number of females receiving bonuses has increased from 55.7% to 62.8%. The number of males receiving bonuses has increased from 61.4% to 66.2%.
- b. Our bonus gap is worth specific comment as it is larger than our regular pay gap. There are several reasons for this. A key reason is that the law requires us to include the actual bonus amounts received by part time colleagues, not the full time equivalent. Given the larger proportion of our part time employees are female, the average bonus payment is lower as compared to males, the majority of whom are full-time (and therefore receive proportionately a larger bonus payment. So, there is a disproportionate effect on our female employees as 66% of part time staff receiving bonuses are women. We have however seen a reduction in the bonus gap from 31.6% to 27.9%.
- c. The proportion of males and females in each quartile pay band ranks all the male and female full-pay relevant employees from the lowest hourly rate of pay to the highest hourly pay rate and then divides them into quartiles with an equal number of employees in each section. The gender proportions in quartiles 1 to 3 are similar to the overall Trust gender mix of 45% female and 55% male. There is a proportionately larger number of males in quartile 4, the quartile with the highest hourly rates. This corresponds with the overall Trust gender mix for Bands 7 to 8D which is 38% female and 62% male.

9. Our action plan

	What we are doing	What we will do
Data	<ul style="list-style-type: none"> Monitoring protected characteristics through the recruitment process 	<ul style="list-style-type: none"> Provide monthly reporting on shortlisting activity for gender (particularly bands 7 and above). Establish a working group to carry out investigations into the data and make recommendations. Introducing a clear and consistent exit interview process.
Recruitment	<ul style="list-style-type: none"> Training for hiring managers. 	<ul style="list-style-type: none"> Refresh recruitment training and specifically focus on unconscious bias. Mandate interview panel mix.
Culture	<ul style="list-style-type: none"> The Trust has a range of family friendly policies in place to support working parents. Revised maternity policy related to expectant mothers working on the front line. 	<ul style="list-style-type: none"> Working group to establish barriers to women moving into senior posts (Band 7 and above)



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Report of the Trust Secretary			
Agenda item:	16			
Report Author(s):	Philippa Harding, Director of Corporate Governance			
Presented by:	Philippa Harding, Director of Corporate Governance			
History:	None			
Status:	<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input checked="" type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
This paper presents the Board with the proposed membership and Terms of Reference of Board Assurance Committees in 2019/20.				
Recommendation(s):				
The Board is asked to agree the proposed amendments identified within 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	<input checked="" type="checkbox"/>
Performance	<input checked="" type="checkbox"/>
Financial	<input checked="" type="checkbox"/>
Workforce	<input checked="" type="checkbox"/>
Governance and Well-led	<input checked="" type="checkbox"/>
Reputation	<input checked="" type="checkbox"/>
Other	<input checked="" type="checkbox"/>
This report supports the achievement of the following Business Plan Work streams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

Board Assurance Committee membership and Terms of Reference in 2019/20

Board Assurance Committee membership

1. Board members will be aware of the following changes to the membership of the London Ambulance Service NHS Trust Board towards the end of 2018/19:
 - a. Jessica Cecil (Associate Non-Executive Director) left the Board on 31 January 2019
 - b. Robert McFarland (Non-Executive Director) left the Board on 28 February 2019
 - c. Karim Brohi (Non-Executive Director) joined the Board on 01 March 2019
 - d. Mark Spencer (Non-Executive Director) joined the Board on 01 March 2019.
2. In light of these changes and in line with good practice, the membership of the Board's Assurance Committees has been reviewed and is proposed as follows for 2019/20:

	Members	Regular Attendees
Audit Committee	<ul style="list-style-type: none"> • John Jones (Non-Executive Director, Chair) • Fergus Cass (Non-Executive Director) • Theo De Pencier (Non-Executive Director) 	<ul style="list-style-type: none"> • Lorraine Bewes (Director of Finance & Performance) • Garret Emmerson (Chief Executive Officer) • Philippa Harding (Director of Corporate Governance) • Mark Spencer (Quality Assurance Committee Chair)
	<ul style="list-style-type: none"> • Sheila Doyle to receive papers and provide comments ahead of meetings. 	

	Members	Regular Attendees
Finance and Investment Committee	<ul style="list-style-type: none"> • Fergus Cass (Non-Executive Director, Chair) • John Jones (Chair of the Audit Committee) • Theo de Pencier (Chair of the Logistics and Infrastructure Committee) • Amit Khutti (Associate Non-Executive Director) • Jayne Mee (Chair of the People and Culture Committee) 	<ul style="list-style-type: none"> • Heather Lawrence (Trust Chair) • Philippa Harding (Director of Corporate Governance) • James Corrigan (Deputy Director of Finance)

	<ul style="list-style-type: none"> • Garrett Emmerson (Chief Executive Officer) • Lorraine Bewes (Director of Finance and Performance) 	
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Logistics and Infrastructure Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Theo de Pencier (Non-Executive Director, Chair) • Lorraine Bewes (Director of Finance and Performance) • Fergus Cass (Audit Committee member, Finance and Investment Committee member) • Sheila Doyle (Non-Executive Director) • Ross Fullerton (Chief Information Officer) • Benita Mehra (Director of Strategic Assets and Property) 	<ul style="list-style-type: none"> • Philippa Harding (Director of Corporate Governance) • Senior Operations directorate representative • Senior Medical directorate representative

People and Culture Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Jayne Mee (Non-Executive Director, Chair) • Trisha Bain (Chief Quality Officer) or Deputy • Lorraine Bewes (Director of Finance and Performance) • Patricia Grealish (Director of People and Culture) • Mark Spencer (Quality Assurance Committee Chair) • Paul Woodrow (Director of Operations) • Tina Ivanov (Deputy Director of Clinical Education and Standards) 	<ul style="list-style-type: none"> • Karim Brohi (Non-Executive Director) • Melissa Berry (Equality and Inclusion Representative) • Chris Randall (Head of Workforce Information and Planning) • Philippa Harding (Director of Corporate Governance)

	Members	Regular Attendees
Quality Assurance Committee	<ul style="list-style-type: none"> • Mark Spencer (Non-Executive Director, Chair) • Fergus Cass (Member of the Audit Committee) • Karim Brohi (Non-Executive Director) • Heather Lawrence (Trust Chair) • Trisha Bain (Chief Quality Officer) • Paul Woodrow (Director of Operations) • Fenella Wrigley (Medical Director) 	<ul style="list-style-type: none"> • John Jones (Audit Committee Chair) • Philippa Harding (Director of Corporate Governance)
	(Jayne Mee to receive papers and provide comments ahead of meetings)	

	Members	Regular Attendees
Nominations and Remuneration Committee	<ul style="list-style-type: none"> • Heather Lawrence (Trust Chair, Chair) • Karim Brohi (Non-Executive Director) • Fergus Cass (Non-Executive Director) • Sheila Doyle (Non-Executive Director) • John Jones (Non-Executive Director) • Jayne Mee (Non-Executive Director) • Theo de Pencier (Non-Executive Director) • Mark Spencer (Non-Executive Director) 	<ul style="list-style-type: none"> • Garrett Emmerson (Chief Executive Officer) • Philippa Harding (Director of Corporate Governance) • Patricia Grealish (Director of People and Culture) • Amit Khutti (Associate Non-Executive Director)

	Members	Regular Attendees
Charitable Funds Committee	<ul style="list-style-type: none"> • Fergus Cass (Non-Executive Director, Chair) • Lorraine Bewes (Director of Finance and Performance) • John Jones (Non-Executive Director) 	<ul style="list-style-type: none"> • Philippa Harding (Director of Corporate Governance) • Michael John (Head of Financial Services) • Representation from LAS Communications team

		<ul style="list-style-type: none"> • Representation from the Voluntary Responders Group • Staff side representative
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3. Board members are asked to approve the proposed Board Assurance Committee membership for 2019/20.

Board Assurance Committee Terms of Reference

4. The following Board Assurance Committees have reviewed their Terms of Reference in the last three months:
 - a. People and Culture Committee, at its meeting on 10 January 2019 (ref: PCC/18/785)
 - b. Finance and Investment Committee, at its meeting on 15 January 2019 (ref: FIC/18/78)
 - c. Quality Assurance Committee, at its meeting on 22 January 2019 (ref: QAC/18/83)
 - d. Logistics and Infrastructure Committee, at its meeting on 05 February 2019 (ref: LIC/18/58)
 - e. Audit Committee, at its meeting on 11 February 2019 (ref: AC/18/99)
5. The following Committee have yet to review their Terms of Reference:
 - a. Nominations and Remuneration Committee
 - b. Charitable Funds Committee
6. The proposed (minor) amendments to the Terms of Reference of these Committees are attached at Annex B to this report. Board members are asked to approve the proposed changes.

Philippa Harding

Director of Corporate Governance

Annex A

Board Assurance Committee Membership 2018/19

Audit Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • John Jones (Non-Executive Director, Chair) • Fergus Cass (Non-Executive Director) • Theo De Pencier (Non-Executive Director) 	<ul style="list-style-type: none"> • Lorraine Bewes (Director of Finance & Performance) • Garret Emmerson (Chief Executive Officer) • Philippa Harding (Director of Corporate Governance) • Robert McFarland (Quality Assurance Committee Chair)
<ul style="list-style-type: none"> • Sheila Doyle to receive papers and provide comments ahead of meetings. 		
Finance and Investment Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Fergus Cass (Non-Executive Director, Chair) • John Jones (Chair of the Audit Committee) • Theo de Pencier (Chair of the Logistics and Infrastructure Committee) • Jayne Mee (Chair of the People and Culture Committee) • Garrett Emmerson (Chief Executive Officer) • Lorraine Bewes (Director of Finance and Performance) 	<ul style="list-style-type: none"> • Heather Lawrence (Trust Chair) • Philippa Harding (Director of Corporate Governance) • James Corrigan (Interim Deputy Director of Finance)
Logistics and Infrastructure Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Theo de Pencier (Non-Executive Director, Chair) • Lorraine Bewes (Director of Finance and Performance) • Fergus Cass (Audit Committee member, Finance and Investment Committee member) • Sheila Doyle • Ross Fullerton (Chief Information Officer) • Benita Mehra (Director of Strategic Assets and Property) 	<ul style="list-style-type: none"> • Philippa Harding (Director of Corporate Governance) • TBC (Head of Estates) • Justin Wand (Deputy Director of Fleet and Logistics) • Senior Operations directorate representative • Business Intelligence representative

People and Culture Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Jayne Mee (Non-Executive Director, Chair) • Trisha Bain (Chief Quality Officer) or Deputy • Lorraine Bewes (Director of Finance and Performance) • Jessica Cecil • Patricia Grealish (Director of People and Culture) • Robert McFarland (Quality Assurance Committee Chair) • Paul Woodrow (Director of Operations) or Deputy • Tina Ivanov (Deputy Director of Clinical) Education and Standards) 	<ul style="list-style-type: none"> • Melissa Berry (Equality and Inclusion Representative) • Chris Randall (Head of Workforce Information and Planning) • Philippa Harding (Director of Corporate Governance)

Quality Assurance Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Robert McFarland (Non-Executive Director, Chair) • Fergus Cass (Member of the Audit Committee) • Jessica Cecil • Heather Lawrence • Trisha Bain (Chief Quality Officer) • Fenella Wrigley (Medical Director) 	<ul style="list-style-type: none"> • John Jones (Audit Committee Chair) • Philippa Harding (Director of Corporate Governance) • Paul Woodrow (Director of Operations)
	(Jayne Mee to receive papers and provide comments ahead of meetings)	

Nominations and Remuneration Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Heather Lawrence (Trust Chair, Chair) • Fergus Cass (Non-Executive Director) • Jessica Cecil (Associate Non-Executive Director) • Sheila Doyle (Non-Executive Director) • John Jones (Non-Executive Director) • Jayne Mee (Non-Executive Director) • Robert McFarland (Non-Executive Director) • Theo de Pencier (Non-Executive Director) 	<ul style="list-style-type: none"> • Garrett Emmerson (Chief Executive Officer) • Philippa Harding (Director of Corporate Governance) • Patricia Grealish (Director of People and Culture)

Charitable Funds Committee	Members	Regular Attendees
	<ul style="list-style-type: none"> • Fergus Cass (Non-Executive Director, Chair) • Lorraine Bewes (Director of Finance and Performance) • John Jones (Non-Executive Director) 	<ul style="list-style-type: none"> • Philippa Harding (Director of Corporate Governance) • Michael John (Head of Financial Services) • Representation from LAS Communications team • Representation from the Voluntary Responders Group • Staff side representative



Audit Committee

Terms of Reference (effective March 2019-March 2020)

1. Purpose

- 1.1 The Audit Committee (the Committee) has been established in order to focus primarily on the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

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 Directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.
- 5.2 At least one member of the Committee must have recent and relevant financial experience.

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 Finance and Performance and the Director of Corporate Governance should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.
- 7.2 The Non-Executive Chair of the Quality Assurance Committee should be invited to attend all Audit Committee meetings.
- 7.3 Other Executive ~~Directors~~ Committee members and officers may be invited to attend to discuss matters as directed by the Committee.
- 7.4 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

8. Quorum

- 8.1 The meeting will be quorate provided that two Committee members are in attendance, including the Chair of the Committee, or their nominated deputy (who must also be a Non-Executive Director). In the absence of the Chair, Committee members may nominate a deputy chair for the purposes of that meeting from their midst.

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 The Committee shall meet a minimum of four times per annum. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

11.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12. Duties

Purpose

12.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

12.2 The Committee shall review the corporate risk register and the Board Assurance Framework and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.

12.3 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

12.4 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

12.5 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

12.6 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

12.7 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Assurance Committees of the Board and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

Internal Audit

12.8 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

12.8.1 approval of the appointment of internal auditors and any question of resignation and dismissal. review and approval of the Internal Audit strategy,

12.8.2 operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

12.8.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

12.8.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

12.8.5 an annual review of the effectiveness of Internal Audit.

External Audit

12.9 The external auditor is appointed by the Trust Board on recommendation from an Auditor Panel established through the Audit Committee.

12.10 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

12.11 The auditor panel's functions are to:

12.11.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules
- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

12.11.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed external auditor;

12.11.3 Advise (if asked) the Trust Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

12.11.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

12.11.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor

12.12 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

12.12.1 consideration of the performance of the External Auditor;

12.12.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

12.12.3 discussion with the External Auditors of their local evaluation of audit risks;

12.12.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

12.12.5 discussion and agreement on the Trust's Annual Governance Statement.

Risk and Assurance Functions

12.13 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

12.13.1 review of the work of the Quality Assurance Committee in the management of clinical risk including assurance gained from the clinical audit function;

12.13.2 review of the work of the Finance and Investment Committee in the management of financial risk;

12.13.3 review of the work of the People and Organisational Development Committee in the management of workforce risk;

12.13.4 review of the work of the Logistics and Infrastructure Committee in the management of risk relating to IM&T, Estates, and Fleet & Logistics;

12.13.5 review of the Executive Leadership Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Risk Compliance and Assurance Group;

12.13.6 review the Board Assurance Framework to ensure that it is focused on the key strategic risks to the business and clearly identifies controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;

12.13.7 review of the findings of any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);

12.13.8 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

Counter Fraud

12.14 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

12.15 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

12.16 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

12.17 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

12.18 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

Whistleblowing

- 12.19 The Committee shall ensure that arrangements are in place for investigation of matters raised in confidence by staff relating to matters of financial reporting and control, clinical quality and patient safety, or other matters.

Other

- 12.20 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 to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.
- 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 26 March 2018



Finance and Investment Committee

Terms of Reference (effective April 2019-March 2020)

1. Purpose

- 1.1 The Finance and Investment Committee has been established in order to provide assurance and make recommendations to the Trust Board on the proposed plans of the Executive ~~Leadership Team Committee~~ and to be assured of their consistency through discussion with other Board committees.
- 1.2 The Finance and Investment Committee shall conduct independent and objective review(s) of financial and investment policy and performance.

2. Constitution

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

3. Authority

- 3.1 The Committee is authorised by the Trust Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.
- 3.2 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
- 3.3 The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the conduct of its functions.

4. Accountability

- 4.1 The Committee will report directly to the Trust Board.

5. Membership

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

6. Chair

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

7. Attendance

- 7.1 The Trust Chair should normally attend all Finance and Investment Committee meetings.
- 7.2 The Director of Corporate Governance and the Deputy Director of Finance should normally attend all Finance and Investment Committee meetings.
- 7.3 Other Executive ~~Directors~~ Committee members 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~~ nominated Chair of the Committee; and
 - 8.1.2 At least one of the two Executive ~~Directors~~ Committee members, one of whom must be the Chief Executive or Director of Finance and Performance.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

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

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

11. Frequency of meetings

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

12. Duties

Financial Policy, Management and Reporting

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

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

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

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

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

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

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

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

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

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

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

Investment Policy, Management and Reporting

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

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

Procurement

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

Other

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

13. Review and reporting responsibilities

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

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

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

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

14. Equality and diversity

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

TO BE Approved by the Board at its meeting on 26 March 2019



Logistics and Infrastructure Committee

Terms of Reference (effective April 2019-March 2020)

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 Directors 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~~ Committee members 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~~ nominated Chair of the Committee; and
 - 8.1.2 At least one of the two Executive ~~Directors~~ Committee members, 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 26 March 2019



People and Culture Committee

Terms of Reference (effective April 2019-March 2020)

1. Purpose

- 1.1 The People and Culture Committee has been established in order to assure the Board on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

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 Directors and Executive Directors-Committee of the Trust (including the Director of People and Culture and the Director of Finance and Performance) and shall consist of not less than eight 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, the Head of Workforce Analytics and an Equality and Inclusion Representative should normally attend all People and Culture Committee meetings.
- 7.2 Other Executive ~~Directors~~ Committee members 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~~ nominated Chair of the Committee; and
 - 8.1.2 At least one of the two Executive ~~Directors~~ Committee members, one of whom must be the Director of People and Culture or Director of Finance and Performance.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

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

11. Frequency of meetings

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

12. Duties

- 12.1 To enable the Trust Board to obtain assurance that the Trust achieves the following in a spirit of inclusion and diversity:

Leadership and Performance

- 12.1.1 Performance – is able to maximise the potential of its people both in delivering against their role and in developing their skills
- 12.1.2 Leadership Development – is taking appropriate steps to develop its current and future leaders
- 12.1.3 Multi-disciplinary training – has the systems and processes in place to ensure that its people are well equipped to undertake the tasks that are expected of them and that it can fulfil its workforce planning
- 12.1.4 Statutory and Mandatory training – ensures that its people have timely access to relevant statutory mandatory training and that they are compliant at all times

Healthy Workplace

- 12.1.5 Staff support – has appropriate systems and process in place to ensure the health and wellbeing of its people, occupational health offered and supporting them following their involvement in major incidents
- 12.1.6 Bullying and Harassment – is taking appropriate steps to prevent inappropriate behaviours in the workplace

Engagement

- 12.1.7 Recognition – has recognition schemes in place which recognise excellent contributions that reflect the Trust's values contributes to the accomplishment of its goals
- 12.1.8 Employee relations – has an effective strategy for dealing with employee relations and effective partnership arrangements with recognised Trade Unions
- 12.1.9 Employee voice –has effective methods of staff engagement that promote the concept of 'you said we did' in support of an inclusive approach to working with its people

Talent

12.1.10 Values based recruitment – has the systems and processes in place to ensure that it has the workforce it requires to deliver its goals

12.1.11 Succession planning – is able to replace people in key roles should they no longer be able (short term) or wish (longer term) to fulfil them

12.1.12 Equality, Diversity and Human Rights - has a dynamic workforce that reflects the diversity of its patients

Workforce Analytics

12.1.13 Strategic workforce planning – has appropriate people-related plans and strategies in place to enable delivery of the Trust's strategy and business plans

12.2 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 26 March 2019



Quality Assurance Committee

Terms of Reference (effective April 2019-March 2020)

1. Purpose

- 1.2 The Quality Assurance Committee has been established in order to provide the Trust Board with assurance on the achievement of the London Ambulance Service NHS Trust's strategic objective in relation to the provision of a high quality, safe, and effective service.
- 1.3 The Trust's definition of quality encompasses three equally important elements:
 - **Care that is safe** – working with patients and their families to reduce avoidable harm and improve outcomes.
 - **Care that is clinically effective** – not just in the eyes of clinicians but in the eyes of patients and their families.
 - **Care that provides a positive experience** – to patients and their families.

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 ~~Directors~~ and Executive ~~Directors-Committee~~ of the Trust (including the Medical Director and the Chief Quality Officer) and shall consist of not less than five members (of whom three should be Non-Executive Directors), 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 should normally attend all Quality Assurance Committee meetings, with the Chief Executive invited to attend at least annually.
- 7.2 The Non-Executive Chair of the Audit Committee should be invited to attend all Quality Assurance Committee meetings.
- 7.3 Other Executive ~~Directors-Committee members~~ and officers may be invited to attend to discuss matters as directed by the Committee.
- 7.4 At least twice a year the appropriate Internal Auditor representative should attend Quality Assurance Committee meetings.

8. Quorum

- 8.1 The meeting will be quorate provided that the following are in attendance;
- 8.1.1 ~~Two Non-Executive Directors, including t~~he Chair or ~~Vice-Chair~~ nominated Chair of the Committee; and
 - 8.1.2 At least two Executive ~~Directors~~Committee members, one of whom must be the Chief Quality Officer or Medical Director, or their delegated representative.

9. Meeting administration

- 9.1 A member of the Corporate Governance Team will act as the secretary to the Committee, ensuring the agreement of the agenda with the Chair of the Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.
- 9.2 The draft minutes and action points will be available to the Committee within five working days of the meeting.

10. Notice of meetings

- 10.1 Meetings of the Committee shall be called by the secretary of the Committee at the request of the Committee chair.
- 10.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be circulated to each member of the Committee, any other person required to attend and all other Non-Executive Directors, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.
- 10.3 Late and additional papers will be tabled at the discretion of the Chair of the Committee.

11. Frequency of meetings

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

12. Duties

- 12.1 To enable the Trust Board to obtain assurance that:

- People are protected from abuse and avoidable harm (*Safe*)
- People's care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible (*Effective*)
- Staff involve and treat people with compassion, kindness, dignity and respect (*Caring*)
- The leadership, management and governance of the organisation ensures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture (*Well-Led*).

- 12.2 To receive the following standing items:

- A summary of actions report relating to the appropriate Care Quality Commission (CQC) domain/s to include an update report from the appropriate Executive Led Group/s including exceptions, notifiable events and relevant performance metrics.
- A report from the Quality Oversight Group (QOG) on any key issues and escalations.
- The Trust's corporate risk register – section relating to the appropriate domain in relation to quality and safety. To review the impact of any corporate risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion onto the Board Assurance Framework.
- The Trust's Board Assurance Framework – section relating to the strategic objectives and associated risks delegated to the Committee or that may

impact on the quality and safety of services to patients and their families (quarterly).

- 12.3 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 26 March 2019



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Trust Board Forward Planner			
Agenda item:	17			
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:	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Information
Background / Purpose:				
<p>This report provides the Board with an updated forward plan for Board meetings until the end of the 2019/20 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.</p> <p>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.</p>				
Recommendation(s):				
<p>The Board is asked to comment on the proposed forward plan for Board meetings until the end of the 2019/20 financial year.</p>				
This report relates to the following Board Assurance Framework (BAF) or other risk:				
<p>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.</p>				
Please indicate which Board Assurance Framework (BAF) risk it relates to:				
Clinical and Quality	<input checked="" type="checkbox"/>			
Performance	<input checked="" type="checkbox"/>			
Financial	<input checked="" type="checkbox"/>			
Workforce	<input checked="" type="checkbox"/>			

Governance and Well-led	<input checked="" type="checkbox"/>
Reputation	<input checked="" type="checkbox"/>
Other	<input checked="" type="checkbox"/>
This paper supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input checked="" type="checkbox"/>
Partners are supported to deliver change in London	<input checked="" type="checkbox"/>
Efficiency and sustainability will drive us	<input checked="" type="checkbox"/>

Trust Board forward planner: 2017/18 + 2018/19

		2019/2020					
Area	Lead	Thursday 23 May 2019	Tuesday 31 July 2019	Tuesday 24 September 2019	Tuesday 26 November 2019	Tuesday 28 January 2020	Tuesday 24 March 2020
Standing items	HL	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies
	All	Declarations of Interest	Declarations of Interest	Declarations of Interest	Declarations of Interest	Declarations of Interest	Declarations of Interest
	HL	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting
	HL	Matters arising & action log	Matters arising & action log	Matters arising & action log	Matters arising & action log	Matters arising & action log	Matters arising & action log
	TB	Patient Story	Staff Story	Patient Story	Staff Story	Patient Story	Staff Story
	HL	Report from the Chair	Report from the Chair	Report from the Chair	Report from the Chair	Report from the Chair	Report from the Chair
	GE	Report from the CEO	Report from the CEO	Report from the CEO	Report from the CEO	Report from the CEO	Report from the CEO
Strategy & Planning	LB						Operational Plann Approval
	LB						Business Plan Approval
	FW						
	BM		Estates Strategy				
	BM		Fleet Strategy				
	FW	Volunteering Strategy					
	TB	Patient Engagement Strategy					
	PG	Learning & Education Strategy					
AF	Strategy Update				WRES Action Plan Strategy Update		
Quality, Performance & Assurance	LB	Integrated Quality & Performance Report	Integrated Quality & Performance Report	Integrated Quality & Performance Report	Integrated Quality & Performance Report	Integrated Quality & Performance Report	Integrated Quality & Performance Report
	PH	Board Assurance Committee Reports	Board Assurance Committee Reports	Board Assurance Committee Reports	Board Assurance Committee Reports	Board Assurance Committee Reports	Board Assurance Committee Reports
	PH	BAF & Corporate Risk Register	BAF & Corporate Risk Register	BAF & Corporate Risk Register	BAF & Corporate Risk Register	BAF & Corporate Risk Register	BAF & Corporate Risk Register
	TB	Serious Incident Management	Serious Incident Management	Serious Incident Management	Serious Incident Management	Serious Incident Management	Serious Incident Management
	TB	SI Thematic Review	SI Thematic Review		SI Thematic Review	SI Thematic Review	
TB			Quality Accounts & Quality Priorities - biannual report			Quality Accounts & Quality Priorities - biannual report	
Annual Reporting	LB, PH	Annual Report and Accounts (incl AGS)					Approach to Annual Report & Accounts
	PH	Self Certification of Compliance with Provider Licence					
	JJ	Audit Committee Annual Report					
	TB	Patient Experiences Annual Report					
	TB	Annual Quality Account					
	LB			Unaudited Charitable Funds Annual Report & Financial Statements for 2018/19			
FW				CARU Annual Reports			
Governance	PH					Approach to Annual Corporate Governance Review	Annual Corporate Governance Review
	PH		Annual Public Meeting preparation				
	PH	Freedom to Speak Up Quarterly Report	Freedom to Speak Up Quarterly Report		Freedom to Speak Up Quarterly Report	Freedom to Speak Up Quarterly Report	
	PW			Business Continuity Update		EPRR Update	
Concluding matters	PH	Trust Board forward planner	Trust Board forward planner	Trust Board forward planner	Trust Board forward planner	Trust Board forward planner	Trust Board forward planner
	HL	Questions from members of the public	Questions from members of the public	Questions from members of the public	Questions from members of the public	Questions from members of the public	Questions from members of the public
	HL	Any other business	Any other business	Any other business	Any other business	Any other business	Any other business
	All	Review of the meeting	Review of the meeting	Review of the meeting	Review of the meeting	Review of the meeting	Review of the meeting
Additional reports	TB	Quality Report	Quality Report	Quality Report	Quality Report	Quality Report	Quality Report



Report to:	Trust Board			
Date of meeting:	26 March 2019			
Report title:	Quality Report			
Agenda item:	Additional report			
Report Author(s):	Helen Woolford, Head of Quality Intelligence and Risk			
Presented by:	Dr Trisha Bain, Chief Quality Officer			
History:	N/A			
Status:	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion
	<input type="checkbox"/>	Decision	<input type="checkbox"/>	Information
Background / Purpose:				
<p>The attached Quality Report shows the performance of the Trust against the Care Quality Commission (CQC) domains as of January 2019.</p> <p>The report highlight a general positive position in many areas and progress against targets. Areas of concern or targets not met relate to</p> <ul style="list-style-type: none"> • Drug room roll out – this is being action by executive and included in the business plan dates for completion are being agreed • Cat 2 and 3 performance targets and the impact on patient experience – PC carrying out a detailed analysis and actions in relation to improving performance. ED conveyance programme being developed via PMB as part of trust-wide programme to improve the position. • Complaints target not being met – recovery plan in place to met >75% target by mid April 2019. • CPI audits still not at 95% currently at 84% - increased pressure with REAP 3, however these need to be managed and this is part of work currently underway with operational, quality teams to review. 				
Recommendation(s):				
The Quality Assurance Committee is asked to review 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	<input checked="" type="checkbox"/>
Performance	<input type="checkbox"/>
Financial	<input type="checkbox"/>
Workforce	<input type="checkbox"/>
Governance and Well-led	<input type="checkbox"/>
Reputation	<input type="checkbox"/>
Other	<input type="checkbox"/>
This report supports the achievement of the following Business Plan Workstreams:	
Ensure safe, timely and effective care	<input checked="" type="checkbox"/>
Ensuring staff are valued, respected and engaged	<input type="checkbox"/>
Partners are supported to deliver change in London	<input type="checkbox"/>
Efficiency and sustainability will drive us	<input type="checkbox"/>



London Ambulance Service – Quality Report



Report for discussion at the Trust Board
Analysis based on January 2019 data, unless otherwise stated

Section	Content	Pages
Executive Summary	• RAG status and key actions for each of the Quality Domains	3
	• Quality Priority Areas and associated targets for FY18/19	
	• Quality Summary Scorecard	4
	• Operational Context Scorecard	5
1. Safe	• Patient Safety	7-9
	• Infection Control	10-14
	• Medicine Management	15
	• Safeguarding	16-17
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2. Effective	• Trust-Wide Scorecard	22
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	• Clinical Audit Performance	25
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	• Maternity	30
	• People and Public Engagement	31

Section	Content	Pages
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6. Quality Action Plan, Projects & Programmes	• Project Management Office (PMO) Overview	45-46
7. Clinical and Quality Risks	• Clinical and Quality Risks Summary	49

Quality Domain	Quality Priorities from Quality Account	Status	Highlights from this report by quality domain	Overall Status
Safe	90% implementation of Health Assure functionality by March 2019.		<p>The total number of adverse patient events was 283 resulting in 2.8 events per 1000 incidents. The Governance Department continues to encourage the reporting of all incidents with a particular focus on no/low harm.</p> <p>There are currently 26 outstanding SI actions: 5 actions concern EOC, 7 for operations, 1 for PED, 1 for Medical Directorate and 3 for LAS111.</p>	
	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.		<p>ROSC at Hospital(* data from Jun-18) is 38% which is above the national standard. The Stroke Care Bundle (data from May 18) is 99% Defibrillator downloads continued to decrease in December to 10% (from 14% previously).</p> <p>Two infographics were designed and posted on LiA by CARU. One highlighting how IV and IO drugs should be given and the other as a reminder regarding conveyance decisions for paediatric patients</p>	
	New quality Indicators developed and being reported via performance scorecards by December 2018.	Complete		
	QI training plan agreed and 100% of first cohort trained by December 2018.	Complete		
	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.		<p>The Mental Health Team presented at the London Clinical Senate – the presentation was extremely well received and highlighted the challenges we face with regards to pre-hospital mental health care.</p> <p>The Maternity team have developed 3 Top Priorities for the coming 2019/20 year: 1. Safety of our patients, 2. Staff are supported, and feel confident with emergency maternity care, and 3. Quality of maternity care provided by our teams is outstanding and evidences user and staff involvement.</p>	
	Evidence of patient involvement in all QI and service re-design programmes.	Complete		
	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.		<p>The Frequent Caller Team (FCT) continue to attend multi-disciplinary meetings and High Intensity User forums to discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS.</p> <p>In January we received 92 complaints with 66% being responded to within the 35 day target. The throughput of complaints in the organisation is the challenge.</p>	
	Over 75% of complaints letter being responded to within the 35 day timescale.			
Well Led	85% compliance with statutory and Mandatory training 2018-19.		<p>Case based discussion events (INSIGHT live) – occur at a local level with facilitation by a member of LfE. An element of teaching regarding a specific topic i.e. human factors, mental health, followed by a case reviews. Cases are from serious incident investigations or the re-contact audit.</p>	
	Leadership programme developed and implementation plan in place.	Complete		
	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

January 2019				Current Performance				Benchmarking			
Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Target	Latest Month	Year To Date Actual	Rolling	National Data	Best In Class	Ranking (out of 10)
Rate of Patient related Adverse Events per 1,000 Incidents	Rate	Jan-19	●		5.0	2.8	2.6	2.8			
Patient related Adverse Events - NO HARM	Count	Jan-19	●		TBC	203	1812	2,368			
Patient related Adverse Events - LOW	Count	Jan-19	●		TBC	36	304	340			
Patient related Adverse Events - MODERATE	Count	Jan-19	●		TBC	18	140	206			
Patient related Adverse Events - SEVERE	Count	Jan-19	●		N/A	9	58	80			
Patient related Adverse Events - DEATH	Count	Jan-19	●		N/A	17	97	158			
Medication Errors as % of Patient Adverse Events	%	Jan-19	●		TBC	6%	6.7%	4.8%			
Needle Stick Injuries as % of Staff Adverse Events	%	Jan-19	●		TBC	0%	1.0%	1.3%			
Never Events	Count	Jan-19	●		0.0	0%	100%	100%			
Number of SEL 111 adverse incidents	Count	Jan-19	●		TBC	97	882	TBC			
Number of NEL 111 adverse incidents	Count	Jan-19	●		TBC	22	108	TBC			
ROSC at Hospital (AQI)	%	Aug-18	●		30%	37%	32%	32%			
ROSC at Hospital UTSTEIN (AQI)	%	Aug-18	●		TBC	50%	53%	TBC			
STEMI to Angiography (AQI) (Mean)	hh:mm	Jul-18	●		N/A	02:03	93%	TBC			
STEMI care bundle (AQI)	%	Jul-18	●		74%	74%	70%	TBC			
Stroke Call to Arrival at Hospital (AQI)	hh:mm	Jul-18	●		TBC	01:12	97%	TBC			
Stroke on scene time (CARU continual audit)	hh:mm	Aug-18	●		00:30	00:31	00:32	TBC			
Survival to Discharge (AQI)	%	Aug-18	●		TBC	9%	10%	TBC			
Survival to Discharge UTSTEIN (AQI)	%	Aug-18	●		TBC	21%	38%	TBC			
STEMI- On scene duration (CARU continual audit)	hh:mm	Nov-18	●		TBC	00:39	TBC	TBC			

- 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

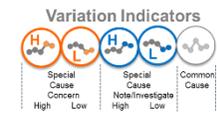


The scorecard below provides an overview of the Operational performance of the Trust in December. The Trust's response time performance was under the 7 minute target for C1 mean, and C2 was over the 18 minute target. C1 and C2 performance year to date is well under target for year to date figures as better performance becomes consistent.

NHS 111 call answering 95% within 60 secs was below target for both NEL and SEL, with NEL having only 69% of calls answered within 60 seconds.

January 2019			Current Performance				Benchmarking			
Indicator (KPI Name)	Basis	Data From Month	Target Status	Statistical Process Control Icon	Target	Latest Month	Year To Date Actual	National Data	Best In Class	Ranking (out of 10)
Category 1 response - Mean	mm:ss	Jan-19	●		07:00	06:20	06:28	07:06	06:17	2
Category 1 response - 90th centile	mm:ss	Jan-19	●		15:00	10:30	10:48	12:24	10:29	1
Category 2 response - Mean	mm:ss	Jan-19	●		18:00	21:36	19:04	22:22	12:29	6
Category 3 response - Mean	h:mm:ss	Jan-19	●		1:00:00	1:05:23	0:52:53	1:06:07	0:36:15	5
Category 4 response - 90th centile	h:mm:ss	Jan-19	●		3:00:00	2:41:50	3:03:42	3:09:39	2:01:16	5
Call answering - 999 (less than 5 seconds)	%	Dec-18	●			88%	84%			
Call answering - NHS 111 SEL (less than 60 seconds)	%	Dec-18	●		95%	76%				
Call answering - NHS 111 NEL (less than 60 seconds)	%	Dec-18	●		95%	69%				

- 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



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.

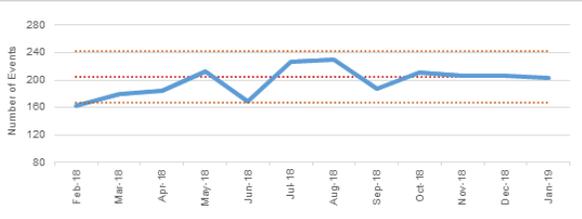


The total number of adverse patient events was 283 resulting in 2.8 events per 1000 incidents. The breakdown of these events is shown in the analysis below:

Monthly Trend

No Harm/Near Miss

Latest Month:
203



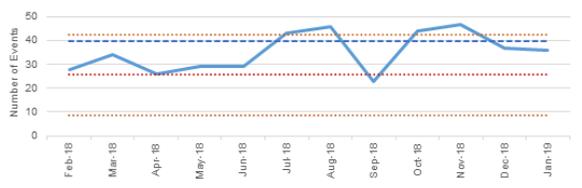
The number of reported No harm/Low harm incidents remains within the upper and lower limit baseline (set on 2017/18 data). This show that no/low harm incidents are being reported more than last year.

The Quality Governance team continues to encourage the reporting of all incident with a particular focus on no/low harm with regular attendances at sector governance meetings and training being in place.

The Quality Governance team also continues to working with key stakeholders to streamline the Datix system to make it easier to report an incident.

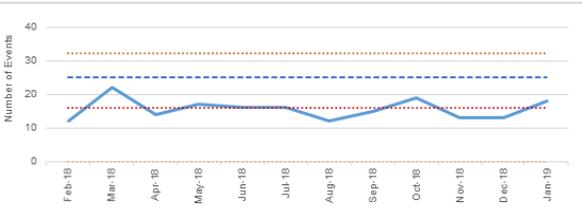
Low Harm

Latest Month:
36



Moderate Harm

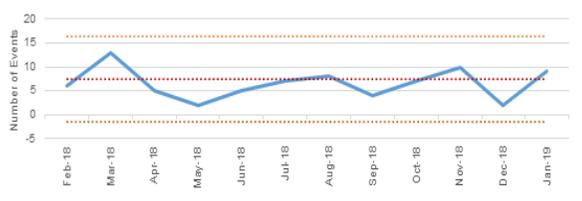
Latest Month:
18



No significant variation when compared to mean and limit thresholds.

Severe

Latest Month:
9



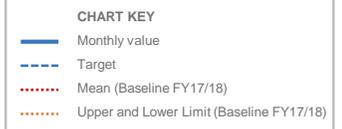
Please note, death incidents do not always reflect the underlying causal factors involved not relating to the treatment provided by the LAS

Death

Latest Month:
17



Data Source:

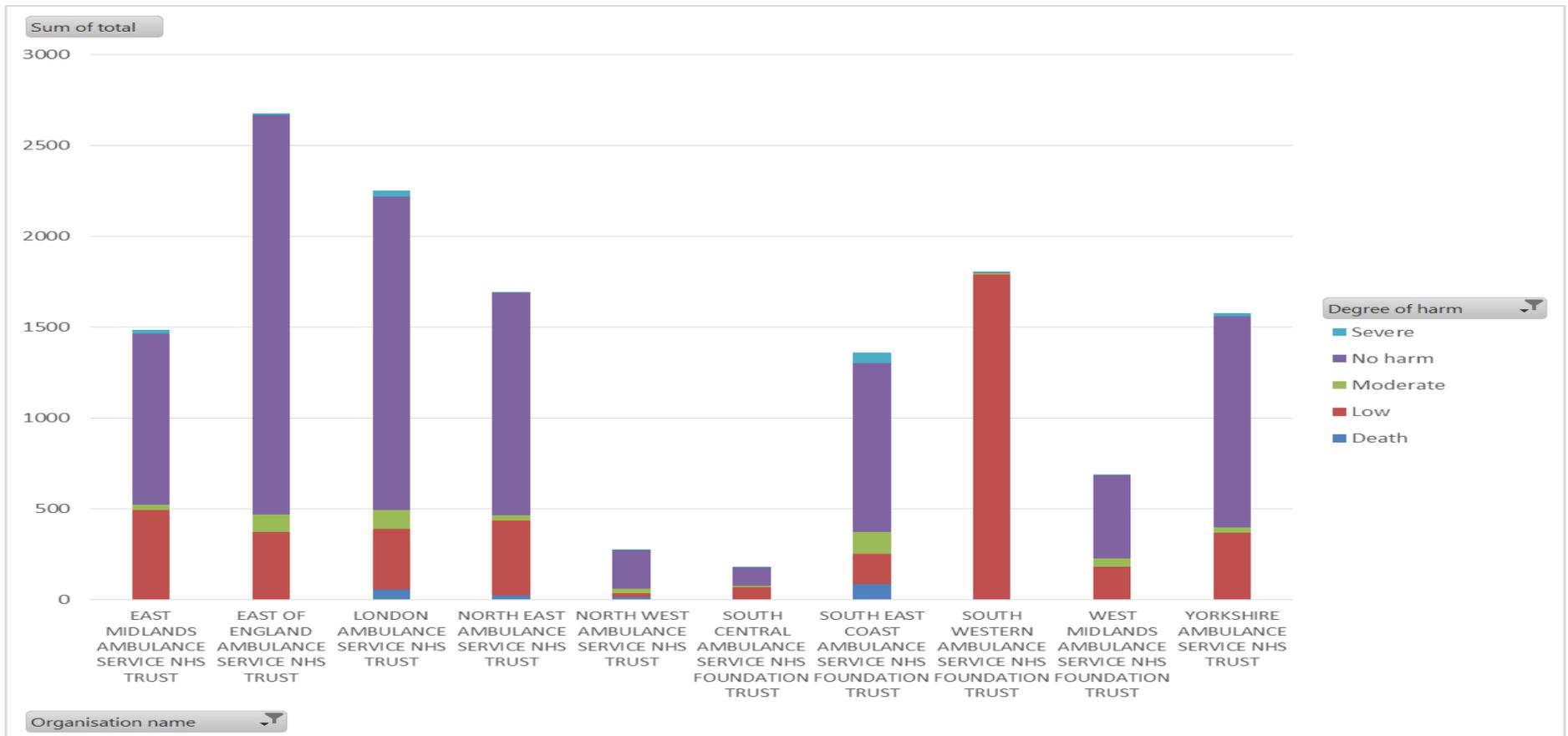




Owner: Helen Woolford | Exec Lead: Dr. Trisha Bain

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 refreshed 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. Below is the Ambulance data for the last 12 months, the London Ambulance Service is the second highest reporter behind East of England Ambulance service. However, when comparing LAS against its nearest comparable service we are the top reporter.

NRLS Analysis January –December 18



Data Source: NRLS



Owner: Helen Woolford | 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 remain the recurring themes. The Core skill refresher medicines management session is being tailored to the incident trends identified. Following the implementation of Nature of Call (NOC) there have been a number of incidents (with 14 SIs involving NOC and breathing difficulties declared.). Actions are being taken to improve the use of NOC including additional training, refraction sessions, local publications to staff and CSR courses.

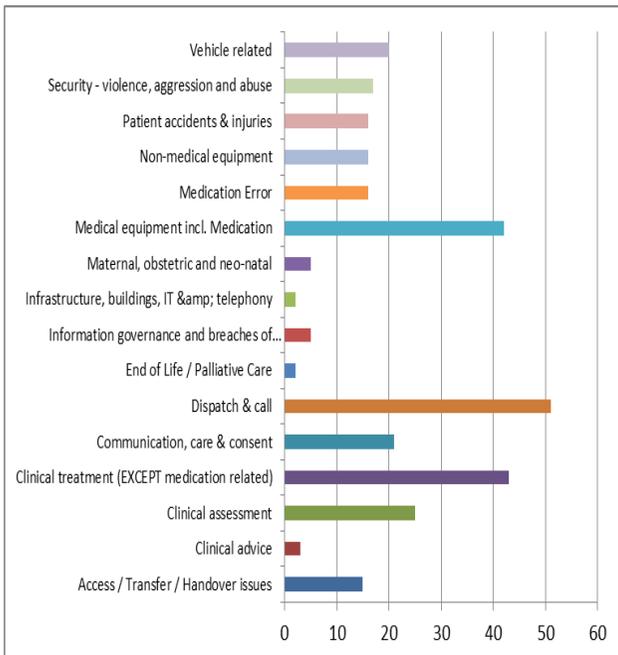
Serious Incidents

During January 2019, 11 reported incidents were declared as SIs after review at the Serious Incident Group (SIG). A new SI Learning Assurance Group is being formed with the first meeting held in January 2019. One of the main objectives of this Group is to ensure that the actions generated from SI investigations are effectively implemented and embedded and the learning is shared across the Trust.

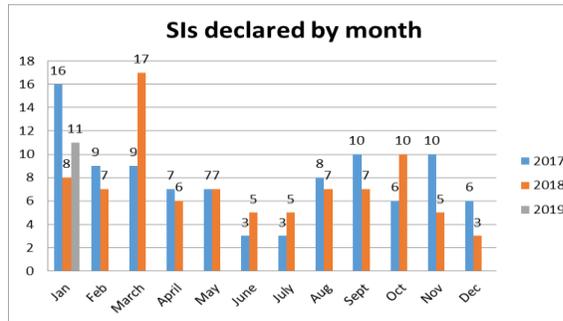
SI by Sector and Outstanding Actions

There has been a notable increase in open SI actions since October 18, with 26 currently outstanding: The team have recently worked on the reporting function on Datix to ensure that it is actions are added with timescales and owners. The team continue to targeted areas to ensure actions are completed and closed down

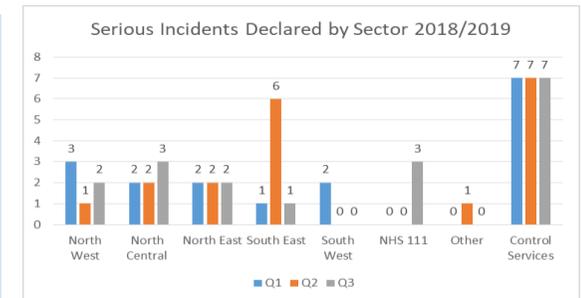
Incidents by Category



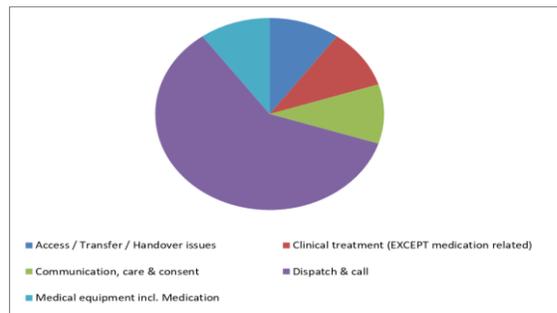
Monthly Analysis



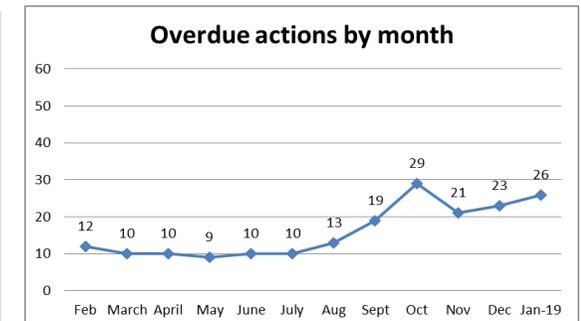
Quarterly Analysis



SI Categories



Overdue Actions



Data Source:



Monthly IPC Training Compliance January 2019 (Target: 90%)

IPC training compliance for Level 1 and Level 2 is monitored via ESR and compliance continues to exceed the Trust performance target of 90%, with both levels of training reporting an increase from previous months.

Performance achieved in January 2019:

- Level 1 – 94.21 % , compared to 93.23% in December 2018
- Level 2 – 95.35 % , compared to 92.95% in December 2018

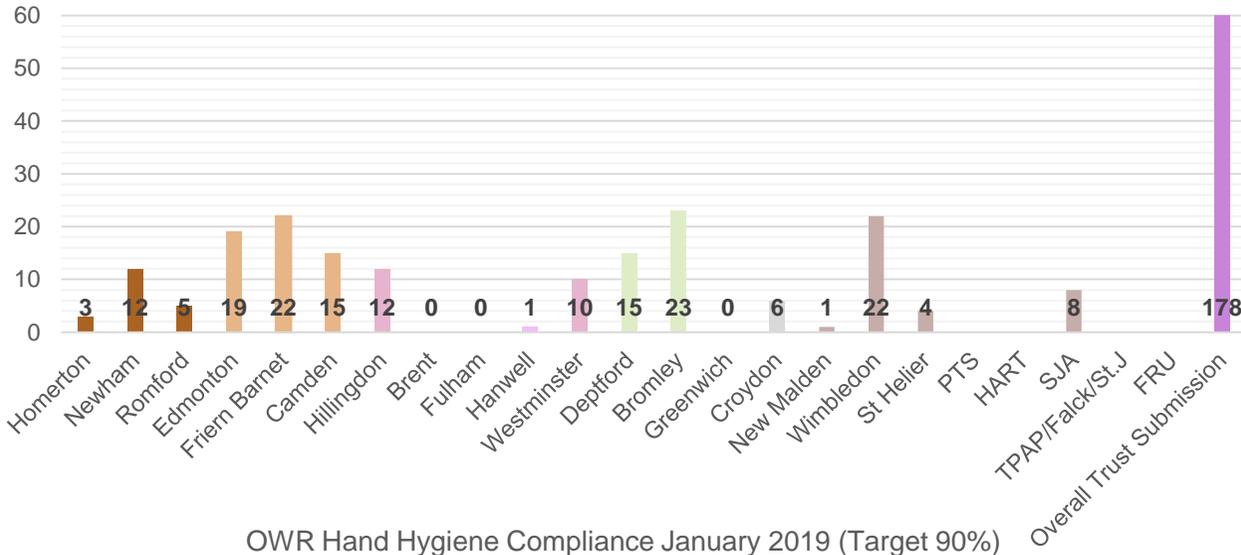
- **Assurance:**
- Monitored via ESR
- Monthly Quality reporting
- Oversight at Quarterly ICDG, IPCC and QOG

Actions taken:

- Monitoring process in place



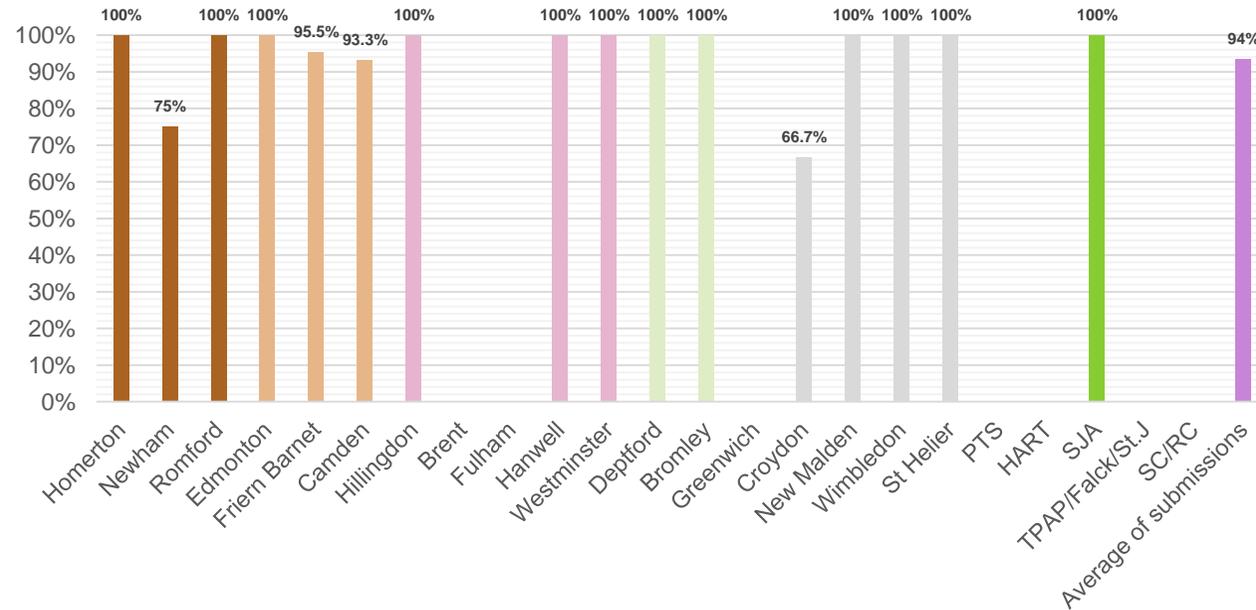
OWR Submissions January 2019



Hand Hygiene Performance

- Of the 16 OWR submissions, 15 are group stations and 1 is a third party ambulance provider (SJA). The January OWR data submission rates for hand hygiene has shown an increase, in comparison to 13 submissions in December 2018.
- Of the 16 submissions, the Trust OWR hand hygiene compliance for January was 94.41%, a slight decrease from 96.04% in December, but still above the Trust performance target of 90%.
- Only 5 group stations (Friern Barnet, Hillingdon, Westminster, Bromley and Wimbledon) submitted OWR to reflect a minimum of 10% of the total front line staff per group station, as agreed at the November IPCC. However, this is an increase from 2 group stations in December 2018.

OWR Hand Hygiene Compliance January 2019 (Target 90%)



Assurance

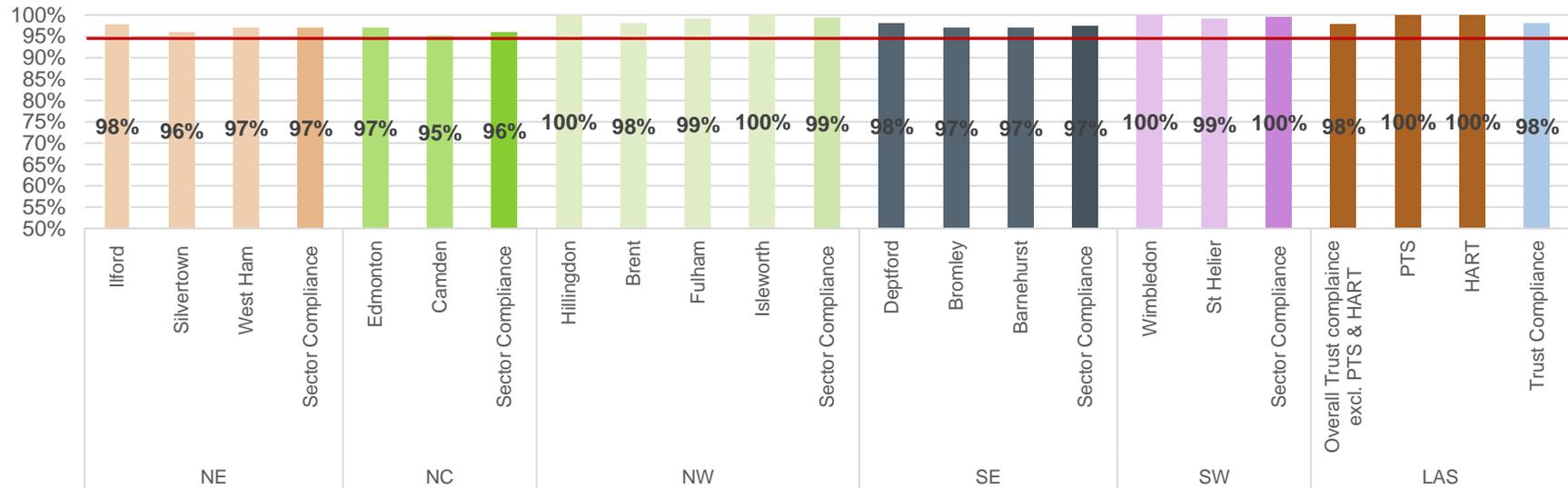
- Monthly Quality Report, CEO Performance Reviews, Quarterly Sector Quality Meetings
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Visits to EDs in London to audit and discuss hand hygiene standards continues
- IPC Champion role to raise standards and ownership at local stations by providing practical Hand Hygiene at stations.

Actions

- IPC team to continue with observational hand hygiene audits at EDs in London as per audit programme
- Agreed at November IPCC that OWR submission each month must reflect a minimum of 10% of total front line staff per group station
- Report to Sector Quality Meeting
- Discuss submission compliance and denominator figures for Operational Workplace Reviews at Quarterly IPCC meetings
- Circulate denominator data figures (i.e. 10% of front line clinical staff numbers) to each LGM



VP Deep Clean A&E Vehicles January 2019 (Target 95%)



Performance

- Data for each Hub including PTS and HART (22) submitted by the VP Contract Manager.
- Trust compliance remained static at 98% , from December, which is above the contractual performance target of 95%.

Assurance

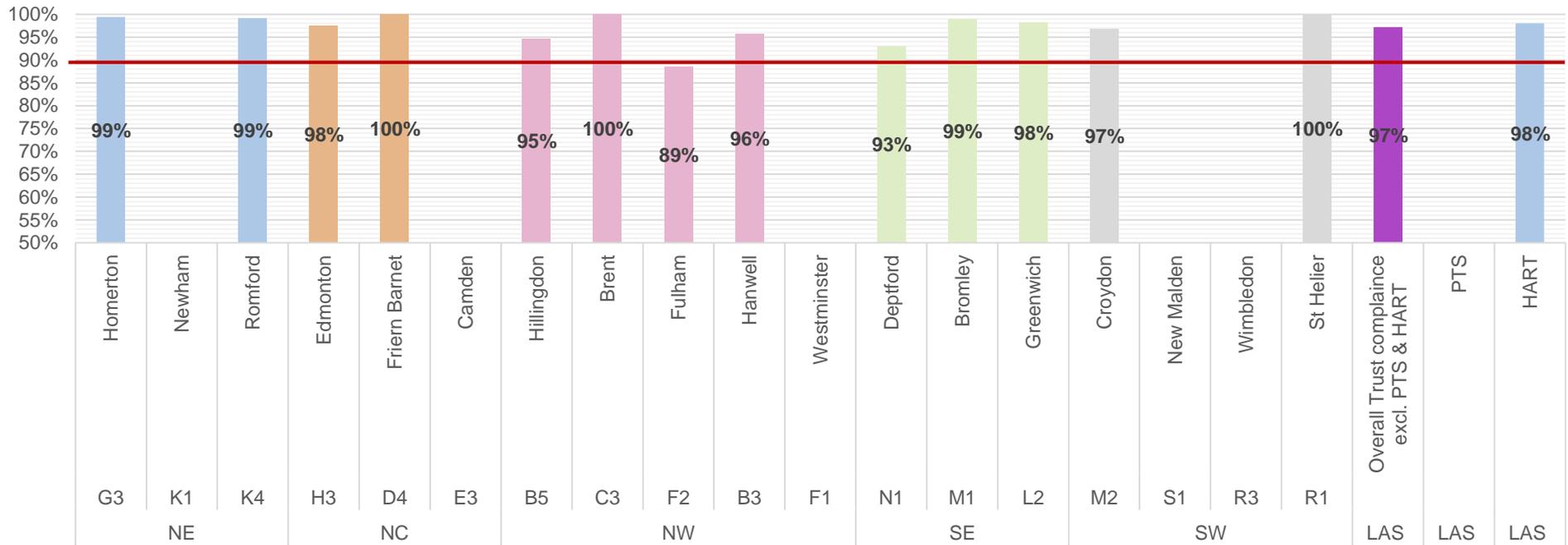
- Monthly Quality Reporting and CEO Performance Reviews
- Oversight: Monthly by IPC service, through formal channels at quarterly ICDG, IPCC, and at QOG
- Logistics managers have regular contract meeting with contractors; action plan for low compliance; regular stakeholder meetings established

Actions

- Logistics to continue to monitor.
- IPC continue to monitor monthly.



Premises Cleaning January 2019 (Target 90%)



Performance

- 13/20 Group Stations/Services submission received by IPC team for analysis, compared to 10/20 Group Stations submitting in December 2018, demonstrating a slight increase.
- Overall Trust compliance for January remained static at 98% from December and above the Trust target of 90%.

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

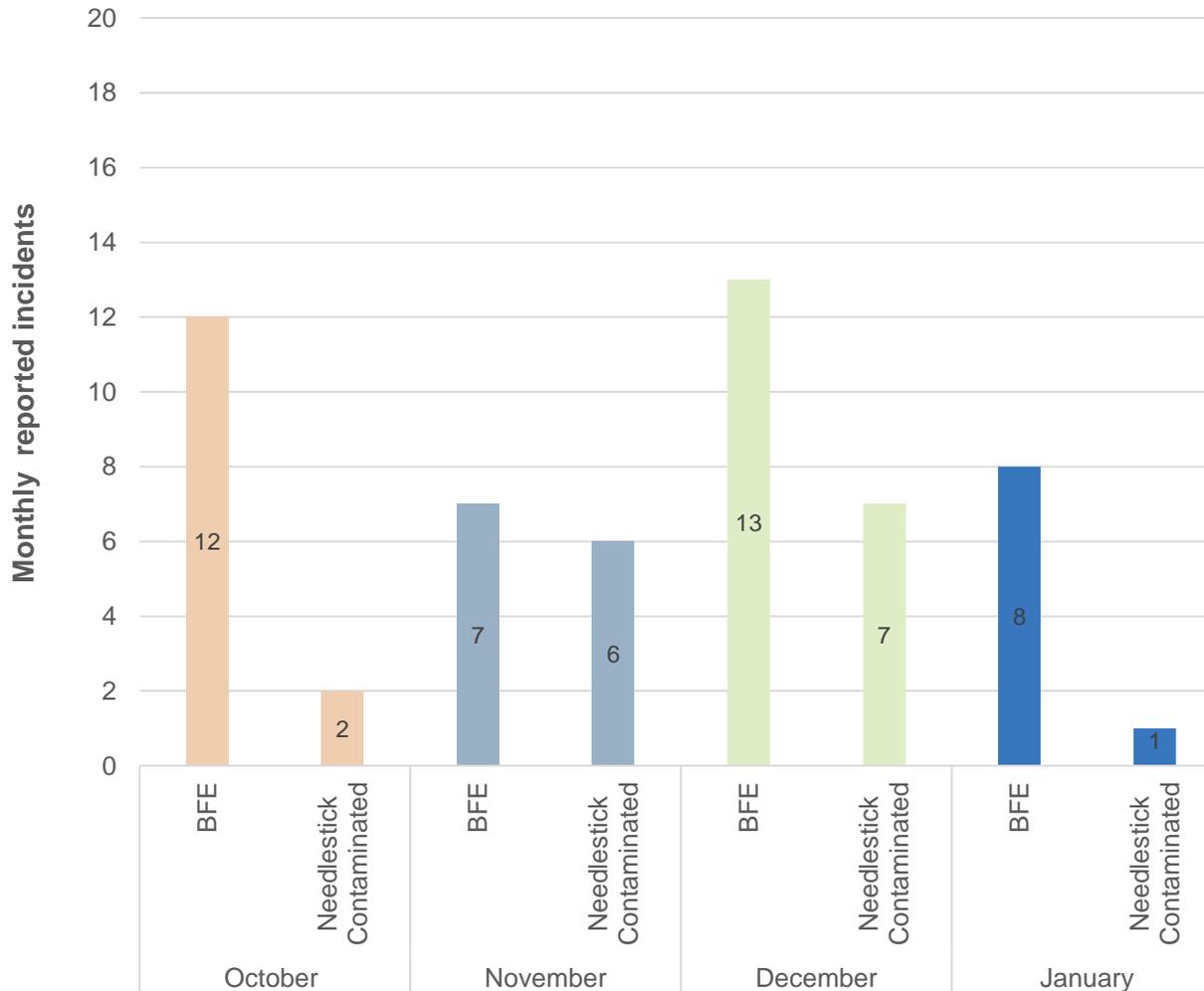
Actions

- QGAMs oversight and action required for non-submissions - QGAMs to ensure Group Stations submit data in a timely way- this was raised at the IPC Committee in November 2018 and will be raised again at IPCC on 20/2/19
- 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) Datix reported incidents Datix Q3 & January 2018-19



Performance

- The reported data of 9 incidents is for contaminated sharps and BFE only- *clean sharps incidents have been extracted from this report.*
- 8/9 incidents reported in January were as a result of exposure to body fluids
- 1/9 incidents reported in January were as a result of contaminated sharps injuries

Assurance

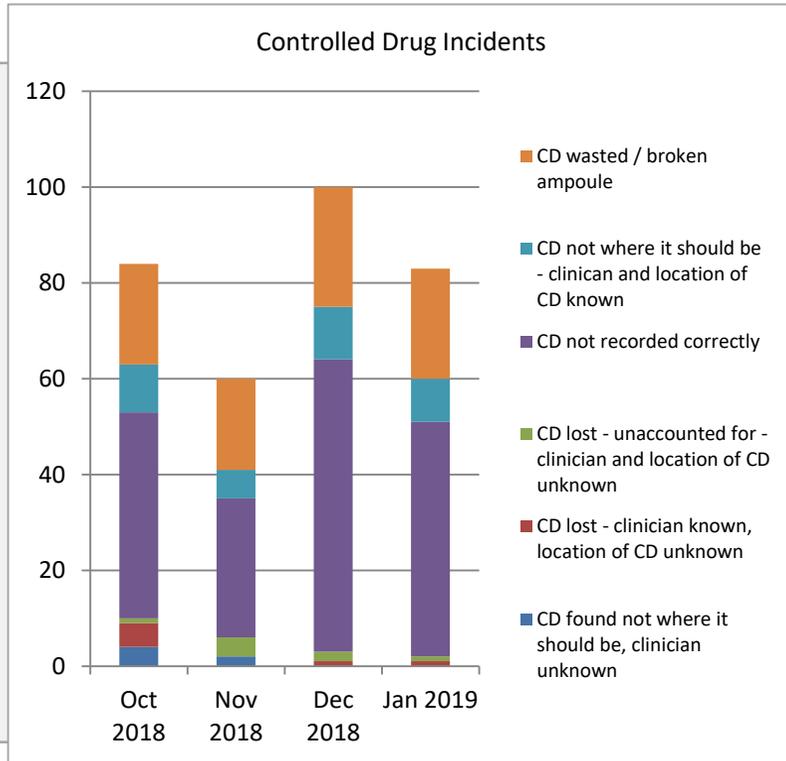
- Monthly oversight by IPC team, Monthly Quality Reports, Quarterly Sector Report, Quarterly ICDG/IPCC/QOG oversight.
- Datix incident follow-up and Datix Risk Reporting.

Actions:

- Daily review of incidents by IPC specialist and/ or IPC advisors highlighting to manager where necessary. to request prompt action
- Discussed at IPC Committee.
- DATIX subcategories are currently being reviewed and streamlined by IPC specialist and Datix manager, to ensure IPC receive the incidents that relate specifically to IPC.
- Interim IPC Specialist adviser has met with Occupational Health lead to discuss targeted collaborative work to address BFE incidents and the barriers to staff using appropriate PPE



Medicines Management



One unaccounted for loss of injectable morphine
 Total of 83 other controlled drug (CD) schedule 2 incidents including

- Morphine retained off duty (n=8)
- Documentation error (n=51)
- CD breakages (n=23)
- Morphine allergic reaction (n=1)

Non-controlled drugs (schedule 2) incidents

- Kitprep discrepancies or malfunction (n=15) and Drug usage forms incomplete (n=3)
- Cabinets unsecured or codes visible (n=5)
- Documentations (n=3)
- Breakages (n=3)
- Unaccounted for losses of non -CD drugs (n=2)
- Supply issues (n=1) and Abloy key issues (n=3)
- Inappropriate doses adrenaline (n=2), amiodarone (n=1), paracetamol (n=2), diazepam (n=1)
- External pharmacy error (n=1)
- Aspirin allergy (n=1)

Actions

- Planning in progress to manage oramorph as a schedule 2 controlled drug
- Core skill refresher medicines management session tailored to trends identified including requirement for reduction in ampoule breakages and incorrect administration of adrenaline underway.

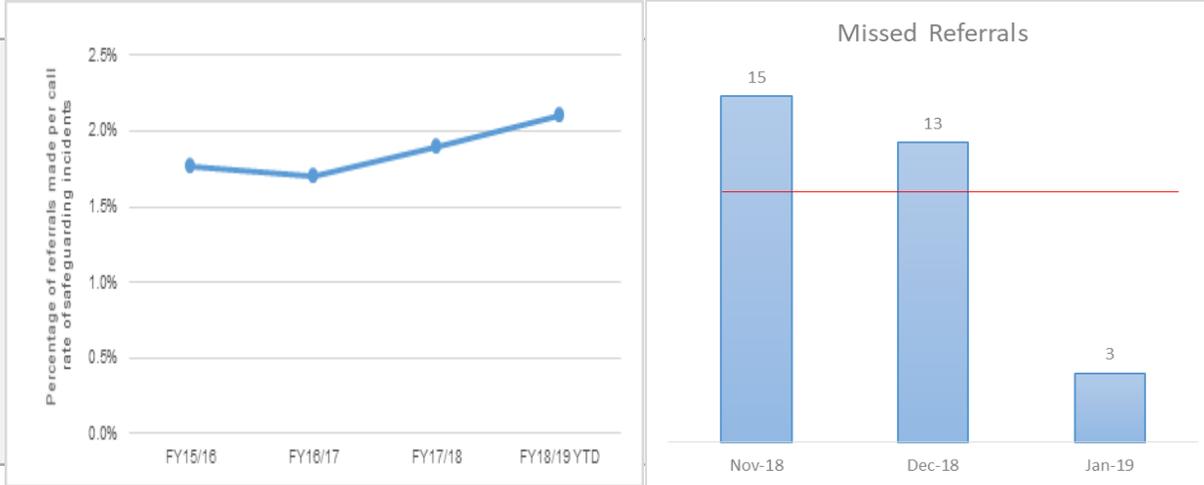
Assurance

- Reduction in errors in drug administration
- Morphine retained off-duty identified in a timely fashion in all cases
- Secure drugs rooms programme roll out continues



Referrals

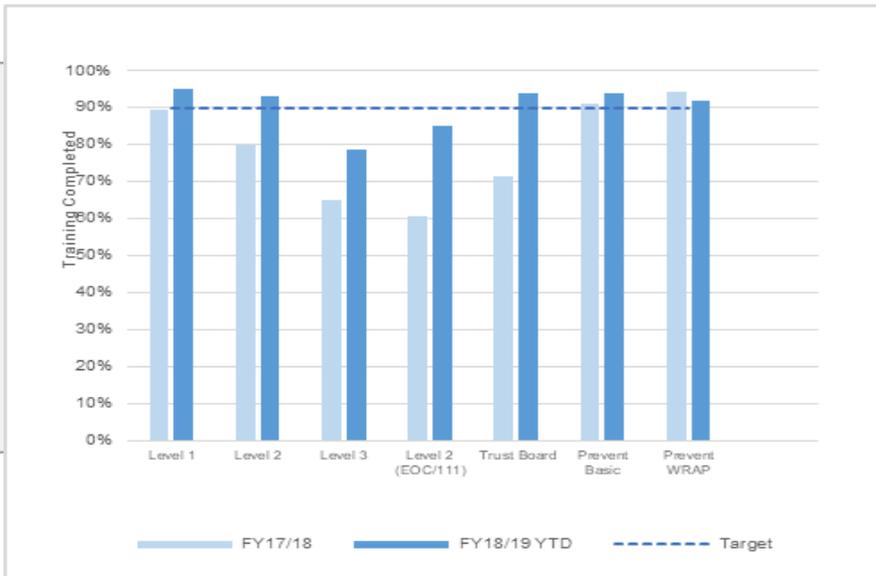
Monthly Rate: 2.1%
Missed Referrals: 3



The referrals rate for January was 2.1%. The referral rate is within the expected level of between 1.8% and 2.5%.
Missed Referrals (which is a shadow KPI) was 3. These were missed children referrals.

Delivery of Training

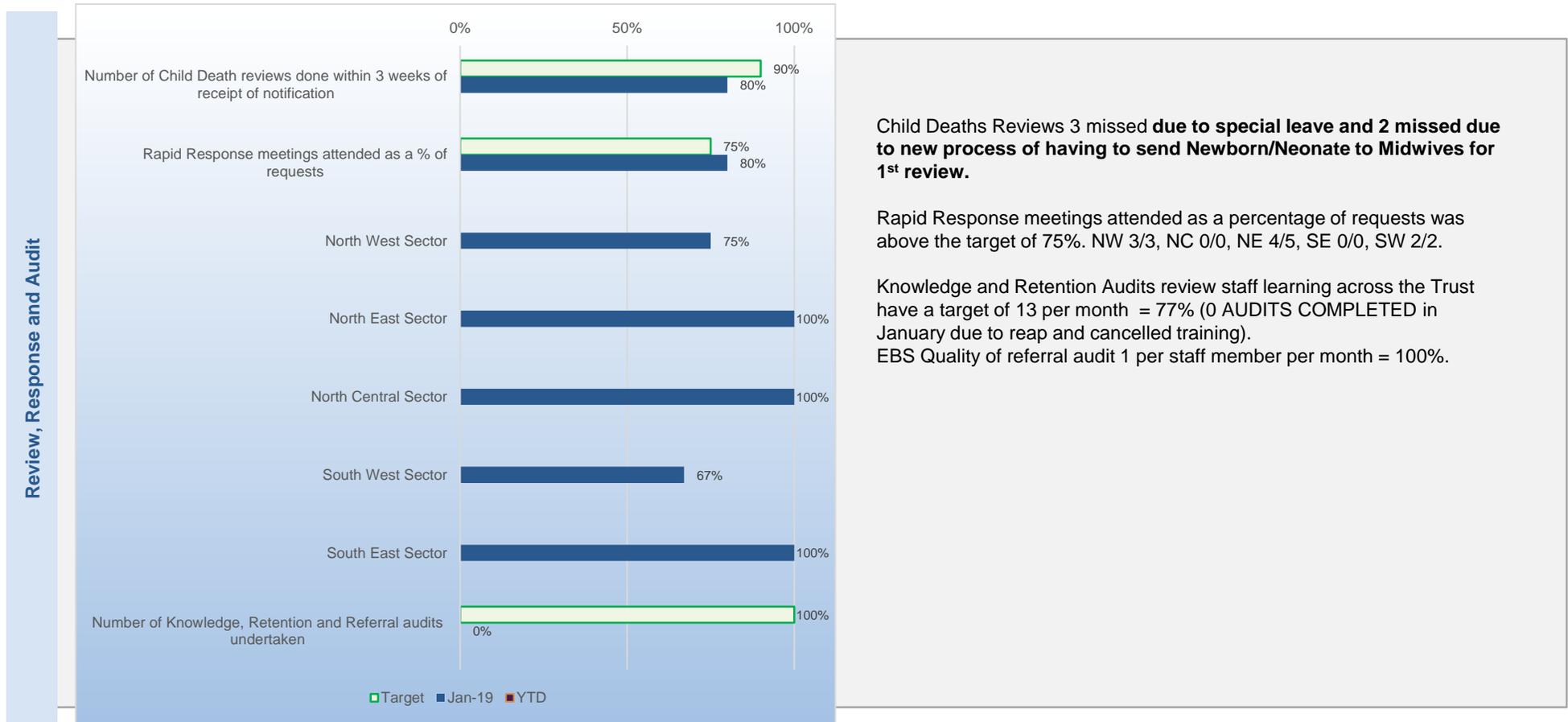
Level 1: 95%
Level 2: 93%
Level 3: 79%



Safeguarding Training level 3 continues to increase with more courses planned to end of March. L2 Control services are currently running CSR including safeguarding.

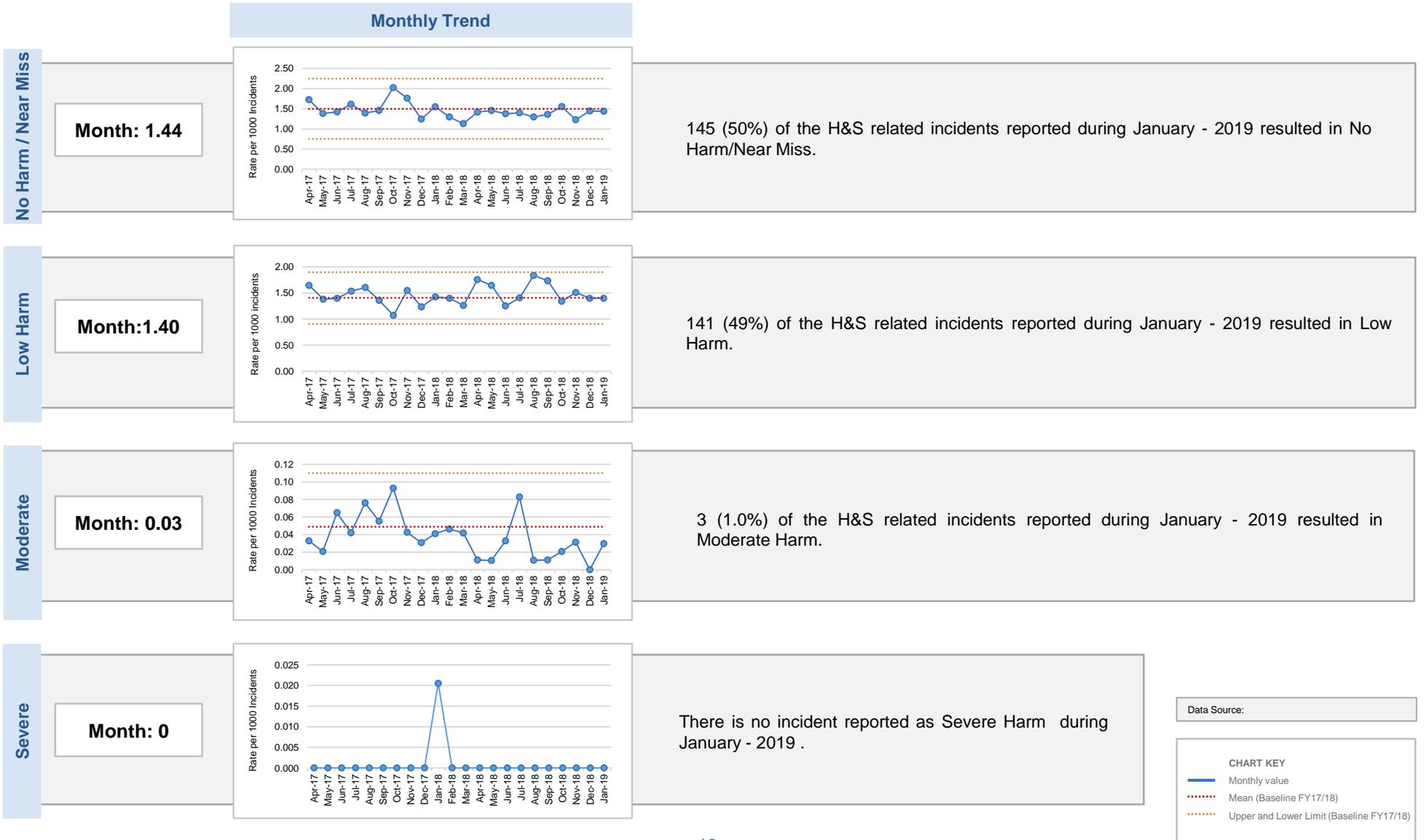


Safeguarding KPIs remain on track and are monitored closely by the Safeguarding Assurance Group.





The total number of H&S incidents was 289 resulting in **2.87 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below:





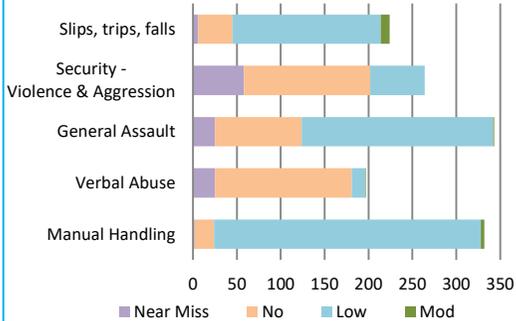
Owner: Julie Parham | Exec Lead: Dr Trisha Bain

Understanding the root 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

Top 5 Incident Sub-Categories by Severity - YTD

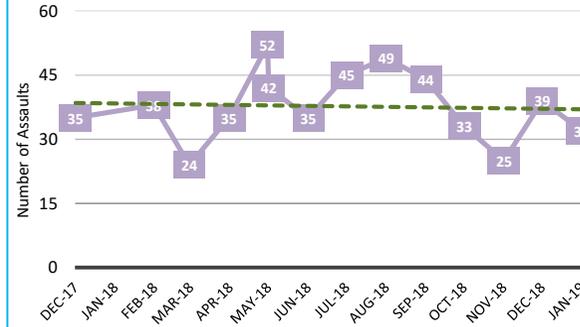


- Manual Handling – lifting patients (MH), General Assault and Security (violence, aggression & verbal abuse), incidents account for the highest numbers reported during January 2019.
- Practical manual handling training is on CSR 2019:1 from April-2019.

Assaults on Staff

Assaults on Staff

Assaults on Staff by Patients

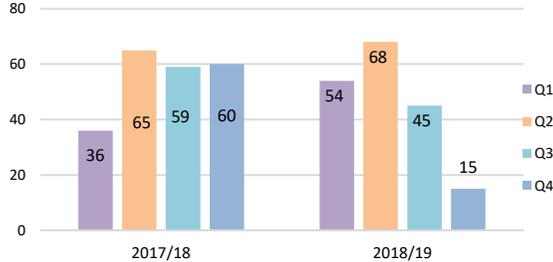


- There was a decrease in the number of assaults on staff by patient related incidents in January 2019.
- The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.
- Pilot for Body-Worn Video is currently being planned to assess its effect in helping to reduce physical assaults.

RIDDOR Incidents

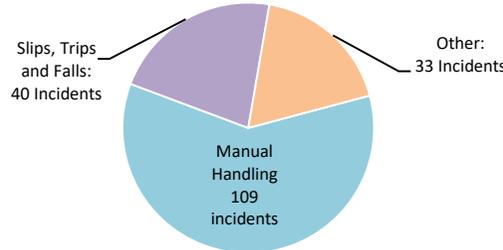
Number of incidents

RIDDOR Reportable Incidents by Quarter



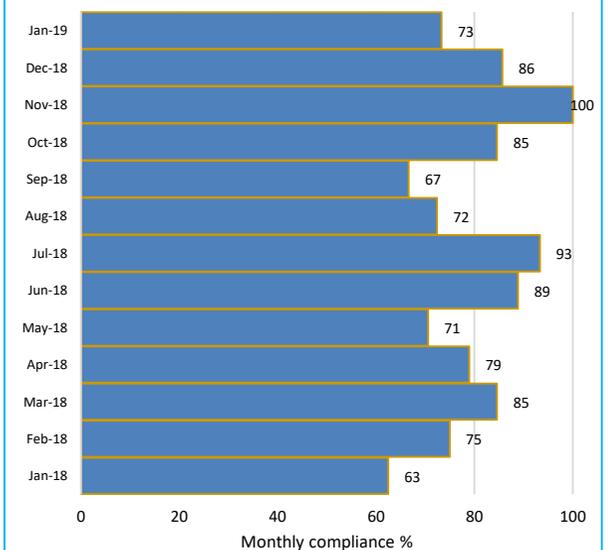
RIDDOR by cause

RIDDOR Reportable Incidents by Cause - YTD



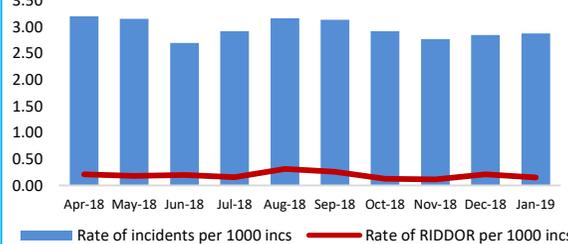
Reporting Time Lag

Trust wide RIDDOR Reporting Time frame (<15 Days) Compliance %



Rate of Incidents

H&S Incidents & RIDDOR Reports Rate per 1,000 A&E (Face to Face) Incidents

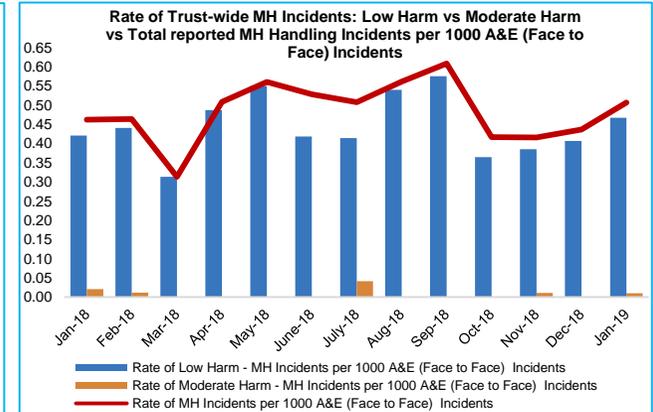
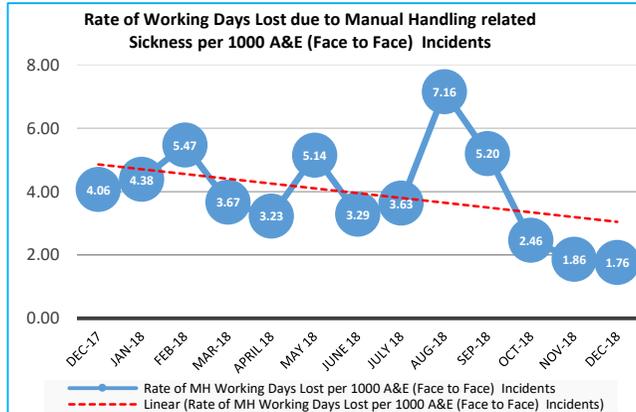
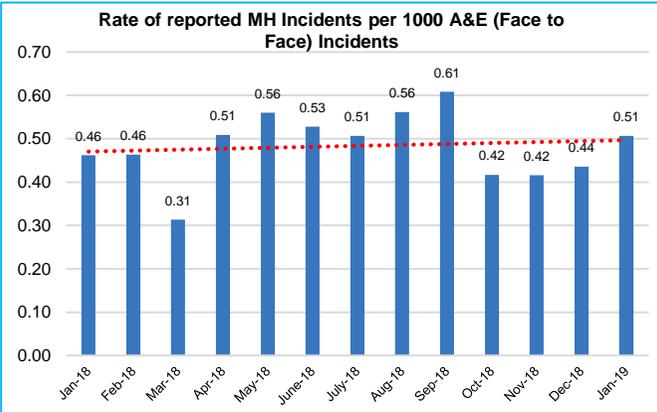


- Total of 182 RIDDOR incidents reported to the HSE during 2018/19.
- 15 RIDDOR incidents reported in January 2019.
- 4 out of the 15 incidents reported outside the 15 days timeframe.
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in January 2019 was 73%.
- Manual Handling incidents account for the highest number of RIDDORs reported across the Trust during 2018/19.

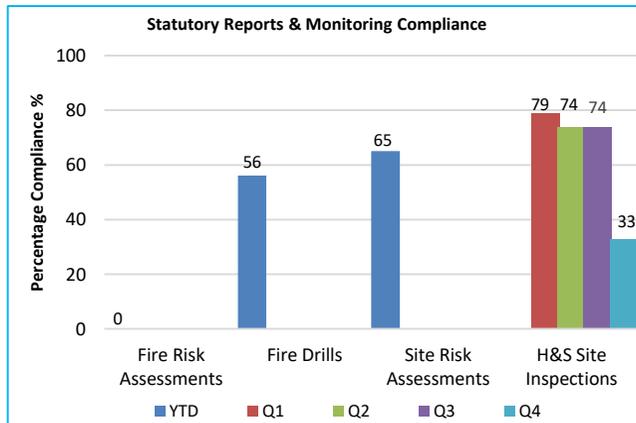
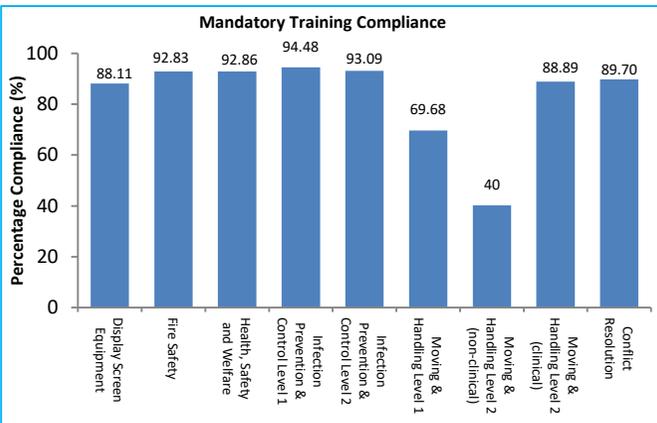


Owner: Julie Parham | Exec Lead: Dr Trisha Bain

Manual Handling related Incident, Sickness and Severity Rates



Mandatory & Statutory Compliance



Key Updates

Key Updates:

- There has been a reduction in the incidents reported involving Manger Elks, Track Chairs and Tail lifts as a direct result of new equipment/vehicles being purchased by the Trust along with a redefined maintenance schedule. Monitoring of these incidents continues through varies groups, e.g. H&S, QOG and QAC.
- The Fire risk assessment programme is due to commence by end of February-2019 and will be undertaken by Trenton Fire Ltd.
- Visits to assess general security issues at ambulance stations is planned to be completed by end of quarter 4.

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.*



Exec Lead: Dr. Fenella Wrigley

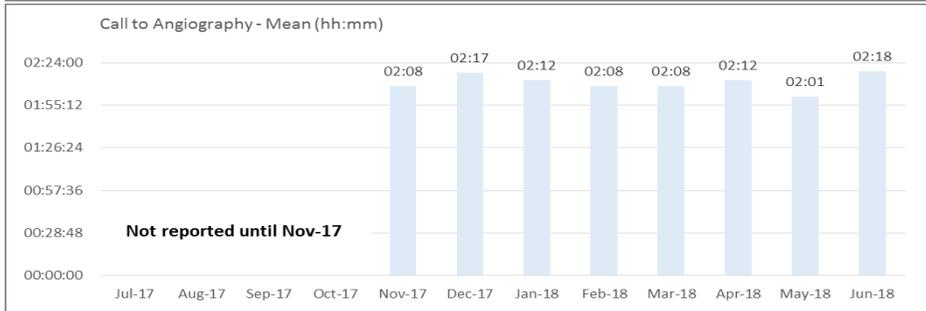
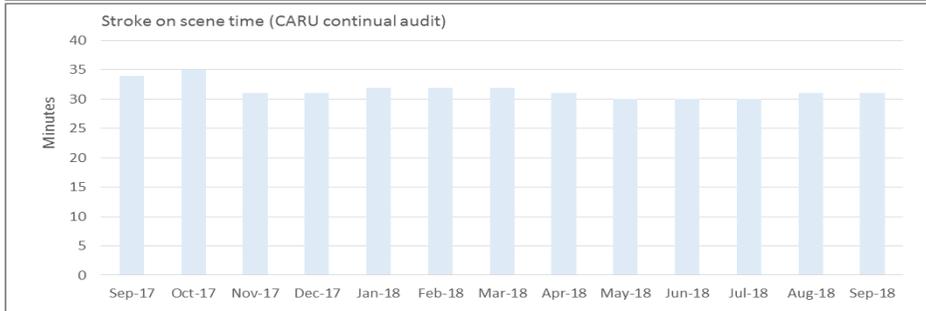
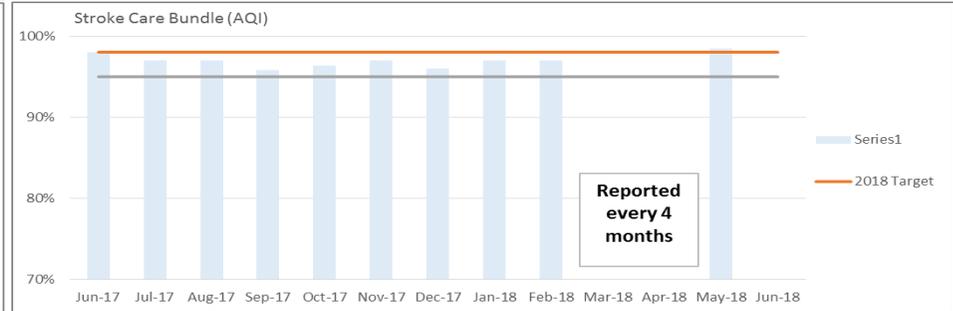
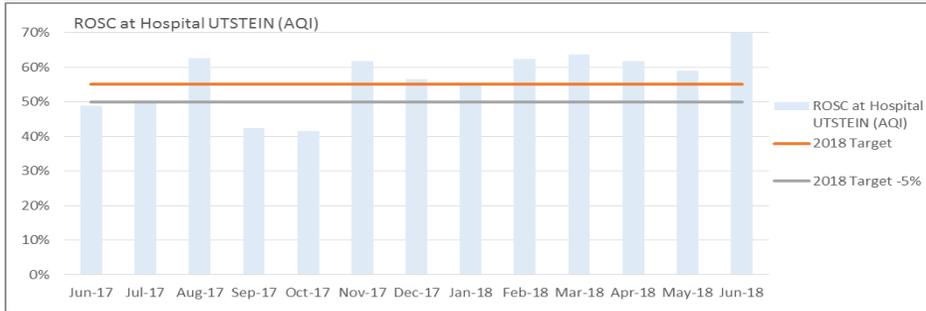
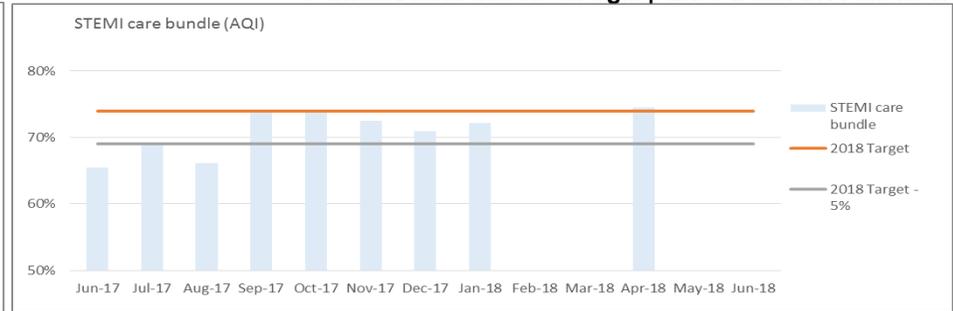
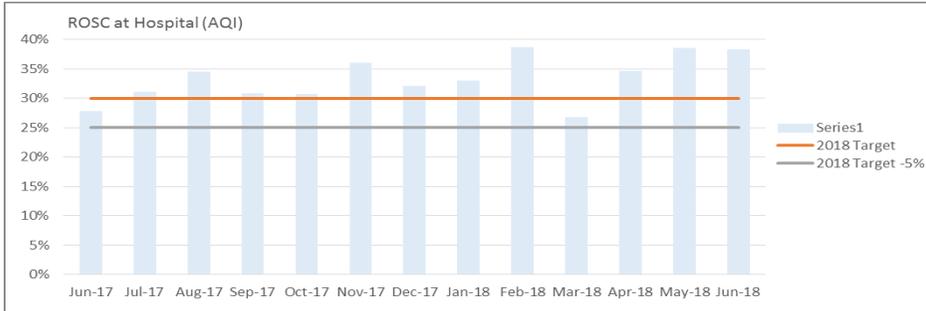
Measures	Target / Range	RAG	YTD 17/18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)		G	0	39%	38%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)		G	53%	59%	70%					↔			LQ1b		
STEMI care bundle (AQI) (Reported 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	0%	90%	90%	90%	91%	92%							
Documented Care - Glycaemic Emergencies Compliance (CPI audit)	95%	G	97%	98%		98%		98%		↔			LQ12		

Assurance and concerns

- Inconsistencies in the CPI data for December continues to delay publication of any CPI data. Vacancies and process changes in IM&T have resulted in no development work on the CPI database since August.
- In December, CPI training was delivered to ten paramedics on restricted duties. CPI auditors placed nine Datix reports and contacted EBS to discuss the potential for seven retrospective safeguarding referrals.

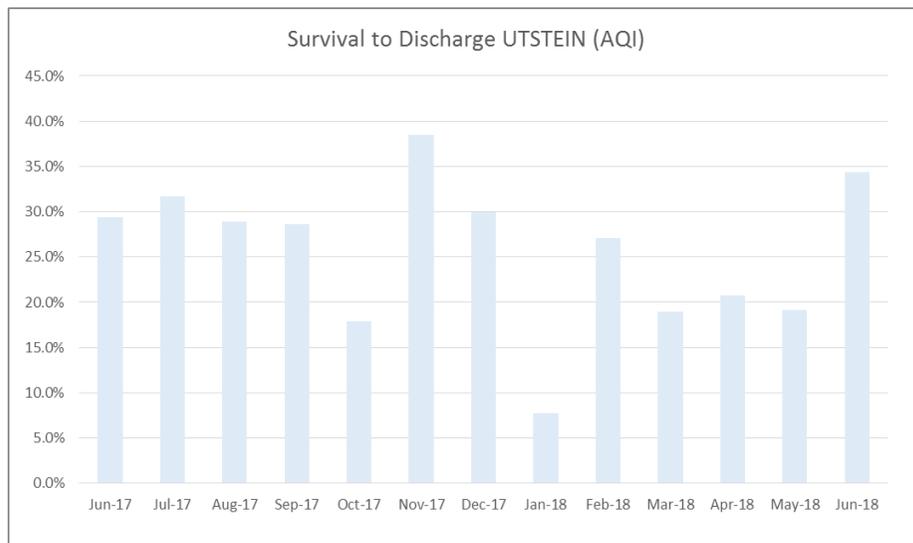
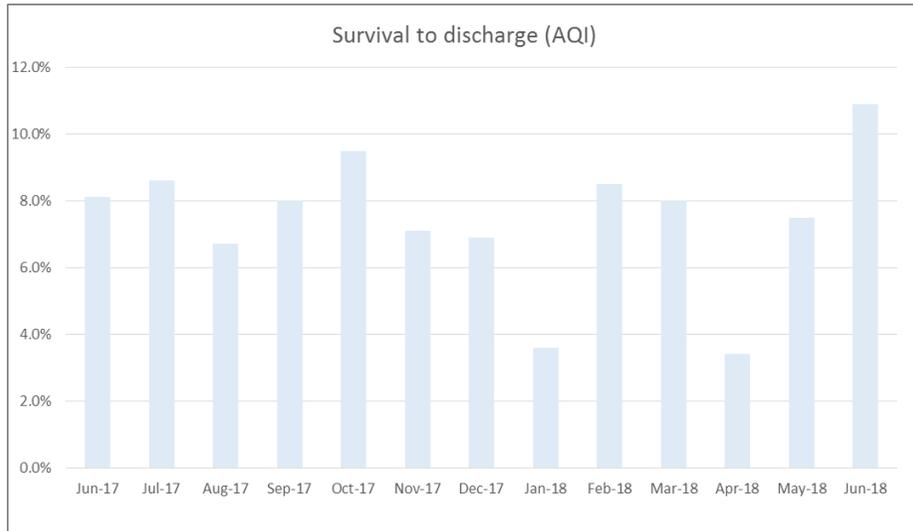


Owner: Dr. Rachael Fothergill | Exec Lead: Dr. Fenella Wrigley





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



AQI: Narrative

In September, ROSC on arrival at hospital for both the overall and Utstein comparator group (37% and 70% respectively) were the highest in the country. The survival to discharge figure for the overall group was in line with the national average at 9% with the Utstein figure above the national average at 32% (compared to 25%). Defibrillator downloads continued to decrease in December to 10% (from 14% previously).

STEMI data for the mean call to angiography time have been republished following ongoing data issues with the Myocardial Ischaemia National Audit Project supplier. The data shows that we continue to perform well against the national average with a mean of 2 hours and 1 minutes (faster than the national average by 7 minutes) and a 90th centile of 2 hours and 43 minutes (faster than the national average by 11 minutes). The average on-scene time maintained at 39 minutes in December.

In August, the mean and 90th centile for call to hospital for stroke patients was 1 hour and 11 minutes and 1 hour and 46 minutes respectively, which was below the national average (by 2 minutes and 5 minutes respectively). The average on-scene time was 32 minutes in December, which is a 1 minute increase from November.

The second sepsis care bundle submission was published this month looking at data from September. The LAS' performance was the highest in the country at 92% compared to a national average of 69%.

AQI: Actions

To improve defibrillator downloads, Group Stations via the Clinical Team Leaders have been issued with access to updated defibrillator software, cables for Lifepak 15 (in addition to the LP1000 infrared dongles that have been previously supplied), and step by step instructions on how to download and label defibrillator data. CARU hope to see increased downloads that can be matched to our cardiac arrest data to allow for reporting and monitoring.

* The time lag for these measures is reflective of the time taken to receipt all the information required from NHS England



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

DEALING WITH KIDS AND CONVEYANCE DECISIONS

IMPORTANT

- Children should not simply be viewed as "little adults"
- Children display important physical differences and they encounter different illnesses
- They pose many pitfalls for even the most experienced healthcare providers

ALWAYS CONSIDER THE CHILD'S...

ANATOMY IMMUNITY PHYSIOLOGY

How old is your patient? AND WHAT TO DO

Jan 2019

<2 years

CONVEY ALL

HOSPITAL

2-5 years

CONVEY

HOSPITAL

NON-CONVEYANCE IMPORTANT INFORMATION

- Record two sets of observations (20min apart) for all children.
- If the child is left on scene, appropriate observations should be within normal range for age. (Refer to your JRCALC National Clinical Guidelines & Pocket book)
- All referrals must be undertaken by the crew staff or EOC and not left for the parents/guardians to do. This will ensure the referral occurs.
- Remember a G and puts the further right.
- Always consider prematurity, C mechanisms & significant ill
- It is vital that a concern at all consideration

ADMINISTRATION of IV/IO drugs



For Paramedics the flow of an IV drug is regulated manually

Drugs are administered this way for various reasons, all of which require control of the rate

Without control, there are reactions that can be harmful to the patient

INFORMATION

REMEMBER

- Always check with JRCALC, as guidelines are subject to change
- Before administering any drug always cross check with a colleague
- Time recorded on PRF is when the drug administration commenced

RAPID IV push

Adrenaline 1:10,000	Amiodarone
ADX RAPID	AMO RAPID
Rapid only in cardiac arrest Administer in large vein	
Atropine	
ATR RAPID	

SLOW Over specified period

Benzylpenicillin	Chlorphenamine
BPN SLOW	CPH Over 1min
If possible, administer en-route to hospital	
Diazepam	Glucose 10%
DZP Over 2min	GLX SLOW
Titrate to restore normal GCS	
Hydrocortisone	Morphine Sulphate
HYC Over 2min	MOR SLOW
Rate approx 2mg per min. Always observe the patient	
Naloxone	Ondansetron
NLX SLOW	ODT Over 2min
IV 1ml at a time Titrate to relieve respiratory depression	
Paracetamol	0.9% Sodium Chloride
PAR Over 2min	SCP1 SLOW
Always ensure the max concentration of drug has not already been given	
Monitor RR, SpO2 & capniox before and after administration	
Tranexamic Acid	
TXA Over 2min	
Infusion given using 100ml fluid bag	

Clinical Audit: Actions

- Two infographic were designed and posted on LiA by CARU. One highlighting how IV and IO drugs should be given and the other as a reminder regarding conveyance decisions for paediatric patients
- A video created by CARU outlining paediatric conveyance decisions was also posted on LiA
- As a result of our Continuous Re-contact Clinical Audit, in December 18 and January 19:
 - 53 crews were recommended for reflective feedback (22 positive & 31 constructive)
 - 14 EMDs were recommended for supportive feedback
 - 6 Datix forms were completed:
 - 4 unexpected deaths, which were reviewed at SIG and it was agreed that all actions had been appropriately taken in each case.
 - 2 severe re-contacts (currently being locally investigated)

Research Update

- The ARREST trial has recruited 195 patients thus far.
- The MPDS Maternity study received approval from the Confidentiality Advisory Group meaning all approvals for this research project are now in place. Three out of the four scheduled focus groups with staff from EOC have taken place (with 17 attendees to date). The focus groups are aiming to understand the experiences of EMDs using MPDS Protocol 24 to triage maternity calls.
- Our paper on repeated adrenaline doses and survival from an out-of-hospital cardiac arrest has also just been published in the Resuscitation Journal:

[https://www.resuscitationjournal.com/article/S0300-9572\(19\)30007-3/fulltext](https://www.resuscitationjournal.com/article/S0300-9572(19)30007-3/fulltext)

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.



Exec Lead: Trisha Bain

Measures	Target / Range	RAG	YTD 18/19	Nov-18	Dec-18	Jan-19	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Mental Health related calls as percentage of all calls			8%	7.9%	7.3%	7.3%	↑				
Mental Health related MPS calls as percentage of all calls			2%	2.1%	1.9%	2.1%	↑				
Mental Health related Incidents as percentage of all calls			5%	5.1%	4.5%	4.5%	↓				
Mental Health related HCP Incidents as percentage of all calls			0%	0.4%	0.3%	0.3%	↑				
Mental Health Related Incidents			79841	8254	7878	7708	↓				
Mental Health Calls closed w ith Hear and Treat			3558	312	362	364	↑				
Mental Health incidents closed w ith See and Treat			29994	2958	3013	2894	↓				
Total MH incidents conveyed as a %			67%	64.2%	61.8%	63.8%	↑				
Mental Health Patients conveyed to an ED			87%	87.4%	95.0%	86.9%	↓				
Mental Health Patients conveyed to an ACP (including other)			13%	12.6%	5.0%	13.1%	↑				
Birth Imminent Incidents			1499	160	180	136	↓				
Conveyance rate of birth imminent			0%	90.0%	93.3%	92.0%	↓				
Head out/head visible Incidents			186	17	18	26	↑				
Haemorrhage after 24 weeks Incidents			1885	210	202	245	↑				



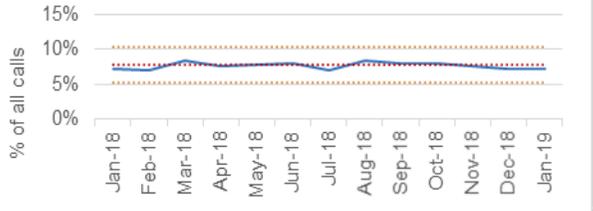
Owner: Carly Lynch | Exec Lead: Dr Trisha Bain

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

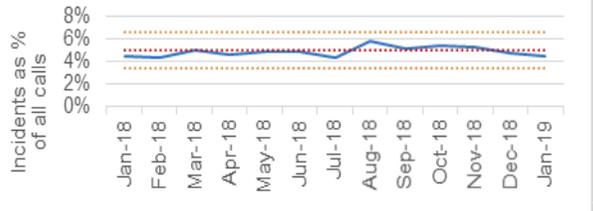
MH as % of all calls

Latest Month: **7.1%**

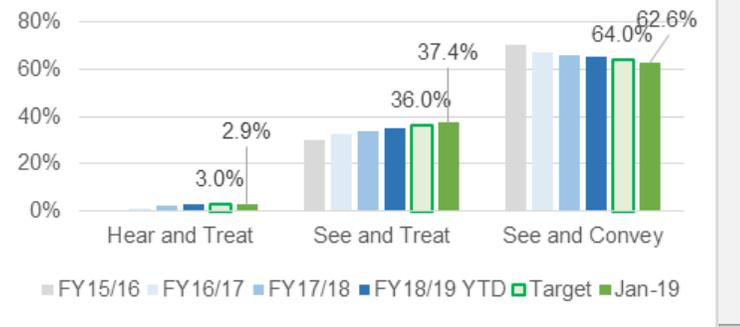


MH related incidents

Latest Month: **4.4%**



MH Incident Response



Highlights:

The Mental Health Joint Response Car (MHJRC) continues to run in the South East Sector.

Ben Lawrie, Mental Health Paramedic Lead, commenced in post on 21st January.

The Mental Health Team hosted a Whose Shoes Stakeholder Event on 07/02 at Guy's Hospital.

The Mental Health Team presented at the London Clinical Senate – the presentation was extremely well received and highlighted the challenges we face with regards to pre-hospital mental health care.

We have also presented the initial results of the MHJRC at the Pan London ACP and Demand Management.

ACTIONS:

We continue to engage with a group of Experts by Experience around co-production.

Evaluation of the Mental Health Joint Response Car will begin on 25/02/2019

Exceptions (Improvement Required):

We are awaiting 2 x WTE Mental Health Nurses to commence in post. This will aid resilience within the rota.

The nurses are due to commence in post in April 2019.

CHART KEY

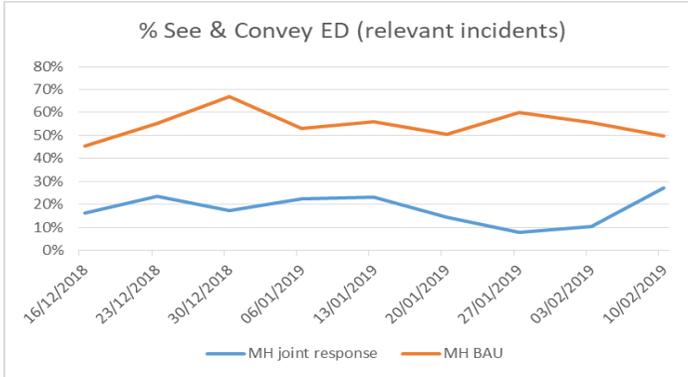
- Monthly value
- Mean (Baseline FY17/18)
- Upper and Lower Limit (Baseline FY17/18)

Data Source:



Pilot launched Mon 26 Nov. Interim (3 month) evaluation analysis due early April.

OUTCOME

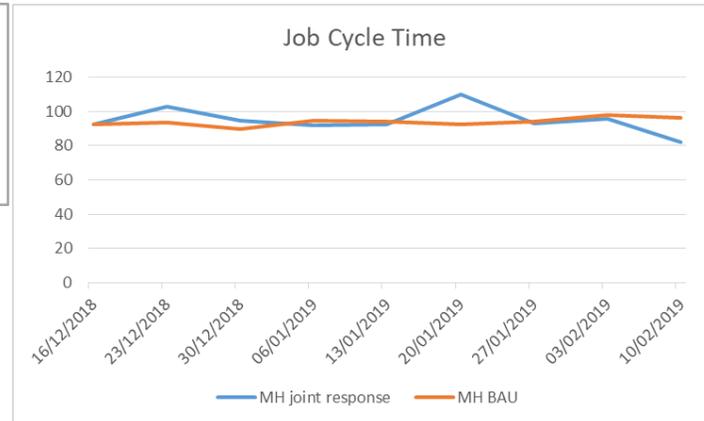


The MH joint response has consistently maintained low (~20%) ED conveyance rates during the pilot, relative to MH incidents receiving a standard response (~55%).

The comparison is against standard business as usual DCA responses to MPDS card 25 (Psychiatric). This is London-wide responses excluding under 18 year olds, section 136s, MH transfers and Cat 1s.

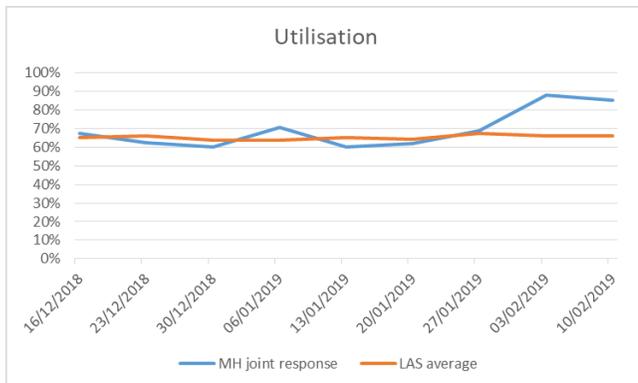
Job cycle time has remained comparable between the MH joint response and the BAU comparison

The comparison is against standard business as usual DCA responses to MPDS card 25 (Psychiatric). This is London-wide responses excluding under 18 year olds, section 136s, MH transfers and Cat 1s.



PRODUCTIVITY

UTILISATION



Utilisation has remained comparable between the MH joint response and the LAS-wide average

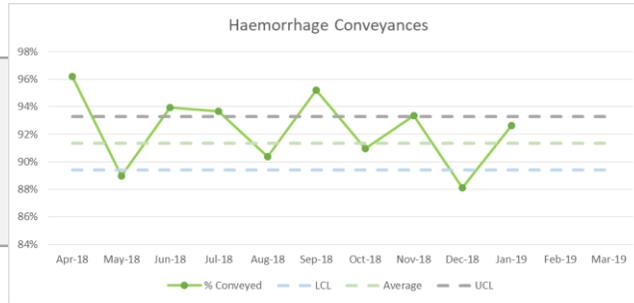
As utilisation is an aggregate measure (as opposed to relating to single MH-specific incidents) the comparison is against the LAS average.



Total Maternity Calls in 2018 is 8505 - Average range 600-700 pm
 Total January Calls = 740 Calls Triage

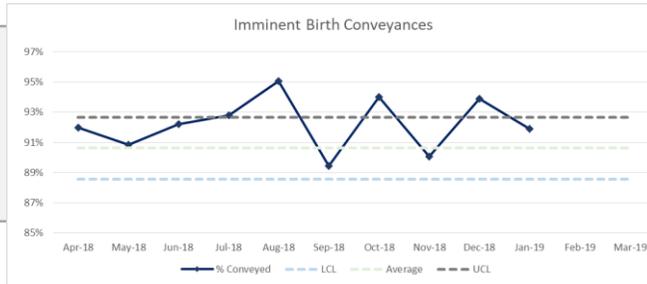
Haemorrhage conveyance

Latest Month:
93% (n=245)



Imminent birth conveyance

Latest Month:
92% (n=136)

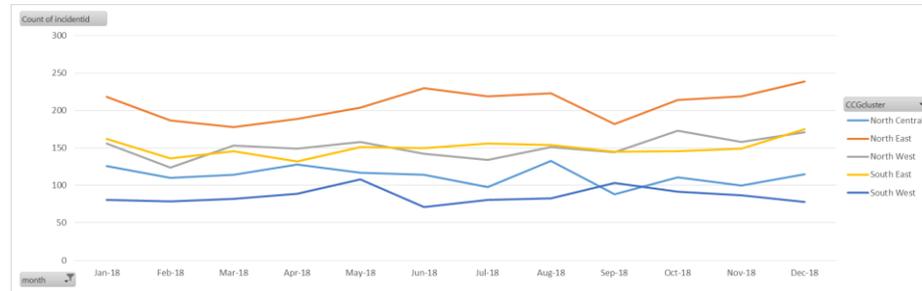


Head out and visible conveyance

Latest Month:
75% (n=26)



Data Source: Incidents



Highlights

Cord Prolapse:

We responded to a call to a pregnant woman 27 weeks gestation

From the EMD to the Paramedic to the Maternity Unit

Baby born in good condition, Mother and Baby Well

TEAM LAS

Exceptions (Improvement Required):

- Monitoring of the new HCP maternity requests

All maternity team trained in Agile PM – ready for Launch of Maternity Pioneer

ACTION: Follow up with Quality Assurance team

Outstanding

- Obstetric Emergency audit in progress



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

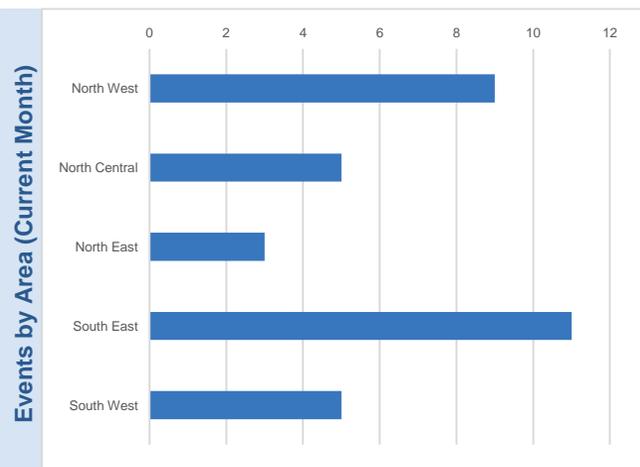
In January we held 33 events across London covering the following types of activity:

Engaging with different groups:

- School visits: Nursery, primary and secondary schools
- Faith groups: Baptist church and Jewish group in a synagogue

Projects on specific topics:

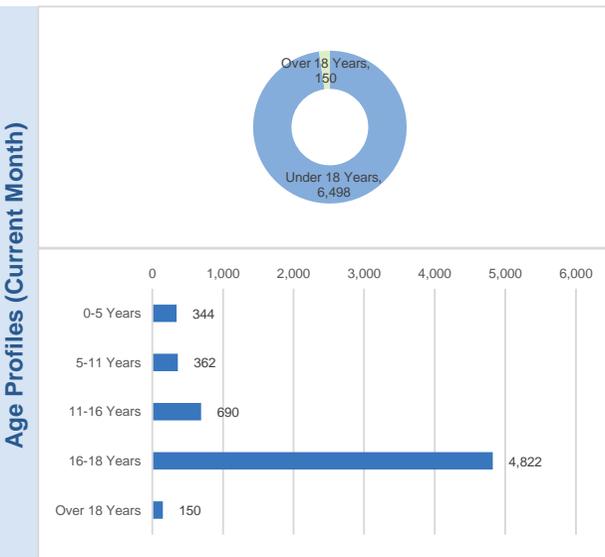
- Knife crime: Your Life, You Choose Prince's Trust project
- Road safety: Safe Drive, Stay Alive held in four areas (Harrow, Waltham Forest, Haringey and Greenwich)



Public Engagement Activities

Supplementary information

No. of public engagement events: year to date (April – January 2019)	476
Approximate audience numbers (January 2019)	6,648
Approximate audience numbers: year to date (April 2018 – January 2019)	73,679
Public engagement: no. of hours (January 2019)	130
No. of staff on LAS Public Education Facebook group	736
No. of staff on contact list	1,436



Headlines from January

Two new members of staff joined the team in January 2019 in the co-ordination role: James (Jim) Maskell and Amy Clarke. They both have a wide range of experience in different roles within the LAS and prior to their career in the Service.

January saw the re-commencement of Safe Drive Stay Alive (SDSA) in a number of boroughs. This presentation was developed to reduce the number of young people killed and seriously injured in road traffic collisions.

SDSA is a multi-agency project, involving collaboration between local boroughs, the Metropolitan Police Service, the London Fire Brigade, the London Ambulance Service and Transport for London. It also includes testaments from a bereaved parent and a survivor of a collision.

The presentation was designed to effect change in school student's attitudes to driving and road safety as they start to consider learning to drive. It takes place at a local theatre and is a powerful full 90 minute stage production. The production uses a filmed reconstruction of a crash involving young people with footage of the services attending. This is interspersed by a police traffic officer, a paramedic and a fire-fighter who come on stage to give an account of their personal experiences. By having the event in a theatre we are able to get the message across to large audiences of 300-600 people.

The audience should leave knowing the risks, be able to identify the common causes for crashes and prevention strategies.

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	Nov-18	Dec-18	Jan-19	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Data Quality
Rate of Frequent Callers per 1,000 Calls			3.73	3.8	3.5	3.6	↑				
Number of Frequent Caller calls			19414	6238	6753	6255	↓				
Total Frequent Callers			6065	613	607	617	↑				
Number of Public Engagement Events			329.00	66	66	33	↓				
Number of service re-design projects involving patients/public			35	5	5	5	↔				
Number of LAS accesses to CMC care plans			3870	542	217	0	↓				
Rate of Complaints per 1,000 incidents			0.9	0.8	0.8	0.9	↑				
Complaints Response (35 Working Day Breach) YTD			261	22	18	33	↑				
Complaints Acknowledged within 3 working days			100%	100%	100%	100%	↔				



Owner: John O’Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

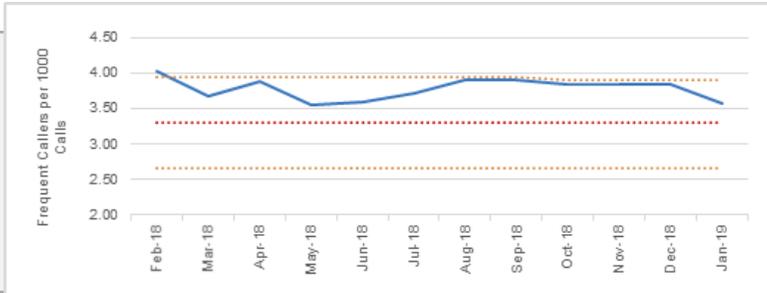
Responding effectively to frequent callers is a significant challenge and one that requires support from our various partners. We have a dedicated Frequent Caller Team working alongside a number of ‘High Intensity User’ initiatives across London, all aiming to better support these patients and ensure 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:
3.57



Calls from Frequent Callers as a proportion of total calls to LAS = 3.57 for January 2019

CHART KEY
 — Monthly value
 Mean (Baseline FY17/18)
 Upper and Lower Limit (Baseline FY17/18)

Data Source:

Frequent Caller Team (FCT) January 19 updates:

Last month the Frequent Caller Management Database (FCMD) identified 617 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 High Intensity User forums to discuss patient behavior, call rates, and formulate multi-agency strategies to reduce calls to LAS.

Positive developments:

A Frequent Caller Manager for North East sector has now been appointed.

The use of Coordinate My Care continues to be rolled out across London with GPs, acute trusts and mental health trusts specifically. This will ensure a holistic approach to patients care and treatment.

Challenges:

Utilisation of Coordinate My Care (CMC) as the pan London repository for shared access to care plans continues to grow however there are some notable gaps being addressed at a regional level.

Familiarisation and training continue to be key challenges for LAS and this is an ongoing focus for the Trust.

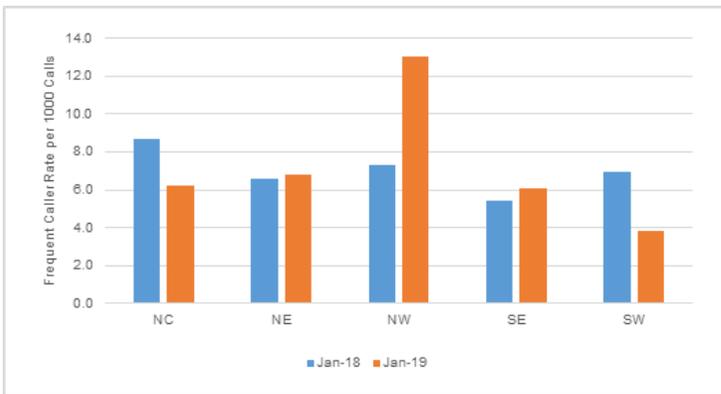


Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Trisha Bain

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 most frequent caller in the last month

Sector	CCG	Patients	Jan-19	Calls last quarter	Calls last 12 months	12 month cost	
NW	HOUNSLOW CCG	18	494	1186	3828	£206,159	
NW	HILLINGDON CCG	23	418	1039	2234	£266,709	
NE	CITY AND HACKNEY CCG	32	369	1379	3955	£422,745	
NW	HAMMERSMITH AND FULHAM CCG	31	369	983	2551	£392,743	
NC	ENFIELD CCG	28	356	989	2923	£273,876	
SE	LAMBETH CCG	23	269	798	2443	£263,311	
NC	HARINGEY CCG	25	255	766	2282	£274,251	
SE	BEXLEY CCG	9	252	359	778	£68,367	
SW	CROYDON CCG	33	248	911	2707	£319,763	
NW	WEST LONDON CCG	24	248	702	3607	£310,260	
NW	CENTRAL LONDON (WESTMINSTER) CCG	20	238	946	2291	£217,666	
SE	SOUTHWARK CCG	23	238	524	1645	£194,802	
NW	EALING CCG	21	228	578	2036	£231,268	
NC	BARNET CCG	28	202	644	2147	£240,147	
NE	NEWHAM CCG	22	176	687	1852	£260,180	
SE	LEWISHAM CCG	16	157	456	1600	£194,865	
NW	HARROW CCG	14	153	307	1018	£114,172	
NE	BARKING AND DAGENHAM CCG	18	138	430	1063	£153,441	
NE	HAVERING CCG	15	138	573	1774	£252,307	
NC	ISLINGTON CCG	27	136	700	2033	£298,190	
SE	GREENWICH CCG	20	134	555	1739	£286,535	
NE	WALTHAM FOREST CCG	13	129	419	1531	£119,181	
SW	MERTON CCG	15	128	346	813	£113,007	
NE	TOWER HAMLETS CCG	12	122	327	914	£123,467	
NC	CAMDEN CCG	20	121	411	1019	£137,581	
SW	WANDSWORTH CCG	18	119	442	1247	£159,713	
NW	BRENT CCG	18	111	421	974	£115,455	
SW	RICHMOND CCG	8	103	263	1031	£77,374	
NE	REDBRIDGE CCG	17	95	294	954	£127,348	
SE	BROMLEY CCG	8	45	202	438	£60,272	
SW	SUTTON CCG	9	36	208	453	£71,637	
SW	KINGSTON CCG	9	30	124	365	£55,231	
TOP 5							
SE	BEXLEY CCG	48 (m)	185	216	429	£18,698	Chest pains, Learning Disability
NW	HOUNSLOW CCG	65 (f)	170	602	2264	£23,859	Diabetic problems, chest pain, Learning Disability
NW	HILLINGDON CCG	66 (m)	94	214	618	£77,336	Chest pains, anxiety
SE	LAMBETH CCG	65 (m)	90	269	800	£55,536	Falls, unwell, Learning Disability
NW	CENTRAL LONDON (WESTMINSTER) CCG	92 (f)	89	483	949	£46,459	Breathing problems, Anxiety

Data Source:



CASE STUDY – Mr R

Presenting Situation

48 year old male with possible learning disability and anxiety.
 Lives alone in sheltered housing with no acute medical problems.
 Identified as a frequent caller in 2014.
 12 month total to January 2019 = 429 calls, costing £18, 698. Conveyed to hospital over 36 times in 12 months.
 Chief complaints when calling: 'Unknown', Psychiatric, Breathing problems
 Presenting issues when crews attend: Intoxicated, suicidal, Anxiety, loneliness & unable to cope.
 Patient calls late afternoon and early evening.

Intervention

LAS requested a review with community health and social care, and a referral to psychology at local hospital.
 Numerous multi-disciplinary meetings held since April 2017.
 Due to his transient nature he was assigned three different social workers in three London Boroughs.
 Local Social Services manage patient's finances, housing and spending.
 Local High Intensity User (HIU) Project initiated, offering intensive keyworker support in September 2018, showing an initial positive impact on calling behaviour.
 Frequent Caller team continued to monitor calls and liaise with keyworker.
 A further multi-disciplinary meeting was held in November 2018 due to patient's physical and mental condition deteriorating. Further clinical investigations pending.
 Patient was imprisoned due to public nuisance, aggravated assault and misuse of emergency services. (12 weeks sentence, six weeks served)

Outcome

Local HIU intervention initially led to a significant drop in calls.
 Patient disengaged from the HIU project before prison sentence.
 Since being released from prison he has started calling at an escalated rate. Probation service arranging multi-disciplinary meeting.
 HIU Project keyworker felt there was nothing more that could be offered if the patient refuses to engage.
 On his recent release from prison a new Social Worker has been reassigned min one of the boroughs.

Challenges /
Areas for
Development

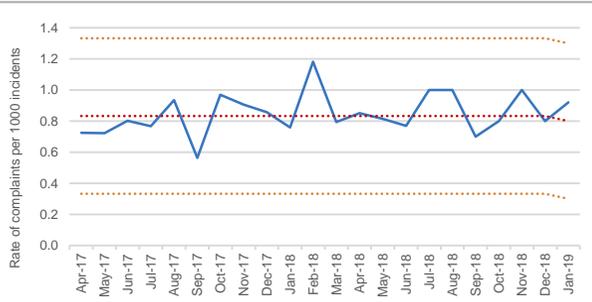
A patient with capacity to make decisions around their care may not realise the impact they have on local resources until brought to their attention through more robust mechanisms. They may however choose to continue to make demands on emergency services.
 A custodial sentence (or the threat of such legal action) can be an effective deterrent for some patients. However, other patients' behaviour may not be significantly modified by such action and ongoing attempts at engaging them in the community must continue.



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: **0.9**

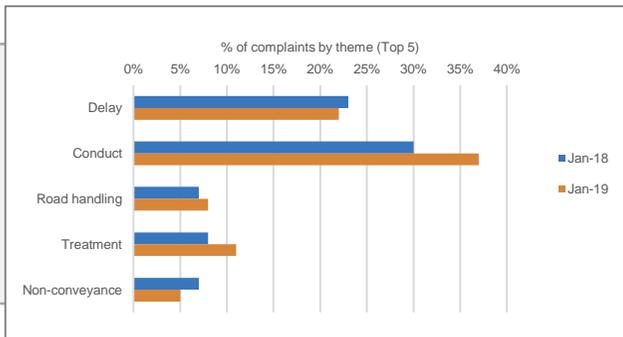


In January we received 92 complaints, slightly more than December (80) but in line with the average per month (83).

We managed 397 PALS which is higher than the annual monthly average of 366 per month, this reflects the increase in call rates over the past two months.

31 Health Partner Alerts were also received during January (the highest number this year) - there have been 190 approaches under this auspices in 2018/19. We are undertaking an analysis of these cases involving concerns at the C2 categorisation under ARP which involves the addition of sub subject codes into Datix.

Categorisation



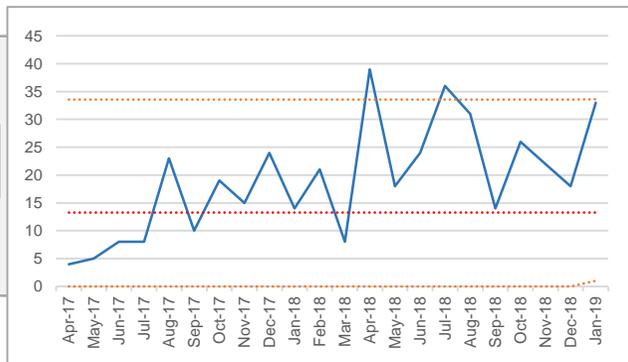
The percentage of complaints regarding **conduct and behaviour** continue to increase. During December there were 30 in this category against 20 'delay' complaints. This is consistent with the trend for 2018/19. The monthly average for conduct complaints is now 26 against 15 for complaints.

By comparison in 2014/15 the average delay complaints was per month was 63 and for conduct and behaviour it was 25.

There were 10 complaints where the main concern was treatment against the annual average of 9

Responding to complaints

Latest Month: **33**



There were **33 complaints that breached the 35 day response target** in January this represents an annual average of 34% out of time.

This increase is partly attributed to the exceptional demands on the Service this month affecting receipt of crew comments, QA reports and clinical opinions.

The increase in both complaints, Quality Alerts and PALS this month has also impacted on throughput in the department.



Data Source:



Case examples

Case Examples of Financial remedy in January

Example one

The patient's daughter complained that the attending staff accidentally damaged the patient's stair lift when removing the patient from the property. The attending staff were a St John vehicle attending on our behalf. We have agreed that St John Ambulance would reimburse the family on receipt of an itemised invoice.

Example two

The patient's son complained that due to confusion over the repatriation booking of his mother who was returning from abroad, resulted in the family booking a private ambulance which incurred substantial costs. We erroneously agreed to arrange the ambulance, unfortunately the booking did not meet the eligibility criteria for us to arrange an ambulance and the family had no option but to book a private vehicle. The other agencies involved declined to contribute. As the primary responsibility lay with our mistake, we agreed to compensate the family and are currently awaiting their confirmation of acceptance.

Example three

The patient's son complained that the patient was expected to walk to the ambulance and as she did so she caught her finger in the door and fractured it. Although this was an accident, the crew should have considered using a wheelchair for the patient and failed to log an incident report. We have offered a compensatory payment in keeping with the Ombudsman's guidance.

Actions and Learning

Parliamentary Health Service Ombudsman.

- Currently 11 cases are with the HSC – either under investigation or where they have requested our file to ascertain whether they will need to undertake a full investigation
- We have added a revised set of outcomes for Ombudsman cases to include financial remedy. (see examples above)
- We expect this area of findings to increase in the future

Improving feedback and monitoring

- Since the introduction of the on-line feedback form, we have received one very positive response from a complainant
- The on-line lost property form has been slightly amended and is proving to be popular with our patients with 36 being managed so far.
- We have applied for a new code in Datix to reflect the two methods of feedback (on-line/printed form) which will be used later this year to see whether the printed version can be phased out.

Staff learning

The team attended a departmental Away Day where we designed a 4 point plan to improve throughput and influencing learning and dissemination opportunities from patients and service user feedback.

Case officers will meet later this month to work on the areas raised in the driver diagram we have prepared and discuss how we can address our aims and prepare proposals to improve a wider understanding of what we do and how we can drive efficiencies.

Further to this, the team have also prepared a culture strategy aiming to improve engagement with contributory departments, to challenge obstacles and encourage a more responsive culture and to develop better internal and external feedback.

We will support a small cohort from the team to liaise with partner contributors, to produce an expectation list of behaviours that we aim to commit to and that we expect of others and to shape our processes around our contributors and how we can improve those.

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.*



Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley



From Jan 2018 – Dec 2018 we have received 318 Excellence Reports
 Operations are the largest group to report and receive Excellence Reports
 Excellence Reports have been used to not only thank staff for their outstanding demonstrations of excellence but also they have featured in INSIGHT magazine in order to share learning and promote learning from excellence.
 We have seen a significant reduction in the number of report received in January 2019 comparable to November however these number are still higher Jan 2018. Reduced promotion and sharing of Excellence Reporting on LIA is a considerable factor.

Some examples of excellence reports:

Reported from operations about the MPS

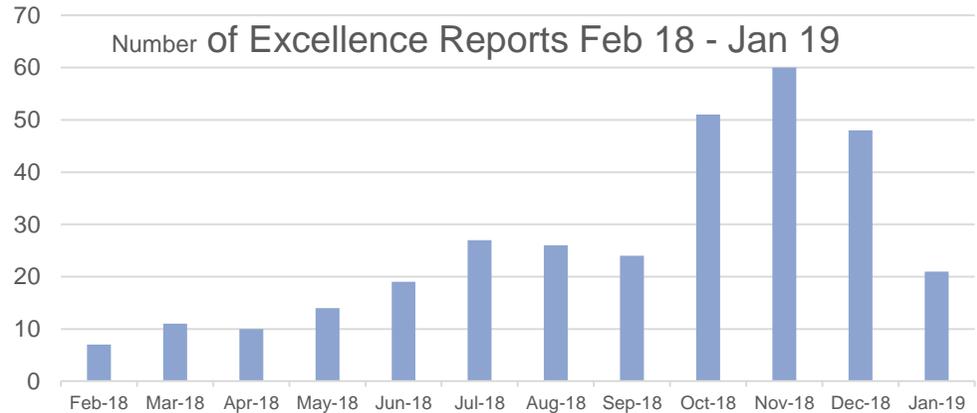
The police officers did a fantastic job in assisting the LAS, predominantly with chest compressions and other clinical tasks. *The police were calm, confident and precise in what they did and enabled the LAS to provide a wider care package.* Without the police and their assistance, the call would have been even more challenging and I am more than grateful for their attendance. It is always a pleasure to work alongside the police and this was the best example of how joint working can be so effective.

Reported about control services

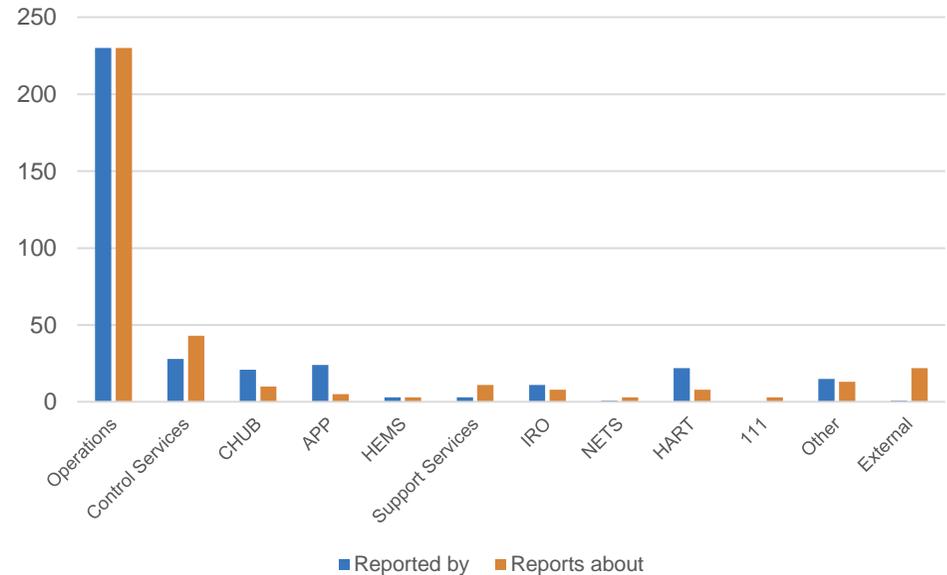
Their work that they have been doing when assigned to the IC Desk has been invaluable. He is *proactive* in assisting with preventing bottlenecks at hospital as well as doing everything he can to maximize availability which in turn provides us with resources to attend to our patients that are waiting for us. *They are conscientious and works extremely hard*

Reported from an external about operations

Their professionalism and calmness was really a spectacle to behold, and I really wished that every resuscitation attempt I have in hospital ran as smoothly as this one did! So please pass on my thanks to them - I was also really appreciative to have been welcomed in to the debrief afterwards with the crews and the CTL leading was very knowledgeable and did led it well. I think what this experience has done for me is highlighted that perhaps I need a career change in to the pre-hospital arena!



Staff groups reporting/being reported for Excellence Since Feb 17





Exec Lead: Dr. Trisha Bain & Dr. Fenella Wrigley



Currently the South East Sector have submitted and received the highest number of reports since we moved to Excellence Reporting in August 2018.

The Learning from Experience group meets monthly to discuss emerging and recurrent themes to devise innovative new ways to ensure dissemination of information and learning from serious incidents. This group has led to the following initiatives:

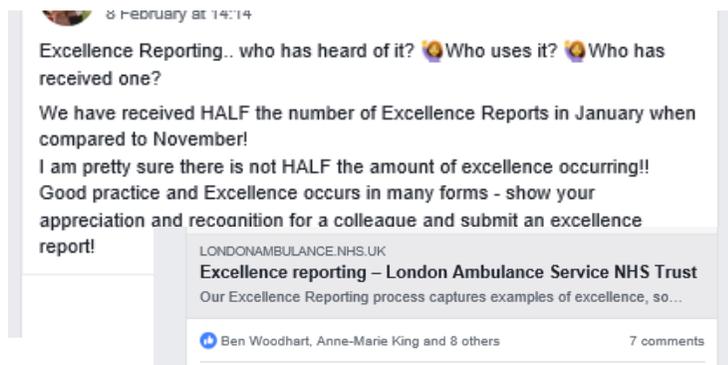
The “perfect PRF” workshop – a practical workshop ran by a member of LfE with APP (urgent care) support. Front line staff can learn some useful tools to enable the to complete more comprehensive paperwork which is more representative of their clinical encounter. To date 5 workshops have taken place accommodating 103 staff

Case based discussion events (INSIGHT live) – occur at a local level with facilitation by a member of LfE. An element of teaching regarding a specific topic i.e. human factors, mental health, followed by a case reviews. Cases are from serious incident investigations or the re-contact audit.

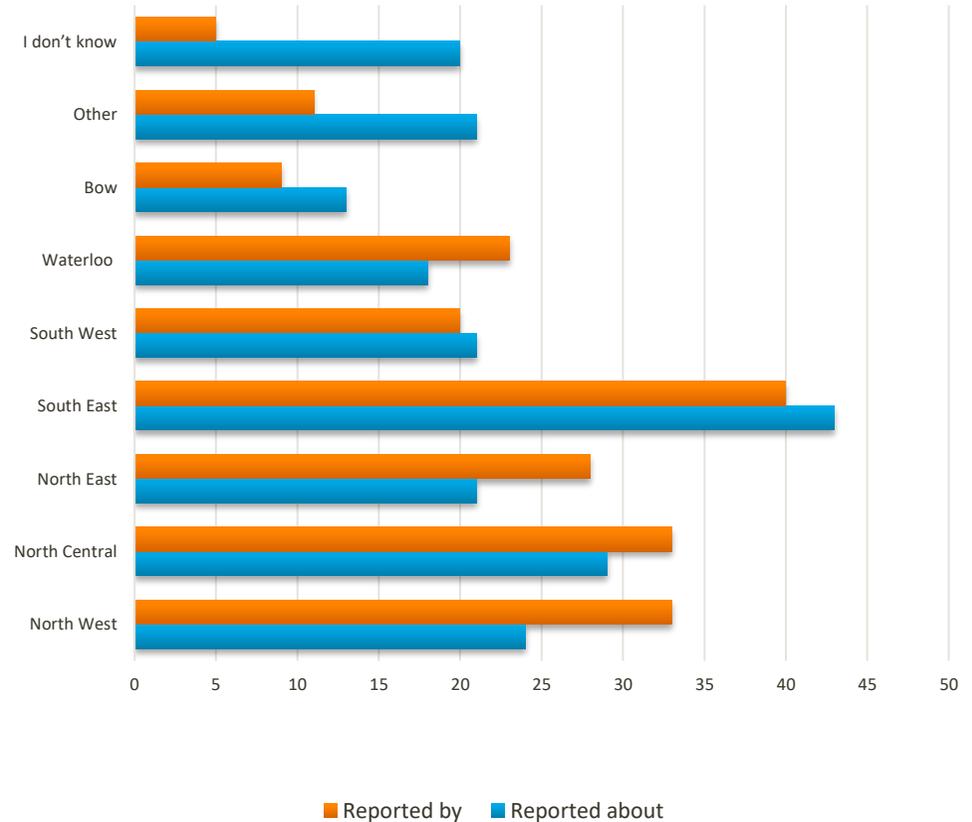
Staff engagement on social media – utilising social media to create a positive workplace culture. For example asking what staff would consider as “always event” (the opposite to a never event) some answers were as follows:

“Always go home smiling if you can and knowing that you’ve done the best you can”

Social media is a great way to promote Excellence Reporting. After noticing a dip in reports in January a simple message on LIA lead to 9 reports being submitted over the three following days



Sector/Location of reports (since August 18)

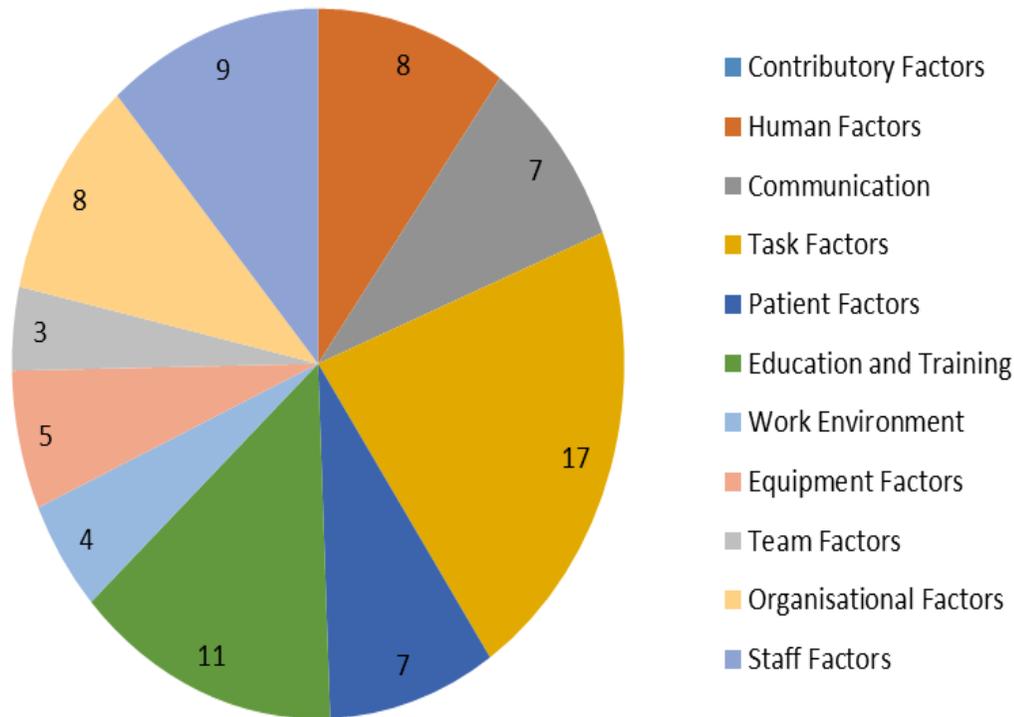




The Quality, Governance & Assurance Team (QGAT) has worked hard to ensure SI investigations are aligned to key internal milestones and external deadlines. As of November 2018, the Trust had over the last 13 months submitted all SI reports within the 60 working days required. There was one breach in December due to a number of factors including competing priorities in the workload of Lead Investigators.

The SI process pathway is being reviewed to confirm milestones, responsibilities and to formalise key points of escalation to ensure the milestones are met.

Trust wide contributory factors



Overarching Serious Incident Themes

Task factors continue to be the highest occurring contributory factor with an increase from 12 in Q2 to 17 in Q3.

These relate mostly to staff not complying with policies and procedures in place and not due to the absence of appropriate policies. The majority are due to staff not being cognisant with the application of these policies to certain scenarios. There has therefore been an increase in the use of case studies on SIs for shared learning across the Trust.

The Learning From Experience Group is being disbanded and a new SI Learning Assurance Group which will report into the Quality Oversight Group (QOG) is being formed with the first meeting in January 2019. One of the main objectives of this Group is to ensure that the actions generated from recommendations from SI investigations are effectively implemented and embedded and the learning is shared across the Trust.

Top 5 SI Contributory Factors



Inquests

Latest Month:
1.1

	2017-18			2018-19				
	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan
Total Prevent Future Deaths in Month	0	0	0	0	0	0	0	0
Total Inquests where LAS asked to give evidence - In month	4	6	4	3	8	6	3	6
Total Inquests where LAS asked to give evidence - Year to date	43	49	53	56	40	46	49	55

- No PFD reports were issued against the Trust in January.

Claims

The NHS Resolution Quarterly Report, Q3 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

No of claims	Total Claim	Damages Reserve	Claimant Costs Reserve	Defence Costs Reserve	Outstanding Estimate	Total Payments
51	£93,595,465	£83,599,292	£7,795,208	£2,200,965	£75,890,588	£17,704,876

No of claims	Total Claim	Damages Reserve	Claimant Costs Reserve	Defence Costs Reserve	Outstanding Estimate	NHSLA Funded Payments	Total Payments
51	£2,583,881	£1,737,013	£668,868	£178,000	£2,324,640	£237,581	£259,241

- In January, 2 clinical claims were reported to NHSR these concerned delay in attending a patient and the availability of equipment on Ambulances.
- There were 3 Employer's liability claims opened by NHSR in January 2019. These concerned an injury sustained whilst in a moving ambulance, and two slip/trip incidents.
- NHSR closed 2 employer's liability claims with damages these concerned a manual handling injury and an electric shock. 3 Clinical claims were closed, 1 settled with damages and concerned injuries further to a fall and the remaining 2 were closed without damages.

6. Quality Action Plan, Projects & Programmes

To further enhance the quality of our organisation we have put in place a comprehensive action plan to enable the Trust to continue its journey to move from Good to Outstanding in the CQC ratings by 2020.

This sections summarise our progress against these actions during FY18/19 along with the key projects and programmes that will directly support the delivery of this plan.



Programme	RAG	SRO	Summary
Pioneering Services	Green	Trisha Bain	There is an allocation in the 2018/19 budget for each pioneer service of £24k, this funding is insufficient to finance the paramedics and kitted vehicles required for pilots. These need to be funded from the operations budget. Meetings are taking place with Murray Keith to ensure that business planning takes account of the project plans for the pioneer services in 2019/20.
#ProjectA	Green	Trisha Bain	The National programme is being aligned with existing projects within the Pioneering Services programme to establish a standardised framework regarding falls and mental health.
Connecting Clinicians	Amber	Fenella Wrigley	Suppliers evaluation is scheduled to commence on 28 January. FBC is on track to be approved at the March board. Meetings have been held with key stakeholders to start to build the benefits case. Focus on the processes surrounding the management of iPads, release management of applications has been increased as the programme recognises that robust processes must be in place to support the effect deployment of ePCR, SCRa, NRLS and One London. SCRa is scheduled for go live on 15 April. Further engagement with the national programmes.
Integrated Urgent Care (111)	Amber	Fenella Wrigley	IUECS Programme is progressing to completion and being closely monitored as AMBER. Final SEL Mobilisation CDSS and Telephony deliverables are in place and testing is on-going.
Contract Management	Amber	Lorraine Bewes	Some stakeholders haven't responded to request for information. Communication to be issued by Lorraine Bewes to remind stakeholders of the importance of supporting procurement and the value of their contribution as the service user / budget holder.



Programme	RAG	SRO	Summary
Spatial Development	Amber	Benita Mehra	Delays in 3rd Floor fit-out tender process have caused delay in programme start – space utilised to support Bow UPS programme and conference room refurbishment. Interim works completed for Operations in HQ. 3rd Floor fit-out due to commence 11th February.
Ready Set Go	Red	Benita Mehra	Secure Drug Rooms: 25 rooms are now complete with 5 rooms in planning and has included an additional station to align with the VP hubs due to be complete in September 2019. Phase 2 of the project is currently also in planning 15 locations are being considered at £1.275m. Multi-dose packs: The business case for the pouches has been approved subject to business benefits and financials. The Advanced Life Support bag will have a phased delivery beginning in March 2019 in preparation for roll out in April 2019. Kit prep: The logistics packing app has been installed, however unable to test fully by the logistics staff due to connectivity issues.
Vehicle Preparations	Green	Benita Mehra	Minor delays in roll out of the cupboard seals and vehicle based forms for DCA vehicles, to be fully implemented in January 19. Repair and secure existing bunkered fuel sites - managed service sought for EU Exit.
IM&T Essentials	Amber	Ross Fullerton	There are risks on a number of projects due to unidentified inter-project dependencies. Redbox, Avaya and HSCN all have financial signoffs required due to extended delivery time frames. Dependency workshop being setup to identify and map all current dependencies between projects and BAU activities.

7. 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.

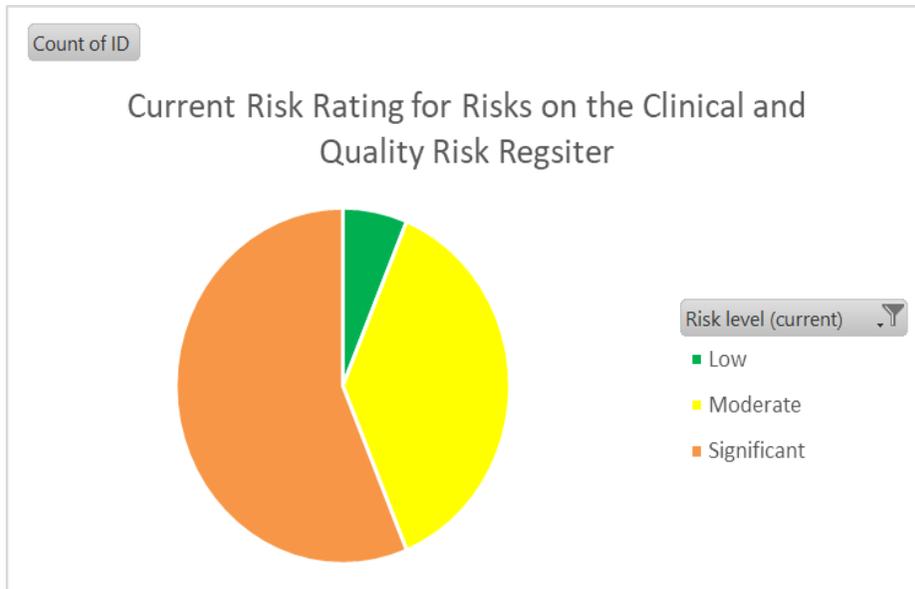


There are currently 48 overall risks on the clinical and Quality Risk Register, this is all risks from all departments within the Medical and Quality Directorates. Of these 48 risks there are 13 that have a current risk grading of 12 or above.

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