MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST <u>PUBLIC</u> BOARD OF DIRECTORS

Tuesday 28 July 2020 at 9.30am – 11.30am via video-conference

Agenda: Public session

Timing	Item		Owner		Status
9.30	1.	Welcome and apologies	HL	Verbal	
	2.	Declarations of interest	All	Verbal	
	3.	Minutes of the public meeting held 26.5.20	HL	Enclosed	*Approval*
	4.	Matters arising	HL	Enclosed	
9.35	5.	Report from the Chair	HL	Enclosed	*Information*
9.45	6.	Report from the Chief Executive	GE	Enclosed	*Assurance*
9.55	7.	Report from the Chief Operating Officer	KM	Enclosed	*Assurance*
Director and Board Committee Reports					
	8	**<u>Director and Board Committee Reports</u>** *(Integrated Performance Report)*			*Information / Assurance*
10.10		<u>8.1. Quality and Clinical Care</u> • Directors Report • Quality Assurance Committee meeting & Terms of Reference	TB / FW MS	Enclosed Enclosed Enclosed	
10.20		<u>8.2. People and Culture</u> • Directors Report • People and Culture Committee	ALS JM	Enclosed Enclosed	
10.30		<u>8.3. Finance & Audit</u> • Directors Report • Finance & Investment Committee • Audit Committee	LB FC RP	Enclosed To Follow Enclosed	
10.45		<u>8.4. Logistics and Infrastructure</u> • Logistics and Infrastructure Committee & Terms of Reference • Digital 999 Status Update • Programme Assurance Committee	SD KM SD	Enclosed Enclosed Enclosed	

Timing	Item		Owner		Status
10.55	9.	**Annual Financial Plan 20/21**	LB	Enclosed	*Approve*
Stakeholder Engagement					
11.05	10.	**Stakeholder Engagement**	HL / Dame Christine / AT	Enclosed	*Information*
Governance and Risk					
11.20	11.	**Governance and Risk** 11.1. Board Assurance Framework 11.2. Corporate Risk Register	SDa TB	Enclosed Enclosed	*Approval* *Information*
	12.	**Any other business**	HL	Verbal	*Information*
		Meeting close			

Date of next meeting:

The date of the next Trust Board meeting in public is on Tuesday 29 September 2020.

Additional reports, circulated for information only:

- Safeguarding Annual Report
- Serious Incidents Update

TRUST BOARD: Public meeting – Tuesday 26 May 2020

DRAFT Minutes of the public meeting of the Board held on 26 May 2020 at 10.00am, via Video Conference

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Trisha Bain	TB	Chief Quality Officer
Lorraine Bewes	LB	Chief Finance Officer
Karim Brohi	KB	Non-Executive Director
Fergus Cass	FC	Non-Executive Director
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
Amit Khutti	AK	Associate Non-Executive Director
Jayne Mee	JM	Non-Executive Director
Khadir Meer	KM	Chief Operating Officer
Rommel Pereira	RP	Non-Executive Director
Mark Spencer	MS	Non-Executive Director
Fenella Wrigley	FW	Chief Medical Officer
In attendance		
Syma Dawson	SDa	Director of Corporate Governance
Victoria Moore	VM	Corporate Governance Manager
Apologies		

Welcome and apologies

1. The Chair welcomed all to the meeting and noted that in light of the COVID-19 pandemic, the Board is functioning by virtual means on this occasion and shall seek to include members of the public at the next meeting in July. The Director of Corporate Governance noted that public Board papers were published on the website with a message inviting members of the public to submit questions ahead of the meeting however, no questions had been received.

Declarations of interest

2. There were no interests declared in any matter on the agenda.

3. The minutes of the meeting held in public on 28 January 2020 were approved as an accurate record of the meeting.

Matters Arising

4. The Board reviewed the action log.

5. Consideration was given to the action in respect of Trust wide training costs and associated abstractions. The Board recognised the complexity of the matter and supported the closure of the action with the creation of a new action to reflect the current Trust position.

Action: Fenella Wrigley (FW), Chief Medical Officer, to review and reframe training action in advance of 28 July 2020 Trust Board meeting.

6. The establishment of a Youth Forum has been paused during the COVID response period and will be further considered in line with production of Stakeholder Engagement Strategy.

7. The draft flu vaccination plan had been shared with the People and Culture Committee for oversight and the Trust awaits further information from the centre in respect of potential vaccine mandating.

8. Finally the Board discussed national procurement of double crewed ambulances (DCA) recognising that this action was suitable for closure as the position had been superseded by the suspension of the national programme. The Logistics and Infrastructure Committee will continue to review the position.

Chief Executive's Report

9. The Board received the Chief Executive's Report noting the provision of a high level summary of Trust actions since the last Trust Board meeting and recognising the significant impact of the pandemic response particularly during March 2020.

10. Members discussed serious incidents and the associated review process, seeking confirmation that duty of candour had been applied; it was confirmed that this process had been applied. Members were further informed that the Quality Assurance Committee had agreed to hold an additional meting to specifically focus on this matters and to seek further Board Assurance.

11. Notwithstanding the acknowledgement of the challenges the Trust faced, the Board recognised that the clinical care delivered by the Trust had been exceptional and that whilst responding to unprecedented volumes of calls, CAT 1 responses had been maintained.

12. The Board were informed of the procurement and supply chain challenges, noting the changes in FFP3 masks from those fit tested to those supplied as well as the process of further fit testing. Assurance was provided that the position had now been recovered. Other PPE quality challenges were discussed and Board members were informed that despite these challenges, the Trust supply chain had met the demand and that the Trust had been in a position to provide mutual aid to others who were not in the same position.

13. The Trust's financial arrangements and challenges were discussed and the Board recognised the measures in place and efforts being taken to sustain the Trust's financial position.

14. The Chief Executive recognised the support received by the Trust from other organisations and added that this support has enabled the London Ambulance Service to deliver its patients and communities the best service possible.

15. The Board extended their thanks to the Chief Executive, Executive team, Staff, Volunteers and Partners who had all provided a valuable contribution to the delivery of the peak COVID-19 pandemic response in London.

16. Finally, the Board were notified that Katy Crichton had been appointed the interim Head of Wellbeing to ensure that the wellbeing of the Trust's staff remain a continued area of focus.

Trust Board Committee Assurance Reports

Audit Committee meeting on 20 April 2020

17. Rommel Pereira (RP), Non-Executive Director, and Chair of the Audit Committee, presented a report of the most recent Audit Committee meeting to the Board, noting that the Committee will continue to monitor COVID-19 related finances and have sought presentation further of a bridge between M11 position and current outturn, including a 2 year forward view.

18. The Standing Financial Instructions and Scheme of Delegation were reviewed and are presented to the Board with a recommendation to approve and the Committee has asked that the Executive review the internal audit plan in the context of the 'new normal'.

19. The Board were informed that the Head of Internal Audit Opinion provided significant assurance with some improvement.

People and Culture Committee Weekly calls

20. Jayne Mee (JM), Non-Executive Director, and Chair of the People and Culture Committee, presented a report of the most recent People and Culture Committee meeting to the Board, noting that during the peak pandemic response the Committee's duties had been conducted via weekly meetings, with the frequency adjusted to fortnightly as necessary. The forward plan will be to hold another meeting in June and resume to the regular meeting format and cycle from July.

21. The Committee has monitored abstraction rates and recognise that these levels are now manageable, although there are still a number of staff shielding or in isolation. The highest levels of sickness are reported in 111 and Fleet. The Fleet position is understood however a deep dive into 111 has been commissioned to further understand and address any underlying issues.

22. People and Culture directorate resourcing has been reviewed with concern raised in respect of use of long term consultants; members recognised the need to backfill the posts and that this will be taken forward. Additionally, Trust resourcing particularly in respect of the new clinical and operating model overlaid with surge capacity requires further monitoring and recruitment issues have been discussed with risks to international recruitment and paramedic provision for Primary Care Networks.

Quality Assurance Committee meeting on 05 May 2020

23. Mark Spencer (MS), Non-Executive Director, and Chair of the Quality Assurance Committee, presented a report of the most recent meeting of that Committee to the Board, noting matters for escalation.

24. The Committee considered staff wellbeing and proactive screening and members challenged the speed of progress. This was further discussed recognising that People and Culture Committee have also discussed the matter and raised the same challenge. It was confirmed that an application is being introduced that will address the requirement and the Board will be updated as implementation progresses.

25. Finally, as noted in the Chief Executive update, the Board were notified that the Quality Assurance Committee has agreed to hold an additional meeting to provide concentrated review of serious incidents.

Digital 999 Programme Assurance Committee on 07 May 2020

26. Sheila Doyle (SD), Non-Executive Director, and Chair of the Digital 999 Programme Assurance Committee, presented a report of the most recent meeting of that Committee to the Board, noting that the Assurance Committee has two independent members and that the programme status of both CAD and ePCR is amber.

27. ePCR programme slippage is being recovered and the planned go-live date is September 2020 is deemed achievable with July 2020 checkpoint in place to review. Members were reassured that changes to the system have been limited to terminology adjustments and the system remains similar to that of other Trusts.

28. The CAD programme remains in high level design stage with programmed delivery April 2021 and further review point July 2020.

Logistics and Infrastructure Committee meeting on 12 May 2020

29. Sheila Doyle (SD), Non-Executive Director, and Chair of the Logistics and Infrastructure Committee, presented a report of the most recent meeting of that Committee to the Board, noting that the meeting had focussed on existing CAD and Telephony review.

30. An approach to proceed with technical hardware only changes to the CAD had been supported as this will provide the current system with greater resilience and minimise risk. In respect of telephony, the Committee identified the requirement to upgrade to CM7, replace call recording systems and provide an improved platform for use.

31. The Committee identified the requirement to receive an integrated plan to understand constraints and resource requirements, and requested that this is delivered to its July meeting.

Finance and Investment Committee meeting on 21 May 2020

32. Fergus Cass (FC), Non-Executive Director, and Chair of the Finance and Investment Committee, presented a report of the most recent meeting of that Committee to the Board, noting matters for escalation.

33. The Board were informed that the 2019/20 financial position had concluded with improved position against the forecast, and that this had been enabled by receipt of all COVID-19 related costs and further to this the Trust has met all statutory duties.

34. The Committee recognised the need to further review contract position to support the ongoing COVID-19 response and to benchmark costs which will be reviewed by Internal Audit.

35. The Board were notified that the Finance and investment Committee were satisfied that under current arrangements the Trust will continue to 'break even' until July 2020 and that post-July, financial planning will be carefully considered in accordance with national and regional updates. This also applies to the Capital position and the Committee has recommended that the capital programme is addressed urgently.

Board self-certification

36. The Director of Corporate Governance reported that NHS Trusts and NHS Foundation Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence. The purpose of self-certification is to ensure that providers carry out assurance on whether or not they can confirm compliance.

37. A detailed response to the requirements of Conditions G6 and FT4 of the NHS provider licence were provided and the Board notified that the Executive Committee had reviewed the submission and agreed that the Trust is compliant with Conditions G6 and FT4 of the NHS provider licence and had recognised that the Head of Internal Audit Opinion clause and Going Concern position requires further review and confirmation.

38. The Board approved the self-certification in principle and recommended that the Audit Committee review and provide final approval to endorse the Chair and Chief Executive to sign.

Resolution
NHS Provider licence approved in principle with recommendation that the Audit Committee provide final approval to endorse the Chair and Chief Executive to sign.

Standing Financial Instructions and Scheme of Delegation

39. The Standing Financial Instructions and Scheme of Delegation were presented to the Trust Board for approval, noting that they had been reviewed and approved by the Finance and Investment Committee and Audit Committee prior to presentation.

Resolution
Standing Financial Instructions and Scheme of Delegation were approved.

NED Schedule

40. The Director of Corporate Governance presented the enclosed schedule of Non-Executive Director lead roles which had been compiled to provide assurance that the Trust has sufficient Non-Executive Director leadership to conduct statutory and formal roles as required, and that some of these areas are reported via the respective Board Assurance Committees.

41. Members noted the schedule and were asked to provide any feedback following the meeting; clarification to be sought regarding responsibility around Procurement.

Board Assurance Framework

42. This Board Assurance Framework was presented to the Trust Board for review and approval. Changes made since the last Board meeting on 31 March 2020 were highlighted. The Trust Board were asked to note the progress made with the mitigation of the BAF risks and to approve the proposed risk for COVID-19 which reflects the sub-strategic risk assessments reviewed by the Board Assurance Committees.

43. Following discussion, the Board supported the approach to COVID-19 BAF risk and recommended that they are continually reviewed to ensure they reflect the current risk position and are consistent in their risk scoring.

44. Board members were asked to note that the Logistics and Infrastructure Committee had requested further revision of BAF risk 58 and that Finance and Investment Committee had recommended the removal of BAF Risk 57 relating to the 2019/2020 Control Total as this risk has now been superseded by the COVID-19 risk with a focus on achieving the financial trajectory.

Resolution
BAF Risk 57 relating to the 2019/2020 Control Total approved for closure.

Corporate Risk Register

45. The corporate risk register was provided for noting and members accepted the document as presented.

Any Other Business

46. There was no other business.

Review of the meeting

47. Consideration was given to the structure of the agenda, noting that the Integrated Performance Report was circulated as an additional report and not included for discussion as an item on the substantive agenda.

48. Timeliness of papers was considered together with encouragement that papers that had been reviewed by Board Assurance Committees should be presented to the Trust Board with a summarisation of the discussion undertaken at the Board Assurance Committee.

Additional Reports

49. The Board received the following additional reports for information only

- Freedom to Speak Up Quarterly Report
- Patient Experience Annual Report
- Integrated Performance Report

Meeting Close

The next Trust Board meeting in public will take place on 28 July 2020

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	Comments / updates *(i.e. why action is not resolved / completed)*
TB/19/51 para 7.7	Present a report on plans to deliver the national Cat 2 response time, taking into account the existing clinical, medical and operational resources.	Khadir Meer	24/09/2019	24/03/2020	A piece of work is required to understand the modelling framework, the accuracies and inaccuracies and what needed to be delivered to resolve before the requested report can be presented.
TB/19/76 para 8.3	Engage with Karim Brohi (KB), Non-Executive-Director, on the feasibility of establishing a London Ambulance Service Youth Forum.	Anthony Tiernan	26/11/2019	24/03/2020 Defer	This has been delayed due to the impact of the COVID-19 response.
Training	Fenella Wrigley (FW), Chief Medical Officer to review and reframe training action in advance of 28 July 2020 Trust Board meeting.	Fenella Wrigley	26/05/2020	28/07/2020	Education goes beyond Clinical Education and Standards (CES) activities. In fact, majority of CES activities are not abstractions, and the records in GRS attributed to 'training' are often nothing to do with CES plans. It was also more than just an 'operations' cost, as all people in LAS do training and therefore it was felt that P&C should own the action. Proposal to separate into two actions: • What is the total abstraction for training (in patient facing hours) remembering 24 hours are CSR (COO) • What is the finite cost of CES services, and we can help define how much abstraction is needed for our programs (Clinical Education)

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Report from the Chair
Agenda item:	5
Report Author(s):	Heather Lawrence, Chair
Presented by:	Heather Lawrence, Chair
History:	N/A

Status:	☐	**Assurance**	☐	**Discussion**
	☐	**Decision**	☒	**Noting**

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

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) / Decisions for the Board / Committee:

The Board is asked to note this report.

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	**Agreed**		**Relevant reviewer [name]**	
Quality	Yes	No		
Finance	Yes	No		
Chief Operating Officer Directorates	Yes	No		
Medical	Yes	No		
Communications & Engagement	Yes	No		
Strategy	Yes	No		
People & Culture	Yes	No		
Corporate Governance	Yes	No		

Report from the Chair

1. Board membership

I. I am delighted to welcome Jill Anderson as our Associate Non-Executive Director (NED). This follows on from the success of Amit Khutti who initially joined us as an Associate NED and was successful in joining us as a Non-Executive Director in March. Jill brings significant expertise in finance, audit and general management leadership from her continuing executive role in the Pharma industry where she currently undertakes a Chief Financial Officer role.

2. Collaborative working

I. Throughout the COVID-19 pandemic, it has been even more important for Chairs of Boards to liaise and contribute to the national debate, share experiences and to listen and learn from others experiences. Communication with Chairs has been critical throughout and I have been involved and contributed to the following groups:-

- NHSE/I Chairs Advisory Group
- NWL Chairs' Sustainability and Transformation Partnership (STP) Group
- SWL Integrated Care System (ICS) Chairs Group
- NHS Providers Chairs WhatsApp Group
- London Chairs WhatsApp Group
- Association of Ambulance Chief Executives WhatsApp Group.

II. There have been a number of common issues under discussion, including:

- COVID-19 themes such as staff wellbeing and personal protective equipment (PPE);
- Governance and support for the executive teams;
- The development of ICSs ,Governance and their role now and going forward in relation to the statutory duties of the Provider Trusts; and
- Black Lives Matter and Equality and Diversity.

III. As we have progressed through the pandemic, the focus has moved to post pandemic recovery, finance and the impact on NHS staff due to the adverse impact of COVID-19 on staff with protected characteristics and underlying health conditions.

3. Board Effectiveness

I. In the initial stages of COVID-19 we agreed to lighten our governance meetings to reduce the burden on executives to enable them to focus on the pandemic response. We agreed a rapid auditable decision-making process, reduced the lengths of subcommittee meetings which were held remotely using video conferencing technology.

II. During the peak period, I had daily catch up sessions with the CEO or COO and weekly NED meetings with the CEO to ensure the Board was adequately briefed and to offer guidance and support. These sessions have reduced as we move to phase 2 and phase 3 of the pandemic. We have now returned to normal governance arrangements whilst holding meetings remotely and reducing the length of meetings where possible.

III. We have also held Board development sessions on strategy, Black Lives Matter and Equality and Diversity.

4. Black Lives Matter

I. A few months after joining LAS as Chair I went on record to say that I was ashamed to be leading an organisation that did not adequately address equality and diversity issues. Our Workforce Race Equality Standards (WRES) evidence that we have progressed in a range of areas however, the impact of COVID-19 on the Black, Asian and Minority Ethnic (BAME) community followed by the death of George Floyd in the USA led to extreme distress being experienced by our black staff and has brought to light how much more we still have to do particularly for our black staff. I have joined all of the sessions with our staff, held by Melissa Berry our Race Equality Consultant, and listened to them sharing their experiences of being a black person in London and as an employee of LAS.

II. The first session was so distressing for all that I asked Melissa and Agatha Nortley-Meshe, Chair of our BAME network to come to a NED briefing session to share directly how they and our black staff are feeling. It is the case that staff from other ethnic minorities are impacted by COVID-19 but it is the effect of George Floyd that has led to the need to specifically address Black Lives Matter as well as refocusing on the culture of the organisation and equality and diversity.

III. We followed this up with a Board seminar, inviting Yvonne Coghill, Equality and Diversity Advisor to NHS London, to advise us on best practise and to support Ali Layne-Smith, Director of People and Culture, in developing our specific action plan to address Black Lives Matter. Today, the Trust Board will receive an action plan to address both the immediate issues faced by black people in our organisation and equality and diversity. It is important that we do not waste the opportunity once and for all to get the culture right at LAS by listening to our staff, educating colleagues and taking firm action where people are treated unfairly and discriminated against for reasons of race or other protected characteristics. The Board's ask is that the Trust is effective and focuses on achieving this high priority.

Board to Ward Assurance

I. Although we have been unable to undertake site visits I have now held two Staff and Volunteers Advisory Panel discussions. These meetings have been well received by staff who have fed back that they have felt listened to as a result. There is to be a Co-Chair member of staff who will also be invited to be present at the public Board meetings. The membership offers the Board frontline feedback and supplements the formal meetings that the organisation has to involve and listen to staff. This is further covered under the agenda item stakeholder engagement.

Heather Lawrence OBE
Chairman

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Report from the Chief Executive
Agenda item:	6
Report Author(s):	Garrett Emmerson, Chief Executive
Presented by:	Garrett Emmerson, Chief Executive
History:	N/A
Purpose:	☐ Assurance ☐ Approval ☐ Discussion ☒ Noting

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

- The Chief Executive's report provides a strategic level overview of key events and activity within the London Ambulance Service NHS Trust (LAS) since the last time the board convened in May 2020.

Recommendation(s) / Decisions for the Board / Committee:

- The Board are asked to note the content of the Chief Executive's report.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		Trisha Bain
Finance	Yes	X	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer
Medical	Yes	X	No		Fenella Wrigley
Communications & Engagement	Yes	X	No		Antony Tiernan
Strategy	Yes	X	No		Ross Fullerton
People & Culture	Yes	X	No		Ali Layne-Smith
Corporate Governance	Yes	X	No		Syma Dawson

Report from Chief Executive

My report to the May 2020 Trust Board gave a high level update on the Trust's response to the unprecedented national health emergency of COVID-19, including the immediate actions we took to enhance the organisation's overall response capability and care for our patients. The Chief Operating Officer's update will demonstrate how we have, since then, achieved our core performance targets.

It is clear that COVID-19 has profoundly affected the way patients access urgent and emergency care, and we have had to innovate and adapt our operating model considerably over the past few months to respond quickly and effectively to this and the demands we saw on our services. We must assume that COVID-19 will continue to place considerable demands on our services going forward. The Trust will need to maintain a sustainable plan to respond to subsequent peaks and other seasonal demand pressures as well as continue to deliver against the wider NHS aspiration to deliver the right care first time to our patients.

In response to the COVID-19 challenge, London's health and care system is necessarily being transformed to meet the changing needs of its patients. We therefore have a unique opportunity to accelerate delivery of our strategy to provide the right care, first time for our patients; meet national quality and performance targets every single day; and meet our financial targets and drive economic benefits in the London healthcare system. This requires a sustainably funded long term plan, which accelerates delivery of our estates vision (which we published in 2019) and implementation of a new model of patient care. We are being supported by North West London (NWL) Health and Care Partnership (HCP) to deliver this ambition.

We met with Lesley Watts (Chief Executive of Chelsea and Westminster NHS Foundation Trust and SRO for NWL HCP) and Stephen Bloomer (NWL Chief Financial Officer) to set out our ambition and associated funding requirements. Their support has resulted in an increased allocation of £35m capital funding, meaning we have a total of £44m for 2020/2021 to address the immediate investments required in our critical infrastructure. This includes: fully funding our computer aided dispatch system (CAD) replacement; telephony and other renewal programmes; the development and rollout of our new electronic patient care record (ePCR); replacing our oldest ambulances; creating fit for purpose training facilities for staff, and; ensuring we can continue to work safely in a COVID-compliant environment.

We have agreed to jointly develop with NWL HCP a strategic outline case for the longer term investment required to deliver our ambition and create a better working environment for our staff and volunteers.

Transforming our Culture - Building a World-class Workplace

In February 2020, we set out our ambition to transform the culture of the Service and build a 'world-class workplace'. Organisationally, we have come a long way in recent years, both in respect of operational performance and the care we provide to our patients, but also in terms of improving the experience of our staff and volunteers. However, we are not yet the organisation we need to be.

Our 2019 staff survey results demonstrated that there is still much to do. If we truly want to be a world-class ambulance service, we must aspire to have a world-class workplace. That means building an organisation that people feel truly proud to work for; recommend to their friends, families and colleagues, and one that; exceeds the expectations of our employees. There is much to do to improve the culture, compassionate leadership and working environment of the organisation.

Prior to the challenges of COVID-19, we started a programme of engagement with the core leaders of the organisation to help us better understand what we needed to focus on to deliver cultural transformation and what support our managers needed to help them deliver change. We

held sessions with our Extended Leadership Team (c75 senior managers) and ran two 1- day Sector Leadership Conferences with our Clinical Team Managers (CTMs) in North West London (on 28 February 2020) and North East London (on 6 March 2020). The South East London conference was due to take place at the end of March but necessarily had to be postponed. We are about to restart the sessions, and will be holding a Sector Leadership Conference for South West London in August.   These sessions were really positive and focussed on getting the basics right; communicating better; and empowering our managers. We will have met with over 700 managers across the organisation by the time we have completed the sector conferences.

Our Chair, Heather Lawrence, has now also held two meetings of the new Staff and Volunteer Advisory Group, which has been set up to help the Board listen to the views of staff and volunteers, and will help shape the culture change journey.

Black Lives Matter – Improving Race Equality and Diversity

This cultural change programme will complement and support the focussed work we must now progress to deliver real and effective change for our Black and Minority Ethnic (BAME) staff and volunteers to improve their workplace experience.

We have delivered significantly against our Workforce Race Equality Standard (WRES) Action Plan over the last few years, including: the diversity of our overall workforce, improving BAME representation on our Board and in executive and other senior positions, as well as improving perceptions of career opportunities amongst BAME staff and reducing discrimination in the workplace (as measured by our WRES indicators). However, there is still much more to do. For example: 51% of our job applications are from BAME people, but only 24% of our successful candidates are from those backgrounds; and BAME staff are still 1.8x more likely to enter our disciplinary processes than white staff.

The killing of George Floyd in the United States on 25 May has had a considerable impact on black people both in the United States and here in the UK.   It is important we understand and respond to the impact this has had on our black staff and volunteers. The Black Lives Matter movement has shone a spotlight on all the work we have done in respect of the WRES, but it is clear we have not sufficiently impacted on the culture of the Trust in respect of race and how some individuals conduct themselves in the organisation. We must learn from this and re-double our efforts to find and root out racism where it exists in LAS, and make changes moving forward to tackle unacceptable behaviours from a position of honesty. This will require sometimes difficult conversations, but the Board and I are clear that we will be a truly anti-racist organisation.

We have therefore started a very open and honest 'big conversation' with our staff and volunteers about race and racism following the death of George Floyd. This has included messages from the Chair, the Chief Operating Officer and a letter from me to all members of staff (appended to this report). We have also worked with our BAME staff network to run meetings for leaders and managers and to promote workshops for staff and volunteers. I also wrote an editorial for the *Evening Standard*.

NHS London has also started an extensive programme of work on this issue and I have participated in the design group for its 'Leading for Race Equality in London' initiative, which will provide significant advice and support to all NHS Trusts in London to tackle racism and improve equality. LAS will be an early pilot in this programme.

Pride Month

In June, there was a focus on Pride Month, which included changing our flag to a rainbow flag for the month, creating news and video content and, in the absence of the usual Pride London celebration event, we took part in the NHS's virtual pride celebrations.

Mental Health & Wellbeing

We have continued to host thrice-weekly LAS TV Live sessions, where staff and volunteers can ask live questions of me and senior managers via the Trust's LIA Facebook Group and Microsoft Stream. Each sessions attracts approximately 1,500 viewers.

On 3 July 2020, our LAS TV Live Session focussed on mental health and well-being and we remembered our colleague Russell Burgess, who sadly took his life a year ago. We discussed the difficulty in speaking openly about our mental health and the stigma that is sometimes attached to it; the support that is available to staff and colleagues and what we might need to do to improve that. We also launched our LAS Wellbeing Hub on 6 July, which brings together all of our wellbeing services under one umbrella, improving ease of access to advice for staff and volunteers.

Public and Patient Engagement

Our new LAS Public and Patients Council held its first meeting on 16 June which was chaired by Dame Christine Beasley. The Council brings together patients, carers, volunteers and the public to examine and advise on the work of LAS. The group will continue to meet every quarter.

The whole of the NHS has been universally praised by all for its response to COVID-19, and we have been incredibly grateful for the public support for, and appreciation of, the work of our staff and volunteers. In May and June, we received nearly 300 'thank-yous' from the public recognising 600 colleagues. All 'thank yous' are shared with our staff and volunteers.

The latest figures from our public perception audit (surveys in April 2020) show that:

- 85% of those who have used our 999 services in the last 12 months were satisfied or very satisfied with their experience; an increase of 6% from the previous survey undertaken in January 2020.

- Satisfaction in our 111/IUC services remains high at 80%, despite the significant increase in demand; up 1% on the previous survey.

- Whilst seven in ten of the UK public feel the healthcare service has responded very well to COVID-19 and affinity towards the LAS was already high, this has increased further with almost nine in ten Londoners (88%) feeling favourable, and half very favourable towards the LAS. This is a sharp rise compared to January 2020, where 82% of Londoners felt favourable and 39% felt very favourable towards LAS. This suggests most Londoners agree the LAS has also handled the pandemic well, and with empathy, as more Londoners agree the Service treats patients with dignity and respect compared to January (an increase of 4% from 87% in January to 91% in April 2020).

We have continued to share the stories of staff and volunteers who are separated from family so they can continue to work on the frontline. Coverage included a *BBC Radio 4* interview with Emergency Ambulance Crews Oli Farran and Lauren Cully who had moved into a hotel to protect Lauren's asthmatic mum, who they had been living with. The *Sunday Mirror* also ran an interview with paramedic Andrew Cox who spent Father's Day alone because he moved into a hotel at the beginning of the outbreak to protect his wife who has a chronic illness.

Our Managers have written to children to thank them for 'sharing' their parents. This was followed up on social media with a very popular post featuring pictures of children with their letters – our press release on the story was picked up by *BBC London TV*.

Our partnership with the London Fire Brigade was celebrated with a fantastic case study: the story of our paramedic Jack Binder and his firefighter brother Tom Binder. Further uplifting

coverage was secured in the *Evening Standard* with the story of two paramedics who were among the first to marry when lockdown restrictions eased on 6 July.

Visit by the Prime Minister

The Chair and I were delighted to host a visit by the Prime Minister to our Waterloo Headquarters on 13 July, when he met with a number of our staff and volunteers and recognised the significant efforts of staff and volunteers over the last few months in responding to COVID-19. The Prime Minister also announced the Government's consultation on plans to increase the maximum sentence for assaults on emergency workers. There was extensive coverage of the visit across national radio, broadcast, print publications and also on social media.

The Board is asked to note and discuss this report.

From: Garrett Emmerson
Sent: 07 June 2020
To: All Staff

Subject: Chief Executive's all staff message

Dear all,

For the first time since January, I took a few days leave last week – something that I know many of you who have been working so incredibly hard over the last few months need to do as well. For me, it was a chance to see the world outside the prism of the London Ambulance Service and the challenges of Coronavirus.

These are unprecedented times: we're fighting an invisible disease infecting our society which, if left to fester and spread freely, is highly contagious. We have to root it out, stop it spreading and ultimately eradicate it once and for all, to enable us all to live, thrive and survive successfully into the future. And the name of this disease - the name of this insidious virus attacking the fabric of our society? Racism.

Like all of us, I have been incredibly shocked and profoundly affected by the events of the last week or so, since the tragic death of George Floyd in America. Across the country, and across the world, people from all walks of life and all ethnic backgrounds have been standing up and saying #blacklivesmatter.

However, a very small minority have reacted against this rallying call, this demand for a fairer, more equal society. And last week we saw some of this on our own internal communication channels, causing great distress to many BME staff who work for the service.

A couple of years ago, when we were refreshing the core values we wanted the LAS to stand for, we undertook a massive staff engagement exercise, involving people from all parts of the service. The one word that came out from frontline staff more than any other was the value of 'Respect'. Today it sits at the heart of our corporate values.

I'm incredibly saddened therefore that, as the events of the last few days have clearly shown, although we are now much more representative of the diverse city we serve, we've still got some way to go to see that progress reflected in how we treat and respect each other in the workplace.

At the same time, I'm incredibly proud of those many many colleagues who've stood up (and kneeled down) to challenge the unacceptable attitudes and behaviours of this minority. I'm also proud of the nearly 130 additional staff who've come forward to join our BME Staff Network in the last week, to speak up for these issues and against those who would undermine or belittle them.

There are now over 1000 BME staff in the London Ambulance Service. It's time for their voices to be properly heard, and it's time for all of us across all levels of the organisation, to stand up and be counted on the issue of racism in the workplace – to call it out when we see it, to root it out when it's not so easily visible, and to make sure that all of us have an equal opportunity to succeed.

However, this is not a problem that can be solved by senior management action alone. This is a challenge that requires every single member of staff to stand up and be counted; to look closely at our own thoughts, words and deeds, and the actions of others around us. We must all challenge unacceptable behaviours - whether deliberately mal-intentioned or thoughtlessly said or done – and change this organisation for the better on race equality once and for all.

To do this we need to start by having open, honest and inevitably sometimes difficult conversations right across the organisation. From mess rooms to board rooms, we need to listen, learn and redouble our efforts to change unacceptable behaviours and achieve genuine equality in the workplace.

I stand shoulder to shoulder with my BME colleagues and with the #blacklivesmatter movement for a fairer and more just society. There is absolutely no place for racism in the London Ambulance Service. Put quite simply, if you are racist, we don't want you working here.

Best regards,

Garrett

Garrett Emmerson
Chief Executive Officer

London Ambulance Service
Respectful | Professional | Innovative | Collaborative
Building a world-class service for a world class city

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Report from Chief Operating Officer
Agenda item:	7
Report Author(s):	Khadir Meer, Chief Operating Officer
Presented by:	Khadir Meer, Chief Operating Officer
History:	N/A
Purpose:	☐ Assurance ☐ Approval ☐ Discussion ☒ Noting

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

- Report from the COO to update on the performance and activities for May - June 2020, as well as plans and priorities for Q2 and beyond.

Recommendation(s) / Decisions for the Board / Committee:

- For noting only.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes	x	No		Chief Operating Officer
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

Report from Chief Operating Officer

The purpose of this report is to provide the Board with an update on the performance and delivery plans of the five operationally focussed Directorate's within the London Ambulance Service.

As we emerge from the first COVID-19 peak, we recognise the extraordinary environment in which we have had to operate in so far this year. The efforts to rapidly mobilise a pandemic response involved radical changes across the operational teams and required fundamental shifts to our existing ways of working to maximise operational capacity to meet unprecedented levels of demand.

Within a matter of weeks, and with the support of urgent investment, we were able to quickly recover from a potentially critical situation and have exceeded national performance targets every day since the beginning of April.

Planning assumptions for the remainder of 2020/21 indicate that continued delivery of the current levels of performance will be dependent on the final financial settlement agreed with commissioners.

The approach for the remainder of 2020/21 is to focus our efforts to delivering five key areas that will address business critical issues in order to secure strong position from which to grow and deliver large scale transformation change during the remainder of 2020/21 and 2021/22. These five key areas are:

1. **Building strong foundations** to deliver success with clear directorate objectives, having the right leadership and governance to manage and transform operational delivery, and well defined and understood systems and processes.
2. To **lead, develop and support staff and managers** as we exit the extreme circumstances of the pandemic and prepare for seasonal winter peaks, working closely with the People and Culture Directorate and wellbeing lead to develop tailored support arrangements.
3. Delivery of **sustainable and affordable BAU operations**, and embedding the positive changes delivered as part of our COVID response.
4. Preparedness to manage **winter surges and potential peaks in pandemic** related activity.
5. Developing a clear understanding of our **future operating model** and driving forward plans to deliver this transformational change from 2021/22 onwards.

Details of our priorities for each of the five operations focussed directorates is set out in our Operational Sustainability Plans which also notes the ongoing engagement with Integrated Care System (ICS) partners, opportunities to develop emerging opportunities for Primary Care Network (PCN) Paramedics, integrated 111/999 services, and pan-London coordination of patient transport and critical care transfers.

These plans have been developed in line with budget setting processes, however as the in-year financial settlement is still subject to agreement with commissioners there may be a need to adjust the work programme to fit within agreed financial limits.

There is a risk is that the Trust is not sufficiently funded to deliver performance standards consistently. Alternative contingency plans have been considered if a less than optimal settlement is offered, but this may have direct implications on our ability to recruit to the staffing levels required to consistently achieve national performance standards.

The document below provides a summary, by directorate, of recent performance, current priorities and areas of focus for the remainder of 2020/21.

1 Leadership and Governance

Strengthening senior leadership across the five operationally focussed Directorates has been a priority to ensure there is the right capacity and expertise is in place to stabilise and optimise the management of operational teams. Recent appointments to the senior leadership team has included: **Barry Thurston** (Interim CIO), **Jon Goldie** (Deputy Director of Integrated Patient Care); **Nic McCullagh** (Director of Programmes and Projects); **Claire Lowe** (Associate Director, Strategic Assets and Property).

Good governance will be essential to driving forward the necessary operational, tactical and strategic changes in the Directorates, where assurance of plans and accountability for delivery will be managed through a number of groups chaired by the Chief Operating Officer:

- The **Daily Strategy Leadership Team (DSLT)** replaces the existing COVID Operational Leadership Team (COLT) and has representation from each of the directorates across the Trust. Its purpose is to manage and respond to immediate operational issues. Should a subsequent peak in COVID activity occur, this group is able to seamlessly transition and revert back to COLT if required.
- The **COO Direct Reports Meeting** is twice-weekly to monitor and review tactical and operational delivery of the business of the organisation.
- The **Clinical Personnel Recovery Group (CPRG)** to undertake a deep dive into our current recruitment plan; to forecast any gaps and to introduce plans to mitigate against clinical workforce shortfalls.

Other new service developments or specific transformation programmes in the five operationally focussed Directorates will continue to be overseen and managed through the **Portfolio Management Board** chaired by the Chief Operating Officer.

2 Integrated Patient Care
## 2.1 NHS 111 / Integrated Urgent Care Services
We have observed a stepped change in patient behaviours with the increased awareness and use of 111 services, resulting in high levels of demand which are expected to remain high for the rest of the year. Current IUC Contacts are 58% higher than the 2019/20 activity, and the impact of the *Help Us Help You* initiative on activity remains unknown.

Our emphasis for NHS 111 is to bolster workforce capacity in 111, to ensure a sufficient and sustainable number of trained call handlers and clinical advisors available to meet elevated levels of demand, and there is infrastructure in place to allow the flexibility for GPs in the CAS to work remotely.

- **2020/21 YTD Performance**

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20
111 / IUC (NEL) - Calls answered within 60 seconds	95%	79.9%	98.3%	99.5%
111 / IUC (SEL) - Calls answered within 60 seconds	95%	77.3%	98.3%	99.8%
111 / IUC (NEL) - Calls abandoned after 30 seconds	5%	7.8%	0.1%	0.0%
111 / IUC (SEL) - Calls abandoned after 30 seconds	5%	8.4%	0.2%	0.0%

- **2020/21 Forecast Demand**

daily IUC Calls
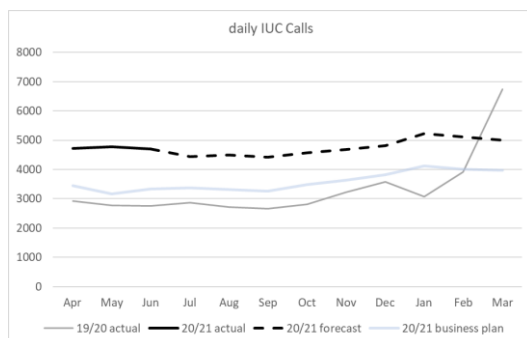
- Current IUC Contacts are 58% higher than the 2019/20 activity. This is c.35% higher than the pre-COVID planning assumptions.
- Call volumes are expected to be at their highest in January 2021.

- **Resilience and Surge Plans** – In the event there is a significant surge in NHS 111 call demand due to COVID-19, then plans are in place to increase call handling hours across NEL & SEL 111 sites meet 10,000 calls per day and ensure 95% of calls answered are answered in less than 60 secs.
- **Business Plan Priorities –** (1) to develop a programme to scope and implement better rostering and scheduling for the IUC to ensure services are staffed effectively to meet expected demand (2) to conduct an extensive review to understand current department costs pressures and to design future ways of working which are cost effective.
- **Next Steps –** Ongoing delivery of recruitment and training plans, and request for capital investment to extend existing estate capacity at Barking and Croydon to accommodate additional staffing numbers.

2.2   999 Emergency Operations Centre

Through the Covid-19 period the EOC teams have had to adapt rapidly to changing levels of demand. This has been achieved through rapid development, training and deployment of new roles utilising the skills of paramedic students. Further to these developments significant progress has been made testing and utilising integrated processes and roles across the 111 and 999 environments.

- **2020/21 YTD Performance**

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20
999 Mean Call Answer	5 secs	55s	0s	0s

- **2020/21 Forecast Demand**
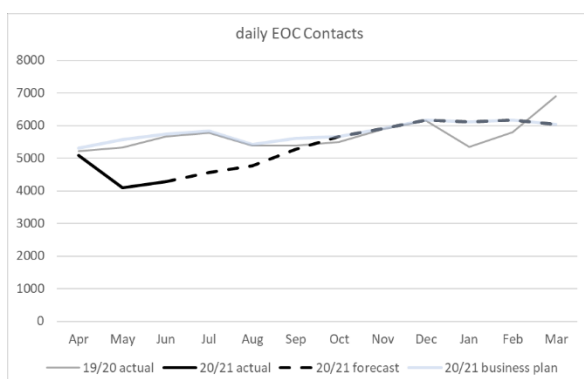
daily EOC Contacts

- Before the onset of Covid-19 the 2020/21 Business Plan forecast for EOC Contacts showed a 3% increase, on 2019/20 activity.
- Recently, demand has been below these forecast levels. EOC Contacts volumes currently expected to return to plan by the beginning of October.
- Call volumes are expected to be highest in December and January.

- **Resilience and Surge Plans** – In the event of a significant surge in 999 call demand then 999 Emergency Operations Centre (EOC) have plans in place to increase call handling hours to meet 10,000 calls per day and ensure average call answering mean remains under 10 seconds for the day end position. This additional capacity includes support from other ambulance services (mutual aid), dual trained staff working flexibly across 111 and EOC call handling and bank and agency staff.
- **Workforce** – In order to deliver against the increased demand assumptions from 2019/20 and improve call handling performance to consistently deliver targets, it is expected that the Call Handling establishment will increase by 18% from the 2019/20 budgeted establishment. The existing recruitment and training plan for the Emergency Call Handling (ECH) role aims to consistently bring on a flow of trained ECH staff on a monthly basis for the remained of 2020/21. A stable position is expected by November 2020.
- **Business Plan Priorities** – (1) Rapid recruitment to budgeted establishment and a reduced staff turnover rate for 999 call handling (2) Functional Tactical Operation Centre completed in Waterloo (3) More workstations equipped with CAD terminals in various sites to support more flexible and resilient working arrangements for EOC staff.
- **Next Steps** – Our immediate focus is development of Winter plans, continued recruitment and training efforts (including dual trained roles to be flexibly deployed between 111 and 999), and delivery of CAD training plans.

2.3   Clinical Assessment

- **2020/21 Forecast Demand** - It is expected that the day to day demand for Clinical Assessment will corelate to the call demand seen in the 111 and 999 services. In the IUC CAS, demand is currently higher than the pre-COVID planning assumptions. This is expected to continue for the remainder of the year.   In EOC CHUB call volumes remain lower than the pre-COVID planning assumptions. These are expected to return to the pre-COVID plan by October 2020.
- **Resilience and Surge Plans** – Existing plans for IUC and EOC resilience have specifically targeted the clinical assessment roles. A significant number of clinical staff have been recruited and provided with training to allow rapid engagement with either our 111 or 999 processes. Additionally, we have ensured access to downstream capacity will be available to support in times of high demand. These options for additional capacity have been strengthened by the addition of remote working capabilities for our clinical teams, allowing more flexibility to those able to work for short periods.
- **Workforce** – Through the updated model of care design, a skill mix review is being planned which will inform the required competencies and capacity of staffing for the CAS and CHUB.
- **Business Plan Priorities** – (1) Clarifying the clinical assessment and staffing models for both the CAS and CHUB (2) establishing individual performance objectives, including quality and productivity outcomes for clinical staff (3) identifying opportunities to integrate processes and procedures between the CAS and CHUB (4) Working with partners to broaden the range of clinical specialities and develop increased access to our of hospital capacity.

3 Ambulance Services

It has been necessary to reshape the deployment model for our frontline crews to maximise our ability to respond to incidents, which has resulted in a greater DCA-led model and reduction in solo responders.

- **2020/21 YTD Performance**

Indicator (KPI name)	Target	Apr-20	May-20	Jun-20
Category 1 response mean	7 mins	00:07:10	00:05:52	00:05:46
Category 2 response mean	18 mins	00:23:32	00:08:54	00:09:32
Category 3 response - 90th centile	120 mins	01:34:37	00:47:32	00:51:02
Category 4 response - 90th centile	180 mins	02:12:07	01:30:16	01:39:54

- **2020/21 Forecast Demand**.
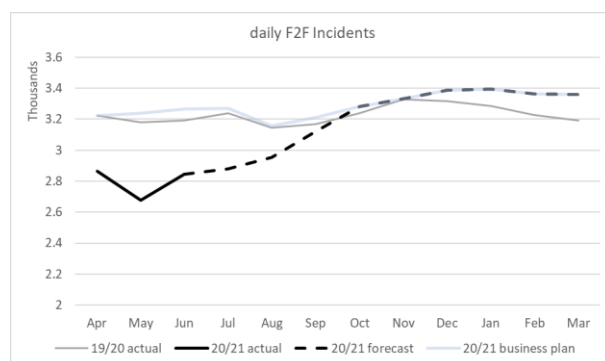
- Before the onset of Covid-19 the 20/21 Business Plan forecast for daily F2F incidents showed a 3% increase on 2019/20 activity.
- Incident demand is currently below the level forecast as part of the pre-covid business planning exercise.
- Activity is currently forecast to return to plan by October as lockdown conditions are relaxed.

- **Resilience and Surge Plans** – In the event there is a significant surge in a demand due to COVID-19, Ambulance operations can deploy an increased number of vehicles to meet this demand. In addition to maximum deployment of Trust resources, we are also able to call upon different groups to provide capacity to meet elevated levels of demand: paramedic students, clinically trained managers, LFB, Clinical Team Managers, St Johns Ambulance and as a last resort Mutual Aid from other Trusts.
- **Workforce** – The Trust is forecasting a workforce shortfall of frontline staff by March 2021 if no action is taken. In addition to the planned 'BAU' recruitment of 253 frontline staff, we have mobilised proposals to introduce a new Band 4 (non-registrant) role. We plan to rapidly recruit, train and deploy c. 184 WTE by the end of the financial year. We also continue to discuss the potential of working with London Fire Brigade (LFB) colleagues alongside a more flexible, responsive approach to the use of overtime.
- **Business Plan Priorities** – (1) recruitment of c184 non registrants (Band 4) trained by the end of March 2021, (2) redesign of our rosters to match the most appropriate resources to the appropriate levels of demand by the end of Q2, (3) DCA led model implemented with proportionally fewer solo responder vehicles in regular deployment, (4) all patient facing resources to be consolidated under the management of the Ambulance Services Directorate, (5) see, treat and refer rates increased from the 2019/20 position and increased use of out of hospital clinical care pathways from scene resulting in a corresponding reduction in absolute ED conveyance numbers.
- **Next Steps –** to focus on right-sizing resources to demand and effective utilisation of overtime arrangements, to ensure we deliver operations that is efficient and offers value for money. This may mean a shift of current C2 mean performance from an average of 10mins to an average of 15mins, which is still within the national performance targets but supports the wellbeing of our workforce and operational resilience.

4 Strategic Assets and Property

4.1 Estates

At the start of the pandemic we moved quickly to consolidate the number of ambulance stations to support operational responsiveness. We reduced the number of active stations from 67 to 33 sites. A small number have subsequently re-opened. The consolidation presented some challenges, including congestion, parking, social distancing and access to rest facilities. There are currently 41 open sites. The ongoing value of the consolidation is subject to further scrutiny and review of the expectations relating to the management of Covid compliance and demand.

Urgent capital funding has been secured to enable the estates teams make essential improvement to the facilities and ensure they met COVID compliance standards. Improvement works are already underway to improve mess rooms, showers, toilets, and parking. These improvements will deliver the following by end-August:
- 17 refurbished or additional mess rooms across 14 stations.
- Refurbished or new toilet facilities at six sites.
- Repaired or new shower facilities at 10 sites.
- Refurbished locker rooms at six sites.
- Increased parking capacity at three sites.
- 9 porta cabins at 6 sites for additional mess rooms or showers and toilets.

All sites have completed a Covid-19 Compliance Checklist against the latest national guidelines. Assessments were undertaken by local management and a union representative then validated by one of the central LAS Health and Safety team. All sites have been issued a Covid compliance certificate which has been published locally on-site and digitally on the intranet ensuring visibility for all staff

Additionally, work is underway to improve our control room and 111 facilitates. We are expanding the number of workstations in Waterloo HQ, Southern House and Maritime. These workstations will provide the capacity for an Integrated EOC / IUC capability for both surge capacity and potentially for new contracts. The expansion will provide the opportunity for the services to socially distance whilst delivering a critical service and provide a replacement space for the corporate area, in the 1st floor West space in Waterloo HQ.

The next priority for the estates team is to commission extensions to our buildings to create more rest space on stations, to expand capacity at our call handling sites for 111 and 999, and work to relocate training centres away from stations so that this space can be repurposed for operational use.

Whilst a challenge remains to address the significant amounts of backlog maintenance of our estate, a review will be conducted to provide an accurate view the rolling programme of maintenance required on each of the Trust's sites and captured through the Invida Computer Aided Facilities Management (CAFM) system. Clarity of the scale and costs of estate maintenance plans will better support financial planning and allocation processes and will be refined as clarity of the wider Trust estate transformation plans is confirmed.

4.2 Fleet and Logistics

The Fleet and Logistics team have continued their efforts to ensure maximum vehicle availability for deployment by frontline ambulance services, however this work has been supplemented by support from third party suppliers including:
- The AA to support commissioning of new vehicles, fleet maintenance and roadside assistance.
- Extended services provided by our existing vehicle preparation provider Interserve, such as additional capacity at hospitals for cleaning to reduce out of service for crews.

Options for longer term solutions need to be considered to ensure sufficient capacity for BAU delivery as well as additional support needed in busier times during periods of surge.

A critical deep dive review of the Logistics Supply Unit was completed in May 2020, which identified several areas of improvement relating to the logistics and the medicines packing functions. The review recommended a number of key changes which are now being progressed at pace to ensure the LSU is right sized to support operational requirements, and that our medicines packing facilities meet compliance with MHRA legislation including:

- Logistics department **organisational restructure** including the transition of the medicine support workers to the medical directorate.
- **Alternative estate** for both LSU functions and medicine packing unit.
- **Closure of Greenwich stores** and consolidation into LSU – **complete.**
- Procurement and introduction of appropriate **fleet for distribution.**
- Investment in **stock management system**(s) and introduction of an **inventory system for medicine management.**
- Named **contract manager** for medicine and logistical contracts.
- Investment in an **asset tracking system**.
- Review **supply of medicines** to ensure future resilience.

5 IM&T

Through concentrated effort and teamwork over the Covid-19 period the IM&T team have delivered support across the LAS:

- Major expansions at NEL, SEL, HQ and Union Street have been implemented.
- Set up, testing and go-live for ITK links to other Ambulance trusts to support 999 call taking during periods of peak demand.
- Remote working has been enabled for teams across the business including:
  - CAS clinicians for the first time allowing GPs to remote work and social distance
  - For fleet – allowing the remote coordinate workshop resources, collision repairs, supply of vehicles and fuel cards
  - Clinical Training - To carry out remote training for paramedics through the provision of laptops with GRS and all necessary applications
  - Other support functions – access to the right tools to remote work effectively
- The provision and set-up of laptops, phones, screens and iPads; equipping for remote working.
- Enabling infrastructure to support video conferencing across the organisation.
- Wellington House and Nightingale Hospital have been set up and the provision of extra operational equipment has been provided where needed.

Under the leadership of the Interim Chief Information Officer, the IM&T directorate have also developed a digital roadmap setting out a clear focus on improving the technology used by the Trust and building resilience of existing systems in 2020/21:

- **Infrastructure and Cyber Security -** Focussed on IT stabilisation and readiness, and supports future IM&T model, improving services and preparing for a future move to Cloud/Hosted services.
- **Electronic patient records (ePCR) and Computer Aided Dispatch (CAD)** - To implement ePCR for frontline clinicians, the re-platform of current CAD and implementation of a new CAD in the 999 Control Room.
- **Telephony Infrastructure -** Upgrade of existing EOC telephony platform, review telephony and recording platforms and propose long term plan to update and standardise across the Trust.
- **National Programme Implementation -** Implement national programme services; Control Room Solution (CRS) - Life X, Mobile Data and Vehicle Solutions – NMA Lite & NMA Full and Emergency Services Network (ESN) – a platform providing secure and resilient mission critical communications.

- **CAS Remote Working** – to deliver functionality that will allow CAS GPs the flexibility to work remotely.

Delivery of key projects will be managed locally through the newly formed IM&T Delivery Board, reporting through to the Project Management Board, and assurance provided by the Logistics & Infrastructure Committee.

In parallel, a deep dive review of the IM&T Directorate will be carried out to seek opportunities for immediate improvements in current operational practices, to gain clarity of IM&T assets and rolling 5-year replacement programme, and to inform design of the longer term IM&T transformation strategy to commence delivery from 2022/22 onwards.

5.1   Programmes and Projects (P&P)

The P&P Directorate is now fully established with a Director in post and senior management team in place, who will provide the organisation with robust PMO discipline and methodologies through the lifecycle of delivering programmes and projects from design through to delivery, within agreed timescales and cost.

At the Portfolio Management Board in June 2020 a full review of programmes and projects was completed and priorities agreed. A portfolio of up to 47 capital and revenue schemes was provisionally agreed. 33 programmes or projects are being scoped and are/or are underway.

A review of programme delivery in 2019/20 was undertaken to gain insight and learning from last year, and the key review recommendations will be addressed going forward include:

1. Implementation of a P&P directorate **governance framework** that is clear and joined up and supports the delivery of the portfolio.
2. Achievement of **baseline compliance** across all live projects.
3. Ensuring the right **leadership, resource capacity and capabilities** are sufficient to deliver the intended outcomes.
4. Strengthening the **financial management** and ownership of the portfolio.
5. Ensuring **Impact Assessments** are embedded as a core component of project & programme architecture, and to better understand the impact of the proposed change. This will also ensure compliance with any statutory requirements.
6. **Strengthen the change management approach** to ensure change delivers the intended benefits.
7. Propose and **implement a benefits realisation approach**.
8. This has resulted in a revision to the roles and functions of those involved in programme delivery:
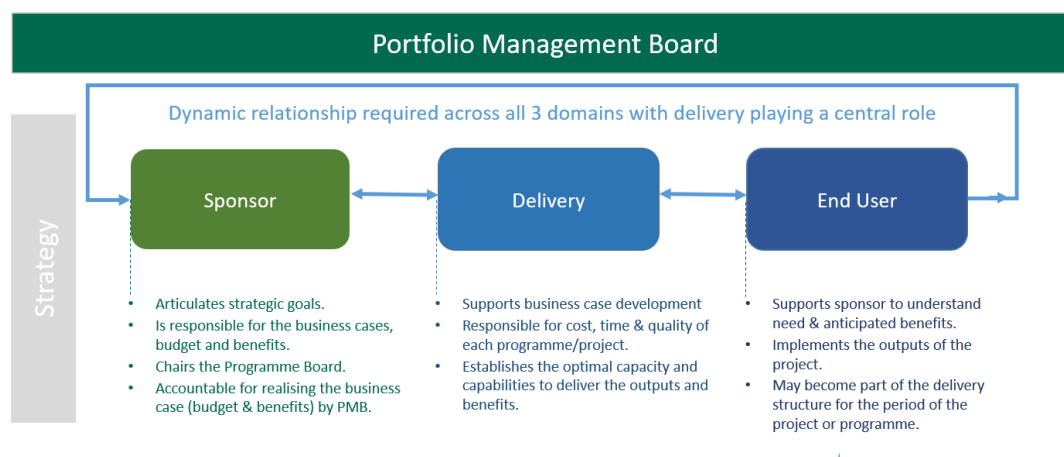
The FY20/21 portfolio of 47 capital and revenue schemes was provisionally agreed pending business case approvals the June Portfolio Management Board (PMB). Due to the disruption of COVID-19 the commencement of P&P schemes for this year is currently behind, therefore

there is a strong imperative to deliver a number of business cases for consideration and approval at two PMB meetings scheduled in August.

The Board is asked to note and discuss this report.

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Integrated Quality and Performance Report
Agenda item:	8
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

Purpose:	☒	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

This high level Integrated Quality and Performance Report serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

Recommendation(s) / Decisions for the Board / Committee:

The Board is asked to note the Integrated Performance Report and receive it for information, assurance and discussion.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed			Relevant reviewer [name]
Quality	Yes		No	
Finance	Yes	x	No	Director of Finance
Chief Operating Officer Directorates	Yes		No	
Medical	Yes		No	
Communications & Engagement	Yes		No	
Strategy	Yes		No	

People & Culture	Yes		No	
Corporate Governance	Yes		No	

London Ambulance Service – Integrated Performance Report

Report for discussion with Trust Board members

Analysis based on Year to February 2020 data, unless otherwise stated

Our Patients – Data is at 4th March 2020 and is subject to change | Public Value – Data presented is for January 2020

Contents Page

NHS London Ambulance Service NHS Trust

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

Update on performance:

Achievements since the last Board (incl. reference to Business Plan deliverable):

Provide outstanding care for **our patients**

999 Performance in all national measures was outside the target in February for all metrics apart from Category 1 mean and Category 1 90th centile. Category 2 - Category 4 performance was challenged due to the impact of COVID 19 demand on the Trust.
Call answering dropped significantly in February 2020 for North East London (NEL) and South East London (SEL) due to the 111 services picking up a large part of the Trust and National response to COVID-19 in assessing, signposting and tracking affected people. Both sites are within target for calls transferred to 999, where we consistently perform better than the London average. However, due to heavy pressure of the COVID-19 response, we have seen higher abandonment rates this month.
Communication with regulators and commissioners to highlight current position have been conducted and risk mitigation measures are being discussed and agreed.

- *When benchmarked across 13 key metrics included in the National Ambulance Services Balanced Scorecard, the Trust continued to be within the top five performing Ambulance Services.*
- *NEL/SEL are playing a big part in the national response to COVID-19, which is impacting the call taking performance.*
- *Due to current pressure we are in a poorer position in relation to AQIs – current position is amber, however predicted to be red by the end of the month (BP1 and BP2).*

Be a first class employer, valuing and developing the skills, diversity and quality of life of **our people**

Our overall vacancy rate has remained at 2.7%. Over 400 Paramedics have started/expected to join the Trust between April 2019 and March 2020. We are forecasting an overall end of year 'in-ops' gap of 120fte frontline posts. Our turnover continues to improve at 9.9%. Trust compliance in Statutory and Mandatory training is at 84% against our 85% target. Sickness rates remain slightly above 5% and are tracking similarly to the same period last year.

- *Staff Turnover rates improved to 9.9%.*
- *Stat and mandatory training at 84%.*
- *PDR rates at 78%.*
- *The 'in-ops' vacancy rate for our frontline registered and non-registered staff is 3% (100fte vacancies).*

Provide the best possible value for the tax paying **public**, who pay for what we do

The Trust's YTD position at month 10 is a £0.1m deficit against a planned £2.1m surplus (£2.2m adverse variance). The full year forecast at month 10 is a £150k surplus, inclusive of £125k prior year adjustments - in line with plan. The YTD and full year positions include assumed technical mitigations as a result of asset re-lifing that are awaiting to be formally signed-off (£1.7m and £2.1m respectively – a reduction from the M9 assessment) and an additional £1.3m of COVID19 funding. The Trust has a use of resources score of 1 at the end of December, which is in line with plan. The Trust is planning a year end score of 1.

- *The Trust remains on forecast to deliver its control total outturn, however this remains dependent on frontline resourcing levels remaining as per forecast until the end of the financial year. This clearly will be challenging throughout the remainder of winter. There remains a risk around the value of the proposed mitigations to the financial position.*
- *Although the Trust Cash position was £3.4m below plan at the end of December, this has improved through January following settlement of outstanding debt from Commissioners.*

Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London

The number of delays and the hours lost remained stable and high in February. There is organisational focus as well as a cost improvement programme to recover this situation with action plans focusing on clarification of targets, improving the hospital handover process and sharing good practice across sectors.

ED conveyance during the month remained within the contractual target with 56.1%. Our national position saw us achieve 5th for H&T, leaving us at 7th position for See & Treat and 5th position for ED conveyance.

- *We have a achieved the ED conveyance target in February (BP19).*
- *H&T performance remains strong in 2019/20*

Trust-Wide Scorecard - 999

Patients Scorecard

February 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	National Data	Best In Class	Ranking (out of 11)
						Current Perfomance			**Benchmarking (Month)**		
Category 1 response – Mean	mm:ss	Feb-20	🟢	07:00	A	00:06:47	00:06:35	00:06:33	07:19	06:21	2
Category 1 response - 90th centile	mm:ss	Feb-20	🟢	15:00	A	00:11:16	00:11:00	00:10:57	12:53	10:44	2
Category 1T response – 90th centile	mm:ss	Feb-20	🟢	30:00	N	00:20:20	00:19:21	00:19:19			
Category 2 response – Mean	mm:ss	Feb-20	🔴	18:00	A	00:22:02	00:20:02	00:19:54	0:22:07	0:13:06	5
Category 2 response - 90th centile	mm:ss	Feb-20	🔴	40:00	A	00:45:56	00:41:22	00:41:03	0:45:07	0:24:03	5
Category 3 response – Mean	h:mm:ss	Feb-20	🔴	1:00:00	A	01:17:24	01:02:50	01:01:43	1:07:18	0:41:16	7
Category 3 response - 90th centile	h:mm:ss	Feb-20	🔴	2:00:00	A	03:05:27	02:31:34	02:28:41	2:37:12	1:32:27	7
Category 4 response - 90th centile	h:mm:ss	Feb-20	🔴	3:00:00	A	07:00:05	03:37:18	03:33:33	03:49	02:12	11
Call Answering Time - 90th centile	ss	Feb-20	🔴	24	I	29	48	46			
ROSC at Hospital	%	Oct-19	🟠	33%	N	33.9%	33.5%	33.7%	31.0%	34.5%	3
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Sep-19	🟢	N/A		91.0%	90.4%	N/A	77.6%	89.9%	1

*National average YTD

Benchmarking Key

Top 3
Ranked 4-7
Ranked 7+

Please note:

999 performance data is correct as at 04/03/20 and is subject to change due to data validation processes

🟢 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: **Sepsis** is measured quarterly*

Patients Scorecard (NEL IUC)

February 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	London Data	Best In Class	Ranking (Pan London)
				Current Performance					**Benchmarking (Month)**		
Percentage of calls answered within 60 seconds	%	Feb-20	🔴	95.0%	A	40.2%	75.3%	76.0%	49.5%	54.1%	5
Percentage of Total number of calls abandoned after 30 seconds	%	Feb-20	🔴	5.0%	A	16.7%	5.0%	4.7%	13.1%	7.3%	5
Total calls - Priority 1: dealt within 15 min	%	Feb-20	🔴	95.0%	C	52.3%	66.4%	64.2%			
Total calls - Priority 2: dealt within 30 min	%	Feb-20	🔴	95.0%	C	44.5%	56.1%	55.4%			
Total calls - Priority 3: dealt within 60 min	%	Feb-20	🔴	95.0%	C	32.5%	51.9%	51.5%			
Total calls - Priority 4: dealt within 120 min	%	Feb-20	🔴	95.0%	C	26.0%	51.7%	52.5%			
Total calls - Priority 5: dealt within 180 min (NEL only)	%	Feb-20	🔴	95.0%	C	41.8%	63.2%	64.2%			
Total calls - Priority 6: dealt within 240 minutes	%	Feb-20	🔴	95.0%	C	37.2%	65.3%	67.0%			
Total calls - Priority 7: dealt within 360 min (SEL only)	%	Feb-20	🔴	95.0%	C	27.1%	27.1%	27.1%	**This priority has been used to capture reporting on COVID-19 cases; effective from 26/02/2020		
% of calls closed with no onward referral (health advisor and clinician)	%	Feb-20	🔴	33.0%	A	28.3%	27.6%	27.5%			
% of calls transferred to 999	%	Feb-20	🟢	10.0%	A	8.3%	8.0%	7.9%	9.3%	7.0%	2
% of calls recommended to ED	%	Feb-20	🔴	5.0%	A	7.9%	9.0%	9.0%	8.6%	7.7%	2

Benchmarking Key

Top 3	
Ranked 4-7	
Ranked 7+	

🟢 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

Patients Scorecard (SEL IUC)

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target & Type (Internal / Contractual / National / All)		Latest Month	Year To Date (From April)	Rolling 12 Months	London Data	Best In Class	Ranking (Pan London)
				Current Perfomance					**Benchmarking (Month)**		
Percentage of calls answered within 60 seconds	%	Feb-20	🔴	95.0%	A	50.4%	76.0%	75.8%	49.5%	54.1%	4
Percentage of Total number of calls abandoned after 30 seconds	%	Feb-20	🔴	5.0%	A	11.5%	4.3%	4.3%	13.1%	7.3%	2
Total calls - Priority 1: dealt within 15 min	%	Feb-20	🔴	95.0%	C	36.4%	72.2%	72.7%			
Total calls - Priority 2: dealt within 30 min	%	Feb-20	🔴	95.0%	C	46.5%	49.4%	49.7%			
Total calls - Priority 3: dealt within 60 min	%	Feb-20	🔴	95.0%	C	24.7%	55.6%	55.7%			
Total calls - Priority 4: dealt within 120 min	%	Feb-20	🔴	95.0%	C	38.4%	61.5%	61.7%			
Total calls - Priority 6: dealt within 240 minutes	%	Feb-20	🔴	95.0%	C	59.0%	74.7%	74.7%			
Total calls - Priority 7: dealt within 360 min (SEL only)	%	Feb-20	🔴	95.0%	C	54.3%	77.7%	78.5%			
% of calls closed with no onward referral (health advisor and clinician)	%	Feb-20	🔴	33.0%	A	29.1%	28.1%	27.7%			
% of calls transferred to 999	%	Feb-20	🟢	10.0%	A	7.0%	8.1%	8.1%	9.3%	7.0%	1
% of calls recommended to ED	%	Feb-20	🔴	5.0%	A	8.3%	9.0%	9.1%	8.6%	7.7%	3

February 2020

Benchmarking Key

Top 3
Ranked 4-7
Ranked 7+

🟢 G — KPI on or ahead of target

🟡 A — KPI off target but within agreed threshold

🔴 R — KPI off target and outside agreed threshold

⚪ — KPI not reported / measurement not started

Variation Indicators

Special Cause Concern High / Low   Special Cause Note/Investigate High / Low   Common Cause
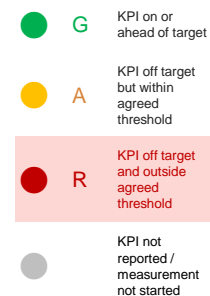
999 Response Time Performance

The February 2020 Category 1 mean returned 6 minutes 47 seconds while the Category 1 90th centile was 11 minutes 16 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 second in the Category 1 mean measure and ranked second in the Category 1 90th centile measure when compared to all Ambulance Trusts across England.

Please note:

999 performance data is correct as at 04/03/20 and is subject to change due to data validation processes

Monthly Trend	**Daily Analysis**

C1

Mean: 6:47

Target: 7:00
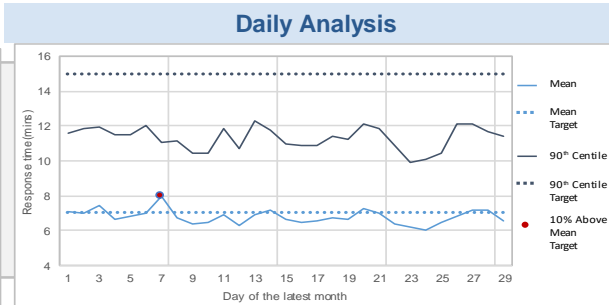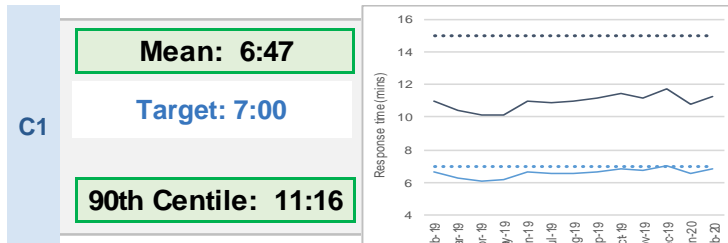
90th Centile: 11:16

The C1 mean performance has been continuously within target since April 2018, apart from December 2019 where we were 1 second outside the target.

The C1 90th centile shows monthly performance successfully within the national standard of 15 minutes, which is also reflected in the year to date position and indicates a safe level of service is being provided in this category.

C2

Mean: 22:02

Target: 18:00
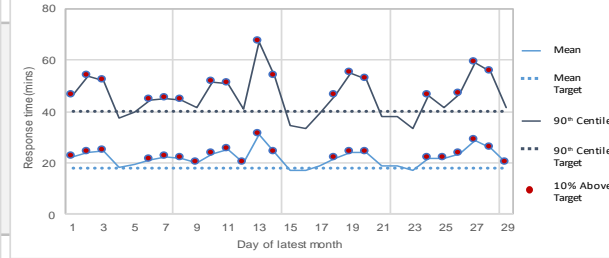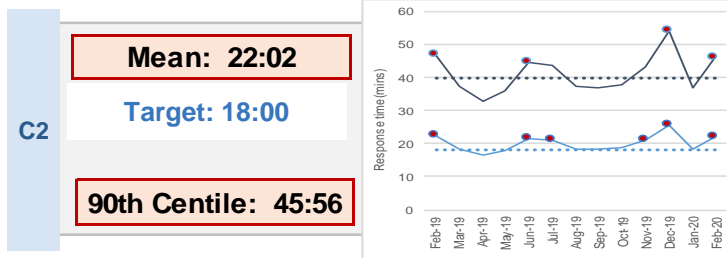
90th Centile: 45:56

During February 2020, our C2 mean and 90th centile were both outside the target. The Figure was 19 seconds better than in February 2019.

A number of particularly challenging days can be attributed to colder weather and seasonal effects, as well at the impact of COVID-19 demand on the trust.

C3

Mean: 01:17:24

Target: 2:00:00

90th Centile: 03:05:27
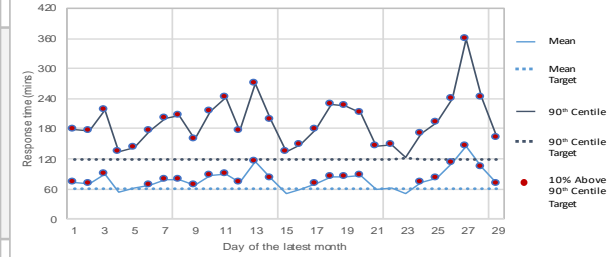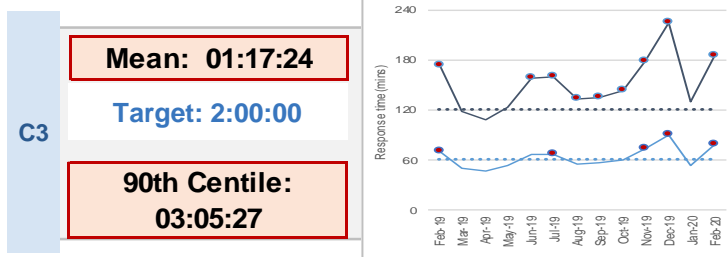
C3 90th centile has been challenged, remaining above the national standard of 2 hours most months. In February 2020 the performance overall was outside the two hour target. Most of the days the performance was above target due to overall pressure of demand. The Trust are working to reduce longer waits for this category of patients.

C4

90th Centile: 07:00:05

Target: 3:00:00
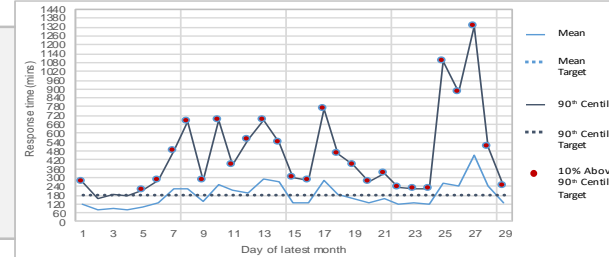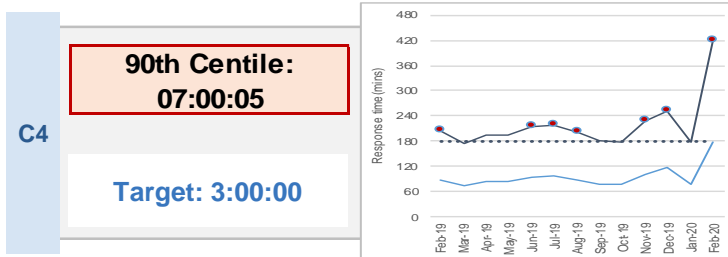
C4 90th centile performance was particularly impacted by the COVID-19 impact on processes and demand as can be seen, the target was not met in February. Due to the balance leaning towards the higher categories and particularly longer response times when patients require swabbing and travel to and from hospital this continues to be challenged. The Trust are working to reduce longer waits for this category of patients by reviewing the process response.

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

February 2020 saw a higher number of calls compared to an equivalent period in 2018/19. Call answering performance has been challenged again against our target on call answering 90th centile, which is less than 24 seconds.

Performance (90th Centile)
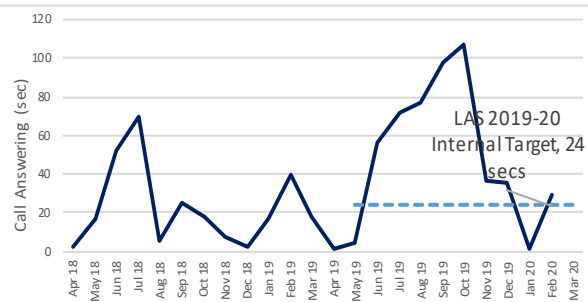
Average Calls Per Day
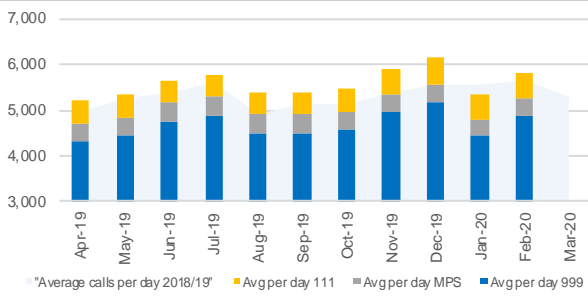
Daily Calls Answered
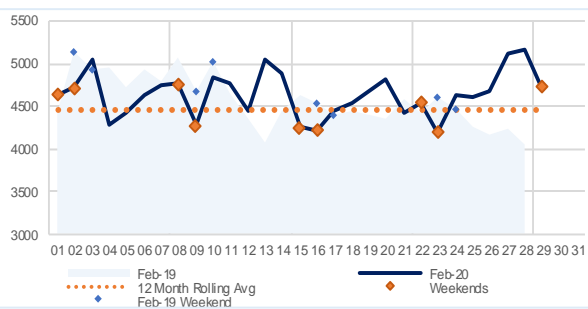
Incidents and Response Type

February 2020 delivered continued pressure on the Trust, with the average number of incidents per day remaining higher than in 2018/19. Performance improved for ED conveyance and Hear and Treat compared to 2018/19 due to concentrated effort on improving these measures.

Incidents
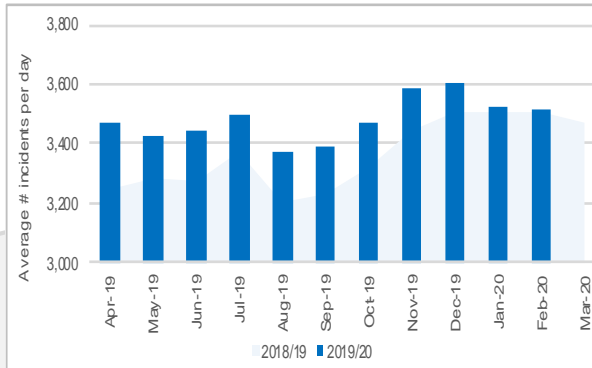
Response Type
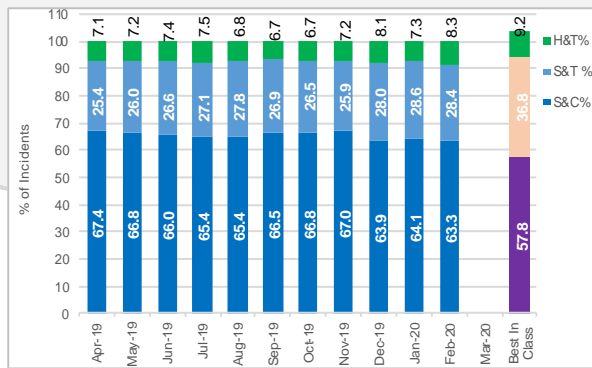
During Feb 2020, SWAS was best in class achieving 36.8% and 57.8% for their S&T and S&C outcome; leaving the LAS at 28.3% (7th place) and 63.4% (7th place) for these response types.

EMAS was best in class for achieving H&T at 9.2%, with LAS at 5th place with 8.3%

Incident Category (By Month)

C1

February saw 9,156 Category 1 patients receive a face-to-face response

C2

February saw 58,523 Category 2 patients receive a face-to-face response

C3

February saw 17,497 Category 3 patients receive a face-to-face response
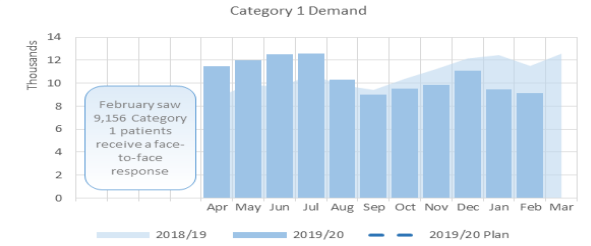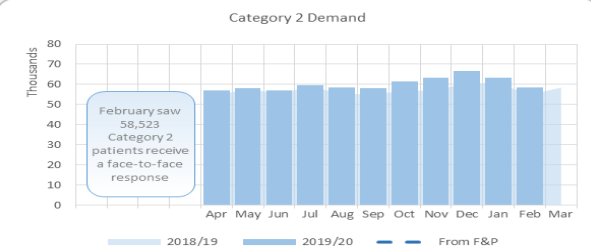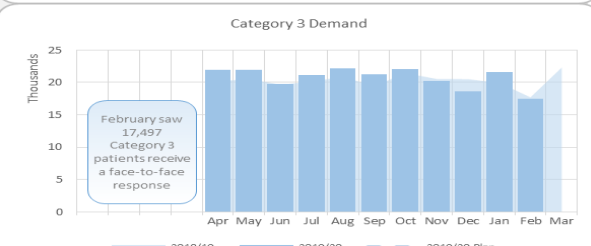
C4/C5
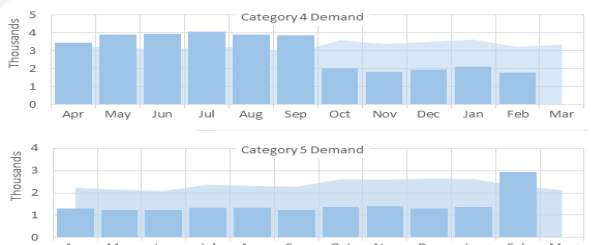
Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

Frontline Operational Staff

The number of filled operational FTE has shown a stable shortfall over 2018/19 and we continue to place considerable effort into our recruitment and retention activity. There has been recruitment improvement in April/May 2019 compared to the same period last year. (See Our People section of this report for further detail across the organisation)

Filled FTE

Legend: Staff In Post 2018/19 — Staff In Post 2019/20 ····· Funded FTE

(Values shown: 3400, 8370, 3288)

Vacancy Rate

(Values shown: 10.7%, 2.4%)

Sickness Rate

Legend: Sickness % Month — Sickness % (12 Months)

(Values shown: 6.27%, 5.76%)
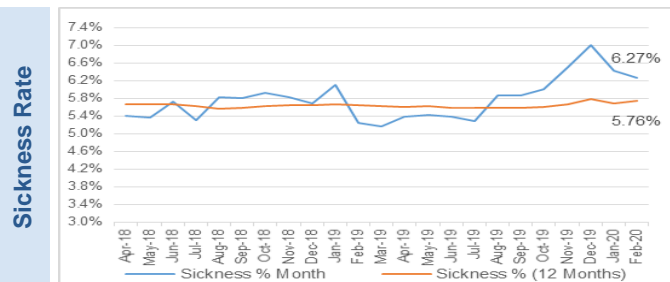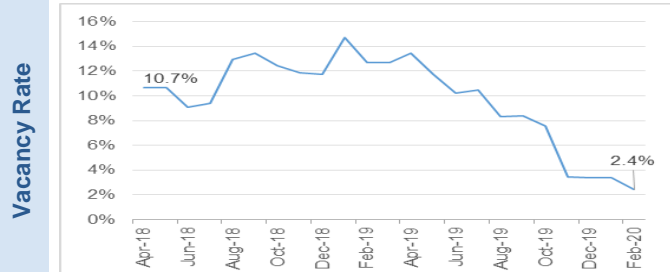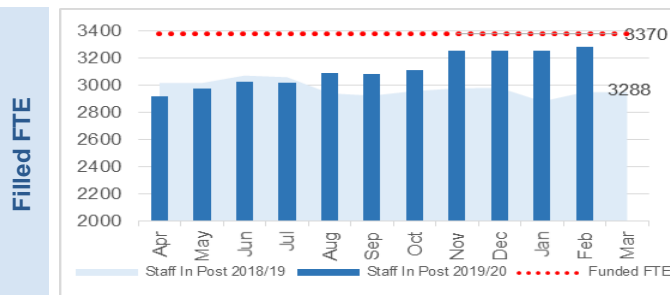
Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate was 8.5% in February, an increase of 2.5% from the previous month. COVID-19 is a significant factor on the increase in OOS in part due to crews undergoing FFP3 fit testing and vehicle decontamination, which has reduced availability. The Trust has provided an average of 7,999 patient facing vehicle hours per day in February 2020. Work is ongoing to increase the trust fleet to support this demand.
The current COVID-19 situation and the daily DCA PVR continues to challenge the Fleet & Logistics Team, The total number of DCA vehicles has increased to 461. OOS for VEHNO(Vehicle in place at start of shift) against actual hours for February 2020 was 0.3% this is a slight increase of 0.09% from January 2020. Operational Placement crews (OPC) numbers have decreased since 2019 but continue to be above 10 and up to 20 on some days which creates pressure on the frontline DCA fleet support for the Operational shift patterns.

Out Of Service %

Legend: 2018/19 OOS — HUB — VRC
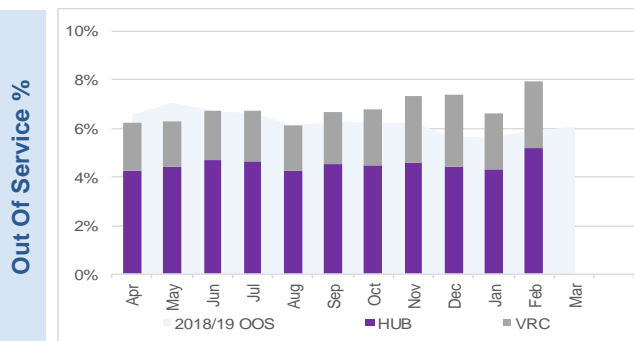
Note:

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

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

All Vehicles (Avg per day)

Legend: Previous Year PFVH — PF VH ····· Planned PF VH

Ambulance Hours (Avg per day)

Legend: Previous Year DCA — DCA VH ····· DCA Planned Hours

PAS / VAS (Avg per day)

Legend: Previous Year PASVAS — PASVAS VH

9
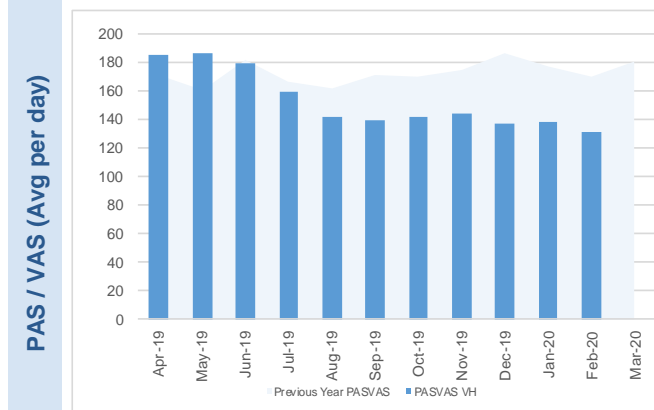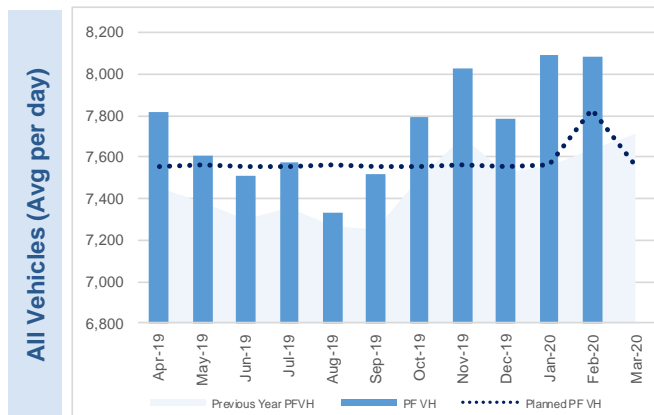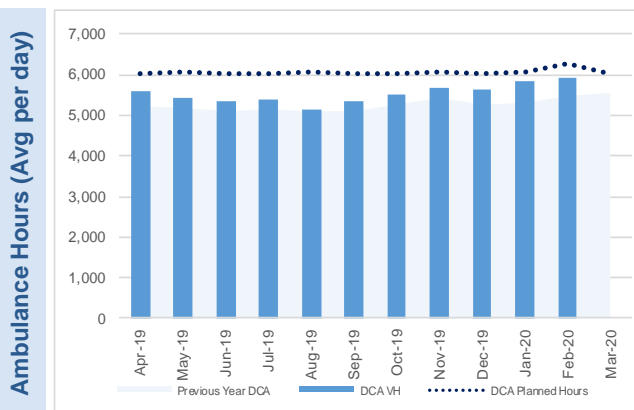
Our Trust-wide scorecard covers four of the key Ambulance Quality Indicators: Cardiac Arrest - Return of Spontaneous Circulation (ROSC) at Hospital, Sepsis - Care Bundle, STEMI - Call to angiography and Stroke - Call to door. The data presented is from October 2019, which is the most recent month published by NHS England.

ROSC at Hospital

Month: 34.6%

Target: 33%
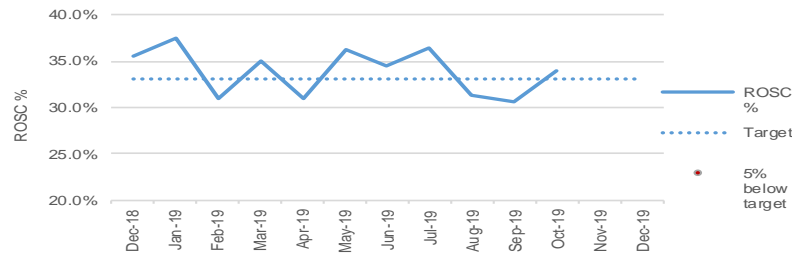
The LAS ranked 3rd for ROSC on arrival at hospital reporting 33.9% against a national average of 31.0%.

Sepsis Care Bundle

Month: 90.3%

Target: 95%

NHS England did not publish Sepsis Care Bundle data for October, the next data due to be published will be for December (in May).

STEMI call to angiography

Mean: 02:06

Target: TBC
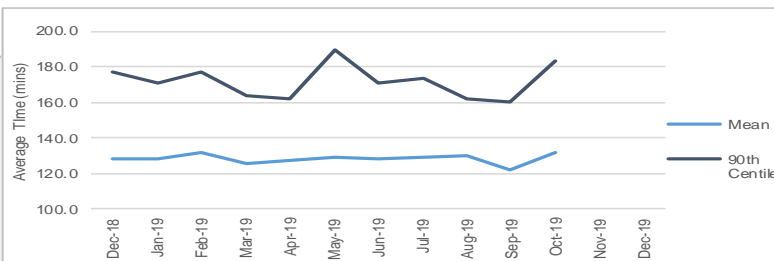
Our average call to angiography time in October was 02:12, an increase of 10 minutes on the previous month but this remains below the national average of 02:16.

Stroke call to door

Mean: 01:09

Target: TBC
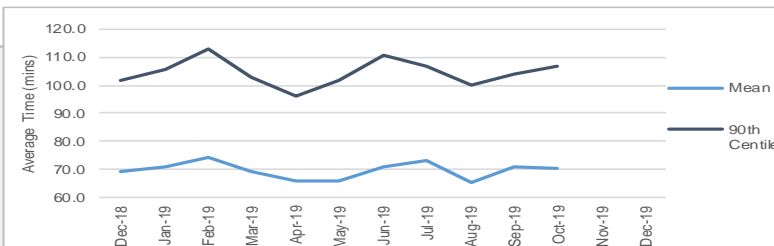
The LAS ranked best in class again for the mean call to hospital for suspected stroke patients (01:10) in October, well above the national average of 01:25.

Call answering dropped significantly in February 2020 for North East London (NEL) and South East London (SEL) due to the 111 services picking up a large part of the Trust and National response to COVID-19 in assessing, signposting and tracking affected people. Both sites are within target for calls transferred to 999, where we consistently perform better than the London average. However, due to heavy pressure of the COVID-19 response, we have seen higher abandonment rates this month.

South East London (SEL) | North East London (NEL)

Call Answering & Abandoned Calls

SEL: **50.4%** /**11.5%**

Target: 95% (CA) and 5%

NEL: **40.2%**/**16.7%**
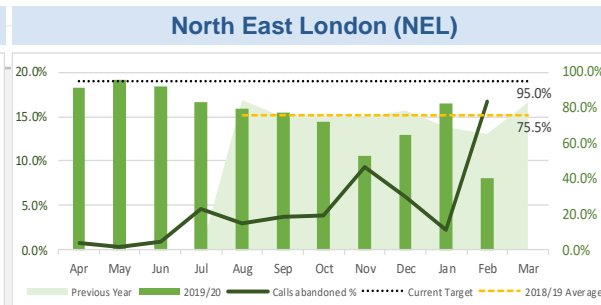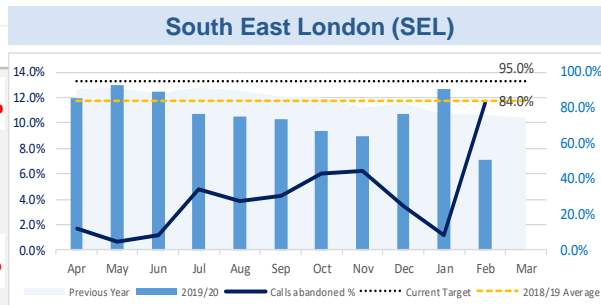
The performance of 111/IUC services is critically important during bank holiday periods given the closure of some primary care services and are continually improving month on month.

The number of calls abandoned by patients has been higher due to the heavy demand of the COVID-19 response.

% of calls closed with no onward referral

SEL: 29.1%

Target: >33%

NEL: 28.3%
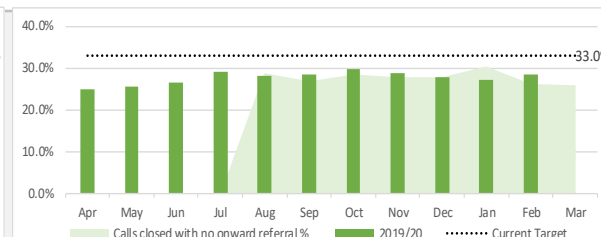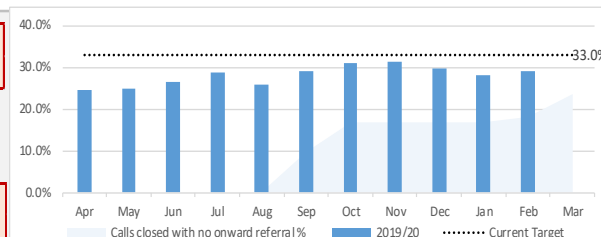
We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system.

Calls Outcome: Transferred to 999

SEL: 7.0%

Target: <10%

NEL: 8.3%
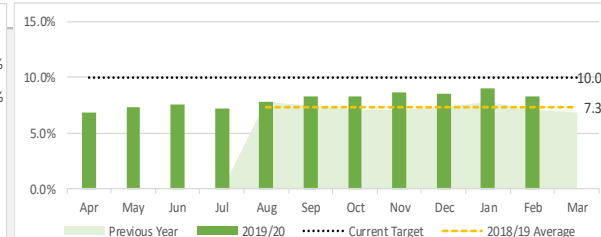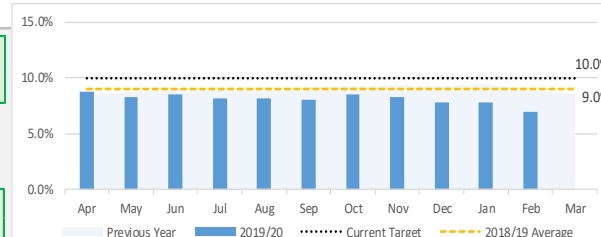
Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During February, NEL delivered 8.3%, with SEL delivering 7.0%. This performance compares positively against the London average which was circa 10% and remains the lowest of all providers in London, indicating the benefits of a clinical assessment service (CAS).

Call Outcome: Recommended to attend ED

SEL: 8.3%

Target: <5%

NEL: 7.9%
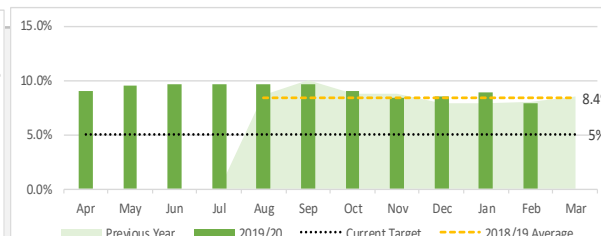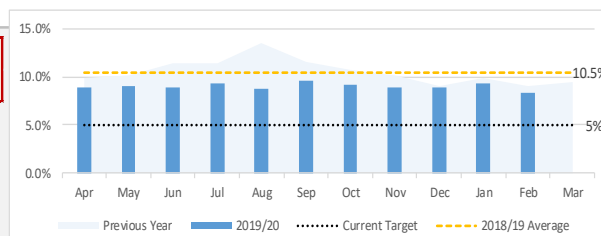
The development of our IUC services has enabled NEL and SEL to consistently outperform other providers in terms of A&E avoidance, however there is still a lot more work to do to minimize the recommendation for patients to attend A&E.

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.1	We will deliver our national performance and quality standards by optimizing our operational response model and delivering our operational plan	Khadir Meer / Pauline Cranmer	🟡	The 999 Operating Plan was approved by the ExCo on 7th August. The focus has now moved to delivering the plan which is targeting improved frontline performance through a combination of higher quality, efficiency and productivity initiatives. Progress against each of the workstreams (efficiencies, clinical response, people, vehicles) is being managed by the biweekly Operational Performance Group chaired by the interim Director of Emergency Ambulance Services. The works streams continue to be managed through their ADO leads, with central oversight from the Director of Ambulance Services. Of the 48 actions within the plan – 39 are recorded as closed (delivered or now as part BAU activity), 7 are Green (on track), 2 are Amber (at risk) and 0 are Red (off track).
BP.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.	Khadir Meer / Athar Khan	🟡	The IUC team have amalgamated three plans into one master plan. This plan covers; • Initial feedback from technical and restructure groups • Feedback from After Action Review • Action plan from Freedom to speak up concerns In addition to this we have agreed a minimum resourcing level, to provide clinical assurance within our financial envelope. The CAS resourcing is overseen by a senior CAS manager and ensures that clinical resourcing as a degree of rigour and compliance. We continue to work with commissioners to build a suitable reporting suite for future CAS metrics. As part of our winter preparations we have changed the resourcing plan which has resulted in better outturn in call handling and abandonment rate. Internally we are developing a model to have a better understanding of short term expected demand which allows to amend call taking resource requirements on a more flexible basis, responding better to demand.

🟢 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.1 Performance and Quality standards Narrative:

The 999 Operating Plan was approved by the ExCo on 7th August. The focus has now moved to delivering the plan which is targeting improved frontline performance through a combination of higher quality, efficiency and productivity initiatives. Progress against each of the work streams (efficiencies, clinical response, people, vehicles) is being managed by the biweekly Operational Performance Group chaired by the interim Director of Emergency Ambulance Services.

The works streams continue to be managed through their ADO leads, with central oversight from the Director of Ambulance Services. Of the 48 actions within the plan – 39 are recorded as closed (delivered or now as part BAU activity), 7 are Green (on track), 2 are Amber (at risk) and 0 are Red (off track). There has been progress with closing a number of actions or transferring these to BAU and ongoing activities and the outstanding actions are expected to be completed by the end of the financial year.

		Complete	**G**	**A**	**R**
Total	48	39	7	2	0

- C Complete
- G On track
- A Off Track, will miss due date, with plan in place to resolve issues
- R Irrecoverable, will miss/has missed due date

BP.2 IUC/111 Performance Narrative

The IUC team have amalgamated three plans into one master plan. This plan covers;
• Initial feedback from technical and restructure groups
• Feedback from After Action Review
• Action plan from Freedom to speak up concerns
In addition to this we have agreed a minimum resourcing level, to provide clinical assurance within our financial envelope. The CAS resourcing is overseen by a senior CAS manager and ensures that clinical resourcing as a degree of rigour and compliance. We continue to work with commissioners to build a suitable reporting suite for future CAS metrics.

IUC/111 Performance is overseen by BAF risk 54

IUC/111 improvement plan measures October 2019

Existing controls:
1. Daily monitoring of metrics including safety.
2. Executive oversight – direct reports meetings.
3. Thematic review of incidents and complaints weekly reflected in monthly quality report.
4. Revised forecast and planning modelling to improve resource productivity and capacity particularly at weekends.
5. Dashboards have been developed by F&P team to improve oversight and understanding of staffing required and these are having a significant impact in improving performance.
6. Scrutiny through both internal and external committees, QOG, QAG, CQRG.
7. Secured the support of regulators and commissioners in identifying further potential sources to recruit and retain medical staff within the CAS.
8. Additional capacity and capability engaged to assist in the delivery of the improvement plan.

Further actions:
1. The simulation software which was approved by ExCo, aiming to achieve a better understanding of staffing requirements and skill mix for optimum performance and safety. The simulation is in it's final stages of completion and the outputs to be shared shortly and implemented.
2. Development of productivity measures to add to the performance score card to ensure oversight of productivity. We have now developed basic productivity measures and are looking at integrating telephony data to enhance them.
3. The Forecasting and Planning department are developing a tool aiming to achieve a stronger understanding of short term expected demand which allows to amend call taking resource requirements on a more flexible basis, responding better to demand.

People Scorecard

February 2020

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Current Performance Latest Month	Year To Date (From April)	Rolling 12 Months	Trajectory FY20/21 Trajectory	Benchmarking National Data	Best In Class	Ranking (out of 11)
Staff Engagement Theme Score	Yearly	(n)	Feb-20	⚪	6.5	Internal	6.1		6.2		6.3	6.6	
Staff Survey Response Rate	Yearly	%	Feb-20	🟢	≥65%	Internal	72%					72%	1
Vacancy Rate (% of establishment)	Monthly	%	Feb-20	🟢	5%	Internal	2.7%	3.1%	3.2%				
Staff Turnover (% of leavers)	Monthly	%	Feb-20	🟢	10%	Internal	9.8%	11.4%	11.5%				
Equality, Diversity & Inclusion Theme Score	Annual	(n)	Feb-20	🟢	8.3	Internal	8.1		8.0		8.5	9.5	
BME Staff Engagement Theme Score	Yearly	(n)	Feb-20	⚪	6.4	Internal	6.2		6.1				
% of BME Staff	Quarterly	%	Feb-20	🟡	17.5%	Internal	16.0%	15.8%	15.7%				
Staff Sickness levels (%)	Monthly	%	Feb-20	🟡	5%	Internal	5.4%	5.3%	5.3%				
Health and Safety (% of RIDDOR reports mtg <15day or less tgt)	Monthly	%	Feb-20	🔴	100%	Internal		47%	79%	80%			
MSK Related Staff Injuries (Staff Survey)	Yearly	%	Jan-20	⚪	<48%	National							
Rate of working days per 1,000 incidents lost due to MSK injuries	Monthly	(n)	Feb-20	🔴	2		0.77	3.41	3.51				
Bullying & Harassment (Safe Environment Theme)	Yearly	(n)	Feb-20	⚪	7.3	Internal	7.0		6.1		7.4	7.5	
Flu Vaccination Rate (Trust Total)	Monthly	%	Feb-20	⚪	75%	Internal	55.0%	55.0%	55.0%				
Statutory & Mandatory Training (85% or above)	Monthly	%	Feb-20	🟢	85%	Internal	85.0%	84.0%	85.0%				
Staff PDR Compliance (85% or above)	Monthly	%	Feb-20	🟡	85%	Internal	78.4%	78.8%	78.6%				
Improve leadership and management across the Trust (Visible and Engaging Leader Programmes - target of 36% of Trust Managers in 2019/20)	Monthly	(n/%)	Feb-20	🟡	36%	Internal	14.0%	14.0%	14.0%				
Level 3 Safeguarding Training Completed (90% target over 3yr period)	Monthly	%	Feb-20	🟢	800	National	100.0%	85.0%	85.0%				

🟢 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
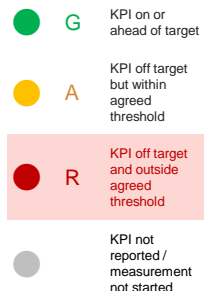
Recruitment

Trust	Monthly Trend	Frontline	

Trust

Month:

5 FTE

Target: 5 FTE

SECTOR OPERATIONS FRONTLINE REQUIRED V FORECAST

Required Frontline: 685FTE

Forecast Supply:646FTE

Forecast Gap: 39FTE

The paramedic position has improved due to a reduction in leavers against plan and the forecasted end of year position for Sector Operations (registered and non-registered) is less than 1% vacancies. For those available to be rostered (the 'in-ops' rate) we are forecasting a 3% gap at year end (80fte). Currently, the 'in-ops' vacancy rate for our frontline registered and non-registered staff is 2.4% (82fte vacancies). Planning for our 2020/2021 frontline requirements is well underway which include the supply of 220fte Paramedics to the London Primary Care Networks from 2021/2022. Activities include a planned international trips to Australia in Q1 and Q4, skype interviews and Band 5 TEAC recruitment.

Vacancy Rate

Month: 2.7%

Target: 5%
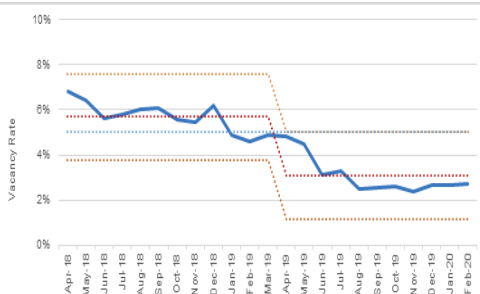
All Frontline: 2.4%

Paramedics: 0.1%

EOC: 3%

Our overall vacancy rate is below target at 2.7%. EOC Recruitment – the recruitment pipelines are now in place to address turnover. For the second successive month we have seen a reduction in the expected number of leavers in EOC and the vacancy rate has improved from 7.1% to 3%. Our end of year forecast is 4.7% (13.6fte vacancies). Work is underway to update the workforce plan to reflect demand. NETS recruitment is progressing well and we expect to be fully established by the end of the year. Overall 111 vacancy rate at 20%. A workforce planning model is being developed to identify requirements and potential pipelines for the next three year period.

Staff Turnover

12 Month Rolling: 9.8%

Target: 10%
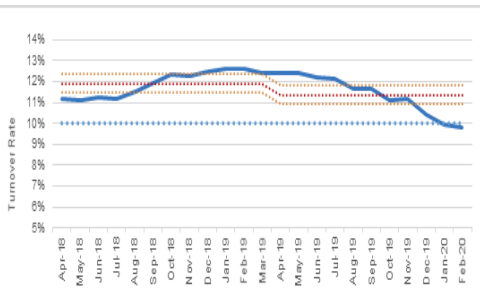
Staff turnover rates have improved to 9.9% and we continue to see a lower number of Sector and EOC leavers than forecasted. A draft retention improvement plan has been collated following feedback received from staff via the LIA Facebook post and RIB Survey (both received more than 300 comments). The plan looks at 4 keys areas (1) Career & progression, (2) Leadership & Management, (3) Recognition and Value and (4) Retention Data; and prescribes tasks which can be carried out to improve the above. The next step will be to set up a Retention Steering Group. The one to one retention interviews with the international paramedics approaching their three year anniversary with the LAS have continued and this is helping to improve retention for this group. We have also agreed to fund any international paramedics who wish to apply for indefinite leave to remain. We are one of the Trusts in the 5th Cohort National Retention Programme, a jointly led programme by NHSIE and NHS Employers. The programme offers trusts a range of support, which now forms an essential part of delivering the interim NHS People Plan and the NHS Long Term Plan.

Sickness

12 Month Rolling: 5.4%

Target: 5%
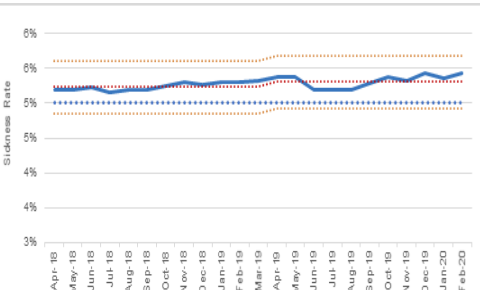
The Managing Attendance Policy (MAP) is currently under review following feedback from the CEO Roadshows, a joint Management and Staffside request in the RIB and free text comments from the Staff Survey. On 11th February, a workshop was undertaken with 8 staff-side representatives, which included a review of the feedback, a discussion regarding the limitations of the current policy and its implementation, agreed common themes which need to be considered when redrafting, and that the Policy should be accompanied by a management / staff-side training programme to ensure changes to practice are embedded across the organisation. The draft is expected to ready by the end of March. The work around the Occupational Health & Wellbeing scoping exercise has concluded, and the business case and specifications are being prepared. Due to the length of a full OJEU process, we have extended the arrangements with PAM for a further 12 month period until September 2021.

Compliance with Health and safety action plan:

Actions arising from the Health and Safety Review have been progressed in line with the action plan; 66/69 actions have been completed (and continue to be embedded) and 3 actions are in progress and on schedule/behind schedule.

Adverse Staff Events

*The total number of H&S incidents was 1231 (917 of which are nCOV related incidents) resulting in **13.17 events per 1000 A&E (face to face) incidents**. The breakdown of these events is shown in the analysis below.*

136 (11%) of the H&S related incidents reported during February – 2020 resulted in Low Harm.

9 (1%) of the H&S related incidents reported during February - 2020 resulted in Moderate Harm.

In line with the Trust Risk Management Strategy all RIDDOR incidents are graded as minimum moderate harm, this also aligns with the HSE RIDDOR requirements. This will help ensure management attention is focussed on proportionate interventions. (Hence the spike from April 2019).

Month:1.46

Low Harm

Rate per 1000 incidents (chart: Apr-18 to Feb-20)

Month: 0.10

Moderate
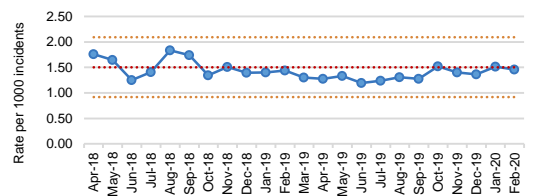
Rate per 1000 Incidents (chart: Apr-18 to Feb-20)
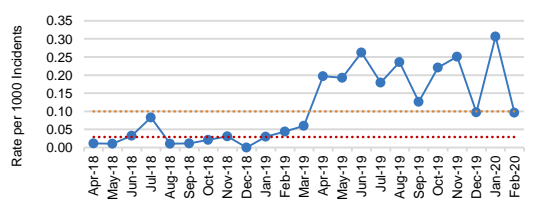
Manual Handling

- *Work to start on formalising Standard Operating Procedures, updating Risk Assessments and producing training aides for Moving and Handling Equipment in collaboration with frontline staff.*

- *The Manual Handling Steering Group is taking place and we are working towards agreeing the next years' MSK work plan.*

Manual Handling

Rate of Trust-wide MH Incidents: Low Harm vs Moderate Harm vs Total MH Handling Incidents per 1000 A&E Incidents

(chart: Mar-19 to Feb-20)
- Rate of Low Harm - MH Incidents per 1000 A&E (Face to Face) Incidents
- Rate of Moderate Harm - MH Incidents per 1000 A&E (Face to Face) Incidents
- Rate of MH Incidents per 1000 A&E (Face to Face) Incidents

Manual Handling Related Sickness

Rate of Working Days Lost due to Manual Handling related Sickness per 1000 A&E (Face to Face) Incidents

(chart values: 4.54, 7.13, 2.67, 3.32, 4.89, 2.66, 4.98, 2.51, ..., 0.77)
- Series1
- Linear (Series1)

New Indicator 2019/20

Health and Safety (% of RIDDOR reports <15day target)

17/18	18/19	2019/20 Year to Date
49%	80%	79%

TB MSK related staff injuries (staff survey) Yearly %

17/18	18/19	2019/20 Target
48%	54%	<48%

Rate of working days lost per 1,000 incidents due to MSK injuries

17/18	18/19	2019/20 Year to Date
3.1	3.6	3.41

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 *:*

Monthly Trend

Rate of Incidents

H&S Incidents & RIDDOR Reports Rate per 1,000 A&E (Face to Face) Incidents

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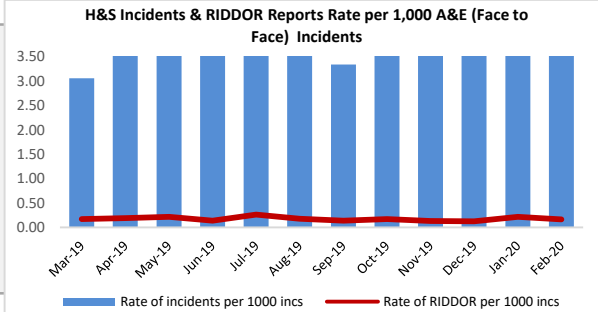
The graph on the left highlights the YTD rate of H&S and RIDDOR incidents per 1000 A&E incidents attended by the Trust.

There is no benchmark/comparable data was received from any of the other ambulance Trusts during February 2020.

RIDDOR by Cause

RIDDOR Reportable Incidents by Cause - YTD

- Slips, Trips and Falls 39
- Security (V&A) 8
- Staff Safety 17
- Infection Control 8
- Incidents affecting patients 4
- Manual Handling 112
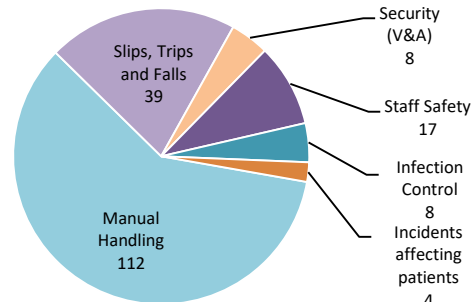
- Total of 188 RIDDOR incidents reported to the HSE during 2019/20 (up to end of February'20)
- Total of 15 RIDDOR incidents reported to the HSE during February'20.
- 8 out of the 15 incidents reported outside the 15 days timeframe during February'20.
- The Trust wide RIDDOR reporting time frame (<15 days) compliance in February'20 was **47%.**
- Manual Handling & incidents account for the highest number of RIDDORs reported across the Trust during 2019/20 (up to end of February'20).

Assaults

Assaults on Staff by Patients

Number of Assaults: 32, 45, 54, 39, 44, 63, 47, 67, 49, 44, 65, 37
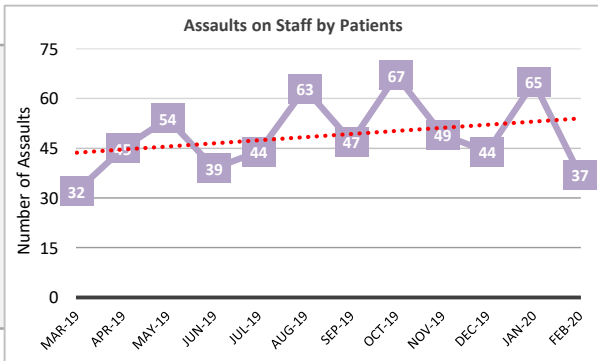
There was an small decrease in the number of assaults on staff by patient related incidents in February 2020 but the trend is up-ward.

The most common underlying causes remain: intoxication (drugs/alcohol), Mental Health related issues, patients recovering from fits/seizures or reacting to medication.

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.

Equality, Diversity and Inclusion Standards	**Statutory and Mandatory Training and Appraisals**

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 2018 to February 2020. During this period we have had 489fte BME starters and 244fte BME leavers, a net increase of 245fte. Overall numbers of BME staff continue to increase (currently 994) although this representation varies at different levels in the organisation.

Trust compliance in Statutory and Mandatory training is **85%.** Over 99% of our 6,020 substantive staff have logged into MyESR and 98% of this group have completed E-Learning. Over 3,800 E-Learning Courses were completed in February 2020 and over 250,000 have been completed since our OLM go-live in September 2017.

Appraisal completions at 78% at the end of February.

BME Starters
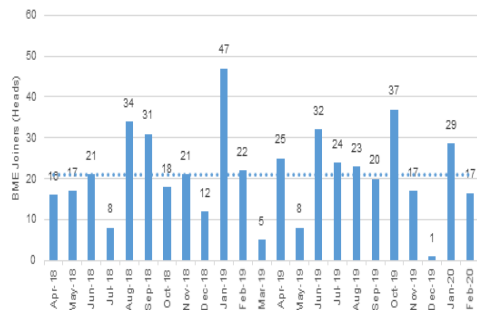
In February the LAS BME network visited Bow to raise the profile of the network. There were a number of drop-in session and this was positively received.

The LAS hosted an event to celebrate LGBT history month event.

Statutory & Mandatory
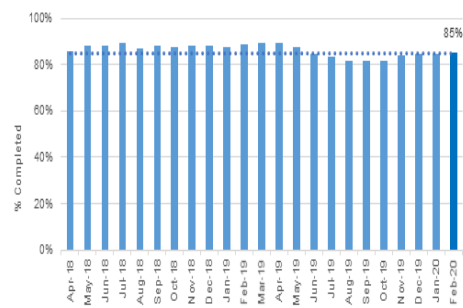
Trust compliance is 85% with Operational teams at 85% and Corporate 82%. EOC, the subject of the CQC Must Do action, is at 91%. Information Governance is at 91% for February and will increase alongside CSR completions.

BME Leavers

Drafting of the annual Gender Pay Report is underway and will be published by the statutory deadline of 31st March 2020. This will report on the position as at 31st March 2019.

Appraisal Compliance
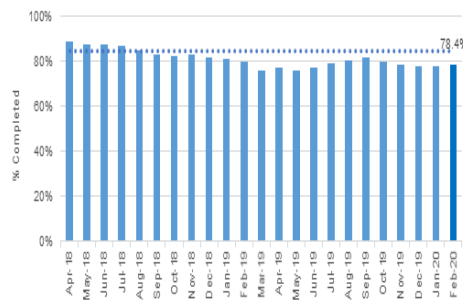
PDR Appraisals were at 78% at the end of February 2020. An improvement plan is being implemented for Corporate (77%) and Operational teams (79%) and weekly reports are provided to Directors to facilitate the required improvement.

Appraisal Narrative

We started the 2019/20 year with an Appraisal compliance rate of 76%. This has stabilised and improved to 78% but is below target. An improvement plan is being implemented for Corporate and Operational teams and weekly reports are provided to Directors to facilitate the required improvement.

This will be formally brought to the ExCo on a quarterly basis.

Appraisal Position as at 29th February 2020

	2019/20											19/20 target	To complete
	30-Apr	31-May	30-Jun	31-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	28-Feb		
308 London Ambulance Service NHS Trust	77.4%	75.6%	76.6%	79.0%	80.5%	81.5%	79.3%	78.4%	78.1%	78.1%	78.4%	85.0%	-6.6%
308 Corporate L3	73.4%	76.4%	78.8%	78.3%	78.8%	81.9%	79.0%	75.9%	73.3%	75.4%	76.8%	85.0%	-8.2%
308 CHX Chief Executive L4	91.7%	83.3%	85.7%	100.0%	78.6%	100.0%	90.5%	88.9%	80.0%	82.6%	75.0%	85.0%	-10.0%
308 CORP Corporate Governance L4	91.7%	91.7%	91.7%	75.0%	84.6%	73.3%	75.0%	75.0%	80.0%	80.0%	60.0%	85.0%	-25.0%
308 SAP Strategic Assets & Property L4	16.5%	29.5%	38.1%	43.1%	48.2%	53.3%	66.2%	69.4%	69.4%	75.5%	84.1%	85.0%	-0.9%
308 FIN Finance L4	97.0%	100.0%	97.1%	88.6%	82.1%	69.2%	50.0%	52.0%	50.0%	48.0%	88.0%	85.0%	3.0%
308 IM&T Information Management & Technology L4	92.1%	87.3%	86.9%	93.7%	88.2%	95.5%	78.9%	79.5%	74.0%	76.1%	91.2%	85.0%	6.2%
308 MED Medical L4	86.1%	87.0%	88.2%	86.4%	86.9%	89.1%	85.1%	80.5%	76.8%	78.1%	78.0%	85.0%	-7.0%
308 NED Chairman & Non Executive L4	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	85.0%	-85.0%
308 PER Performance L4	93.3%	100.0%	100.0%	66.7%	83.3%	80.0%	81.8%	81.8%	75.0%	69.2%	83.3%	85.0%	-1.7%
308 P&C People & Culture L7	88.5%	90.5%	95.2%	88.9%	84.1%	87.9%	74.6%	61.2%	61.2%	60.3%	52.9%	85.0%	-32.1%
308 Q&A Quality & Assurance L4	96.8%	92.3%	91.0%	85.5%	93.0%	91.5%	87.2%	80.8%	79.7%	87.7%	83.8%	85.0%	-1.2%
308 S&C Strategy & Communications L4	76.0%	87.5%	82.6%	91.7%	83.3%	95.8%	100.0%	92.6%	88.0%	75.9%	46.5%	85.0%	-38.5%
308 Operations L3	77.9%	75.4%	76.2%	79.2%	80.7%	81.5%	79.4%	78.8%	78.8%	78.5%	78.7%	85.0%	-6.3%
308 RSA Resilience & Specialist Assets L6	86.4%	91.2%	90.6%	92.1%	89.1%	83.1%	77.8%	80.0%	80.3%	80.3%	77.8%	85.0%	-7.2%
308 999 Emergency Operations Centre L6	63.9%	68.3%	69.7%	73.6%	79.3%	81.1%	76.7%	75.2%	72.1%	72.1%	85.1%	85.0%	0.1%
308 111 & Integrated Urgent Care Services L5	52.3%	26.5%	27.3%	28.1%	43.0%	59.4%	65.5%	64.1%	63.9%	63.9%	62.5%	85.0%	-22.5%
308 ECS SEC North Central Sector L6	87.5%	88.0%	86.3%	84.1%	84.0%	83.1%	80.2%	80.1%	80.8%	80.8%	74.5%	85.0%	-10.5%
308 ECS SEC North East Sector L6	72.1%	72.6%	78.0%	83.6%	86.6%	88.9%	86.4%	86.2%	86.2%	86.2%	83.9%	85.0%	-1.1%
308 ECS SEC North West Sector L6	81.6%	78.3%	81.2%	87.3%	85.7%	88.2%	88.6%	90.8%	90.2%	90.2%	88.9%	85.0%	3.9%
308 ECS SEC South East Sector L6	90.6%	87.8%	86.6%	88.1%	89.5%	89.3%	88.8%	86.6%	87.5%	87.5%	83.6%	85.0%	-1.4%
308 ECS SEC South West Sector L6	82.1%	80.5%	79.0%	83.5%	84.3%	83.0%	79.8%	79.8%	80.4%	80.4%	85.4%	85.0%	0.4%

Background

1. Safeguarding Level 3 is now a National Requirement for all clinical staff as of the 1st April 2019

2. As at this date there are 4,816 staff who need to be trained.

3. We will be reporting and monitoring this from September when the Safeguarding team will have recruited additional trainers in post and additional training sessions will be rolled out from this point.

4. A training plan has been agreed with our Commissioners to deliver the training to all clinical staff by March 2022, and targets have been set for each of the years 2019/20, 2020/21 and 2021/22 as follows:

	Year Start	Year End	Compliance Target	% Completed
Year 1	Apr-19	Mar-20	800	17%
Year 2	Apr-20	Mar-21	3,000	62%
Year 3	Apr-21	Mar-22	4,816	100%

5. This is an additional requirement to the current 24 hour allowance for CSR training. Discussions are on-going to plan for this abstraction.

6. As at 31st January we have achieved a compliance rate of 15% against our March 31st 2020 target of 17%.

Safeguarding Trajectory

Safeguarding Level Three Training Trajectory

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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.	Ali Layne-Smith	🟢	Work has been taking place across the organisation, both corporately and locally since the staff survey results were published in February 2019. Over 40 action plans have been developed by Staff Survey Champions based on local staff survey results and details of these were shared at the CEO roadshows. We had an excellent response to our Pulse Survey in Q1 which was an opportunity for staff to answer the 'Staff Friends and Family Test' questions and other staff survey questions. The 2019 survey was launched on 23rd September alongside the CEO roadshows. We achieved a response rate of 71.5%.
BP.4	We will complete the restructuring and recruitment of all Directorates to produce an efficient and lean organisation.	Ali Layne-Smith	🟢	Significant support is ongoing to some large scale organisational restructures including Finance, Logistics, Executive Restructure, EPMO and Quality.
BP.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.	Ali Layne-Smith	🟢	This programme is on track and has so far seen delivery of the Employee Relations Case Management System, (which will enable stronger oversight of all Employee Relations cases and be able to track and monitor timescales and support lessons learnt), Non Payroll Workers (agency staff) on ESR (including 111 Agency Staff). Authority 2 Recruit E-Form – this went live as planned in July, replacing the Workforce Control Panel and Recruitment Authorisation Form. The GRS to ESR Absence Interface automatically populates ESR with absence information from GRS, replacing the current manual process. We are now able to report on Trust wide sickness absence reasons for the first time. There are 7 projects in Phase 3 of the Programme which are currently being managed through the ESR Programme Board: 1. P301 GRS to ESR Attendance Interface - Delivery 2. P302 ESR & OHIO Integration - Delivery 3. P303 Weekly Payroll - Design 4. P304 Digital HR Files - Scoping 5. P305 Management Hierarchy - Scoping commences in Apr-20 6. P306 Relocation Expenses - Scoping commences in May-20 7. P307 ESR Manager Self Service - Scoping commences in Jul-20 The ESR Programme Team are also supporting the synchronisation of ESR and Active Directory.
BP.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.	Ali Layne-Smith	🟢	The new format WRES Action Plan is well underway and the quarterly WRES Action Plan Group, chaired by the Director of People & Culture is bringing strong focus on driving this work forward. The action plan has senior nominated leads who will be involved in the delivery of the plan. The Trust has achieved its 18/19 target of 15% BME representation. Gender Pay results for 17/18 show an improvement in the bonus gap. The pay gap has remained at 5%. Workforce Disability Equality Scheme (WDES) standards - we have completed and submitted the national template and presented the progress report to the People & Culture Committee in October. The WDES is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop a local action plan, and enable the service to demonstrate progress against the indicators of disability equality.

2. Our People

Business Plan Deliverables

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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.	Ali Layne-Smith	🟢	The work around the Occupational Health & Wellbeing scoping exercise has concluded, and the business case and specifications are being prepared. Due to the length of a full OJEU process, we have extended the arrangements with PAM for a further 12 month period until September 2021. Work on the organisational flu programme continues, with two thirds of staff having completed the on-line form (55% vaccinated, 25% have declined). In terms of operational staff, 62% have received their vaccine with 30% declining. The 'Out of Hours' immunisation service is now underway and in its first month delivered over 200 vaccines. Through the month of December, 30 Winter Wellbeing events took place, The Trust has secured access to the "HEADSPACE" mindfulness app for all staff.
BP.8	We will continue to implement our Clinical Education programme to deliver mandatory training and upskill our operational workforce.	Ali Layne-Smith/ 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.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.	Fenella Wrigley	🔵	Student records have been archived and moved to a secure facility. An electronic Student Management System has been procured and implementation has begun. This will ensure a single source of information for learners in programs, and many of the paper records will be transitioned to electronic files this year.
BP.10	We will roll-out training and development for all our leadership and management staff across functional and operational teams.	Ali Layne-Smith	🟢	Leadership development programme in delivery phase and Management Essential programmes also underway. The roll out of the Visible Leader and Engaging Leader programmes continue and both are planned for delivery across the remainder of this year and into next (for Engaging Leader) as we are training in excess of 800 managers across all roles in the organisation. This work is a pillar of the work to change our culture to align with our strategy and values. Continuous improvement will be built into the leadership development pathway elements as delivery progresses.

Public Value Scorecard

January 2020

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Latest Month Actual	Latest Month Plan	YTD Actual	YTD Plan	Rolling 12 Months	FY19/20 Forecast	FY19/20 Plan	National Data	Best In Class	Ranking (out of 11)
						Current Performance					Outturn		Benchmarking		
Control Total (Deficit)/Surplus	£m	Jan-20	🟡	0.024	A	0.593	1.282	(0.111)	2.089		0.025	0.024			
Performance Against Control Total	£m	Jan-20	🟡	100%	A						100%	100%			
Use of resources index/indicator (Yearly)	Rating	Jan-20	🟢	1	A			1	1		1	1			
% of Capital Programme delivered	%	Jan-20	🟡	100%	A	4%	7%	51%	77%		100%	100%			
Capital plan	£m	Jan-20	🟡	20.853	A	0.922	1.564	11.258	17.725		21.953	21.953			
Cash position	£m	Jan-20	🟢	15.1	A	25.5	23.9			21.3	16.7	15.1			
% spend against Agency Ceiling	%	Jan-20	🟢	92%	A	3%	8%	77%	83%		81%	92%			
CIP Savings YTD	£m	Jan-20	🟢	14.808	A	1.126	1.270	11.479	12.223		13.962	14.808			
CIP Savings YTD	%	Jan-20	🟢	100%	A	89%		94%			94%	100%			
CIP Savings achieved - % Recurrent	£m	Jan-20	🟢	11.808	A	1.011	1.314	9.143	9.223		11.312	11.808			
CIP Savings achieved - % Recurrent	%	Jan-20	🟢	100%	A	77%		99%			96%				
Commercial income generation	£m	Jan-20	🔴	0.25	I	0	0	0	0		0	0.250			
Corporate spend as a % of turnover	%	Jan-20	🟡	<7.0%	I	15.9%	17.7%	15.0%	17.8%		15.3%	18.0%			
Cost per incident	£	Jan-20		£347	I						£ 332	£ 332			
Average Jobs per shift	%	Jan-20	🟢	5.3	I	5.5		5.5		5.3					

🟢 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

CQUINs

The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Details of the Trust's CQUINs is shown in the table below with details from the Q3 review to inform forecasted payments for the rest of the FY.

Urgent Care & Emergency Services CQUIN	Description	Weighting	Owner	CQUIN YTD	CQUIN Target	Total Value FY19/20	Predicted achievement	
Staff Flu Vaccinations	To improve the uptake of flu vaccinations amongst frontline healthcare workers with a target of 80% in 2019/20	0.25%	Fenella Wrigley	Q4	>80%	£843k	£843k	100%
Access to Patient Information – Assurance Process	Achievement of NHS Digital's assurance process for enabling access to patient information on scene, by ambulance crews via one of the four nationally agreed approaches i.e. SCRa (Q1, Q2, Q3 & Q4)	0.50%	Khadir Meer	Reporting is completed via NHS Digital		£1,687k	£1,687k	100%
Access to Patient Information – Demonstration	Achieving 5% of face to face incidents resulting in patient data being accessed by ambulance staff on scene. (Q3 & Q4)	0.25%	Khadir Meer	0.39%	>5%	£843k	£843k	100%
NHS Number reporting	To commence NHS Number reporting via the contractual MDS.	0.25%	Khadir Meer	Q4	>20%	£843k	£843k	100%
TOTAL		1.25%				£4,213k	£4,213k	100%

CQUIN achievement is guaranteed for 2019/20 as agreed as part of the contract settlement with commissioners.

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.

SEL IUC CQUIN	Description	Weighting	Owner	CQUIN YTD	CQUIN Target	Total Value FY19/20	Predicted achievement	
Calls answered in 60 seconds	Proportion of calls answered in 60 seconds	0.25%	Khadir Meer	77.7%	>95%	£22k	£9k	40%
Cat 3 & 4 ambulance revalidation	Proportion of calls initially given a category 3 or 4 ambulance disposition that are revalidated	0.25%	Khadir Meer	76.9%	>80%	£22k	£18k	80%
ED Disposition revalidation	Proportion of calls initially given an ED disposition that are revalidated	0.25%	Khadir Meer	39.5%	>80%	£22k	£0k	0%
Call back targets	Proportion of call back targets being met	0.25%	Khadir Meer	95% across 7 priorities		£22k	£0k	0%
Activity from External sources	Reporting and reviewing of activity originating from external sources e.g. 111 online and other 111 providers	0.25%	Khadir Meer	Multiple targets		£22k	£22k	100%
TOTAL		1.25%				£111k	£49k	56%

NEL IUC CQUIN	Description	Weighting	Owner	CQUIN Target	Total Value FY19/20	Predicted achievement	
Staff Flu Vaccinations	Improving the uptake of flu vaccinations for all NEL IUC staff	0.50%	Fenella Wrigley	> 75%	£45k	£0k	0%
Calls closed as Self-Care	Measuring the total numbers of calls closed which do not require onward referral, reducing pressure on the wider health service.	0.38%	Khadir Meer	>33%	£33k	£17k	50%
Referrals & Management of Patients within the CAS*	To promote hear and treat to support enhanced clinical decision making and avoid unnecessary A&E attendances and subsequent admission.	0.38%	Khadir Meer	95% across 7 priorities	£33k	£0k	0%
TOTAL		1.25%			£112k	£17k	15%

The full year outturn for the Trust is £25k surplus which is on plan to meet our control total. The month ended with a strong cash position of £25.5m.

YTD outturn vs budget
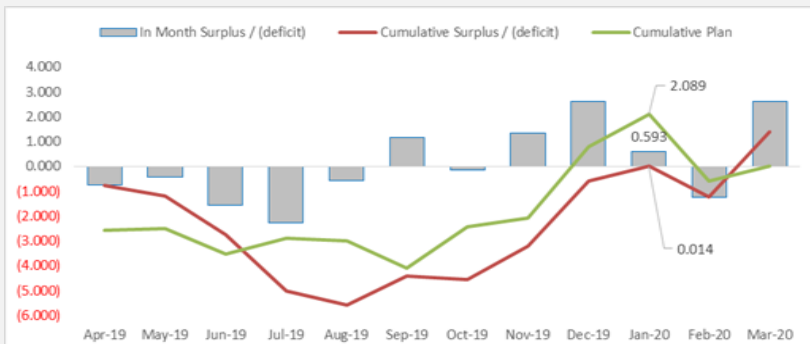
- **YTD position:** YTD position at month 10 is a £0.01m surplus (inclusive of £125k prior year adjustments), against a plan of £2.1m surplus (£2.1m adverse variance). The YTD position includes £1.7m of assumed technical mitigations (YTD Impact) as a result of asset re-lifing that are awaiting to be formally signed-off.

- **Full year forecast:** The full year forecast at month 10 is a £150k surplus, inclusive of £125k prior year adjustments, which is in line with plan. The forecast prior to assumed technical adjustments is a £1.9m deficit (an improvement of £3m), predominantly driven by re-assessment of pre-useful life adjustment depreciation costs and revised non-pay forecast spend assessments, offset by an increase in frontline operations resource costs. The assessment of the full extent of technical mitigations possible has reduced by £3m between month 9 and 10 (from £5.1m to £2.1m) following external audit advice.

- **Risks**: Given the non-delivery of previously identified mitigations in relation to IUC clinical triage costs and frontline pay costs, delivery of the control total will require technical adjustments in relation to asset re-lifing to be successfully completed, and the identification of significant additional savings or income.

Financial Position Metrics

	YTD		Full year	
	Plan	Actual	Plan	Actual
Capital service cover rating	1	1	1	1
Liquidity rating	1	1	1	1
I&E margin rating	2	2	2	2
I&E margin - distance from plan	1	1	1	1
Agency rating	1	1	1	1
Overall rating	1	1	1	1

- **Use of Resources:** NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). The table left shows the Trust's Use of Resources rating for YTD to month 10 and full year forecast. The Trust's YTD rating is a 1 which is in line with the submitted plan.

- **Capital**: YTD capital spend is £11.3m, which is £6.5m behind plan. The Trust reprioritised schemes across its capital portfolio in month 7. Month 10 expenditure was £0.9m, significantly below EPMO forecast (£3.3m) and below the M8 - M9 run rate, putting pressure on the full year forecast. Following reprioritisation, schemes are being managed through the Enterprise Programme Management Office and reviewed at Portfolio Management Board. The Trust is forecasting to spend its full plan of £20.8m, plus an additional £1.1m in relation to the OneLondon project to be transferred from CCGs which has recently been added to its CRL. However in order to deliver this over the remainder of Q4 spend is required to be around £5.3m per month on average.

Cash position
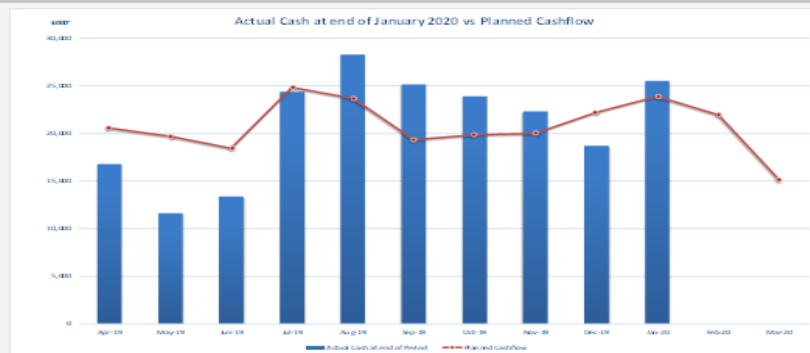
- **Cash:** Cash was £25.5m as at 31 January 2029, £1.7m above plan, primarily due to under spends on capital and provisions and higher cash receipts from income offset by over spending on non-pay expenditure and pay (re-banding of ambulance crews). Cash is forecast to be £16.7m as at 31 March 2019, £1.5m above plan. The main reason for the small favourable position is improved year-end debtor balances and the under spends on capital and provisions being offset by higher than expected pay (re-banding of ambulance crews) and non-pay expenditure.

- **Better Payment Practice Code**: The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days. The NHS and Non-NHS performance by volume for January 2020 was 87.9% and 89.3% respectively. The Trust has a high volume of overdue invoices waiting to be approved and Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.

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 2020)

	Month 10 2019-20 £000			YTD Month 10 2019-20 £000			Full Year 2019-20 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance to budget fav/(adv)
Income									
Income from Activities	34,565	36,274	1,708	333,745	338,561	4,815	397,937	405,584	7,647
Other Operating Income	759	1,297	538	4,795	6,893	2,098	6,418	8,395	1,976
Total Income	35,324	37,571	2,246	338,540	345,453	6,913	404,355	413,979	9,624
Operating Expense									
Pay	(25,162)	(25,762)	(601)	(249,541)	(254,613)	(5,072)	(299,572)	(303,121)	(3,549)
Non Pay	(6,930)	(9,399)	(2,469)	(69,845)	(76,335)	(6,489)	(83,793)	(92,793)	(9,000)
Total Operating Expenditure	(32,092)	(35,162)	(3,070)	(319,386)	(330,948)	(11,562)	(383,365)	(395,913)	(12,548)
EBITDA	3,233	2,409	(824)	19,153	14,505	(4,648)	20,990	18,066	(2,925)
EBITDA margin	9.2%	6.4%	(2.7%)	5.7%	4.2%	(1.5%)	5.2%	4.4%	(0.8%)
Depreciation & Financing									
Depreciation & Amortisation	(1,569)	(1,395)	174	(13,262)	(10,637)	2,625	(16,400)	(13,207)	3,193
PDC Dividend	(388)	(434)	(46)	(3,880)	(3,926)	(46)	(4,656)	(4,794)	(138)
Finance Income	8	16	8	100	142	43	117	161	44
Finance Costs	(2)	(3)	(0)	(22)	(48)	(26)	(27)	(53)	(26)
Gains & Losses on Disposals	0	(1)	(1)	0	(23)	(23)	0	(23)	(23)
Total Depreciation & Finance Costs	(1,950)	(1,816)	134	(17,064)	(14,492)	2,573	(20,966)	(17,916)	3,051
Remove STP funding 2018/19	0	0	0	0	(125)	(125)	0	(125)	(125)
Net Surplus/(Deficit)	1,282	593	(690)	2,089	(111)	(2,201)	24	25	1
NHSI Adjustments to Fin Perf									
Remove Depr on Donated assets	3	3	(1)	32	30	(2)	38	35	(3)
Adjusted Financial Performance	1,285	595	(690)	2,121	(82)	(2,203)	62	60	(2)
Net margin	3.6%	1.6%	(2.1%)	0.6%	(0.0%)	(0.6%)	0.0%	0.0%	0.0%

YTD position

YTD position for the Trust is a deficit of £111k deficit inclusive of PSF (excluding 18/19 STP funding), which is £2.2m behind plan. Key drivers of this position are:

- A&E contract income based on the revised contract of £373m, which is full year over performance of £5m, and additional income to support recurrent workforce cost pressures that have arisen in year of £5m e.g. Emergency Ambulance Crew pay uplift, holiday pay overtime
- Other operating income £2.1m favourable to plan driven by apprenticeship income, training & education funding and stadia & events income.
- An additional £0.9m income in respect of COVID19 costs.
- £1.7m of assumed technical mitigations as a result of asset re-lifing that are awaiting to be formally signed-off.
- Ambulance Services and IUC pay overspends of £7.4m and £2m respectively driven by costs of delivering increased activity and stability of services, offset by underspends in 999 Services (£1.3m) and vacancies across non-frontline operations teams (£3.3m).
- £6.5m unbudgeted spend on managed services and GP costs relating to the cost of delivering safe levels of performance within IUC.
- £1.2m overspend on transport costs, driven by the cost of private ambulance to support frontline operations deliver higher levels of activity being offset by lower fuel, insurance and leasing costs
- £1.5m overspend on non-pay costs relating to frontline staff (subsistence, travel, relocation, uniforms).

Full Year forecast

The full year forecast position is £150k surplus (£25k surplus excluding 18/19 STP funding), which is on plan. Delivery of this forecast position is currently predicated on technical adjustments of £2.1m and additional COVID19 income of at least £1.3m. Key variances in the forecast position align to those as described in the YTD narrative above:

- Income from Patient care is £7.6m above plan due to the new contract settlement and forecast COVID19 income.
- Other operating income £2m favourable to plan driven by apprenticeship income, training & education funding and stadia & events income.
- Pay overspend of £3.5m driven by costs of delivering increased 999 activity (£6.8m) offset by vacancies across non-frontline operations teams.
- Non Pay overspend of £9m, driven by primarily by costs of IUC managed services and GPs (£8.7m).
- A reduction in Depreciation costs of £2.1m due to planned asset re-lifing.

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 2020)

	Aug-19 Actual £000	Sep-19 Actual £000	Oct-19 Actual £000	Nov-19 Actual £000	Dec-19 Actual £000	Jan-20 Actual £000	Jan-20 YTD Move £000	Jan-20 YTD Plan £000	Jan-20 Var £000
Opening Balance	24,366	28,250	25,165	23,902	22,325	18,675	21,718	21,718	0
Operating Surplus	945	2,715	1,403	2,918	2,349	2,409	14,507	18,237	(3,730)
(Increase)/decrease in current assets	2,939	(5,311)	789	(1,592)	(4,363)	5,748	3,996	10,865	(6,869)
Increase/(decrease) in current liabilities	270	2,005	(1,364)	(1,876)	665	2,022	(228)	1,225	(1,453)
Increase/(decrease) in provisions	214	68	(69)	87	(215)	(315)	1,010	(6,962)	7,972
Net cash inflow/(outflow) from operating activities	4,368	(523)	759	(463)	(1,564)	9,864	19,285	23,365	(4,080)
Cashflow inflow/(outflow) from operating activities	4,368	(523)	759	(463)	(1,564)	9,864	19,285	23,365	(4,080)
Returns on investments and servicing finance	7	23	11	19	16	16	116	98	18
Capital Expenditure	(491)	(431)	(2,033)	(1,133)	(2,102)	(3,037)	(13,447)	(19,000)	5,553
Dividend paid	0	(2,154)	0	0	0	0	(2,154)	(2,328)	174
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	(484)	(2,562)	(2,022)	(1,114)	(2,086)	(3,021)	(15,485)	(21,230)	5,745
Movement	3,884	(3,085)	(1,263)	(1,577)	(3,650)	6,843	3,800	2,135	1,665
Closing Cash Balance	28,250	25,165	23,902	22,325	18,675	25,518	25,518	23,853	1,665

Operating Position

- There has been a net outflow of cash to the Trust of £3.8m, this is £1.7m higher than the planned inflow of £2.1m.

- Cash funds at 31 January stand at £25.5m.

- The operating surplus at £14.5m is £3.7m below plan.

Current Assets

- The movement on current assets is £4m, (£6.9m) lower than the planned movement.

- Current assets movement was due to receivables £0.3m, accrued income (£5.8m), prepayments (£0.7m) and inventories (£0.7m).

Current Liabilities

- The movement on current liabilities is (£0.2m), (£1.5m) lower than the planned movement.

- Current liabilities movement was lower than planned due to trade and other payables (£4.1m) and accruals £2.7m.

Provisions

- The movement on provisions is £1m, which is £8m higher than the planned movement. £4.8m of this movement is related to a technical adjustment to the accounts that occurred after the plan was submitted.

Capital Expenditure

- Capital cash outflow is £13.4m, which is £5.6m below plan due to capital slippage.

Cost Improvement Programmes (CIPS) and Capital Plan

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

Cost Improvement Programmes (CIPS)

- The Trust is forecasting £14.0m delivery against its £14.8m CIP target in 2019/20. This £0.8m shortfall is being mitigated through additional savings identified as part of in-year financial recovery.
- Of the £14.0m forecast, 81% is recurrent delivery

CIP Savings

FY Forecast: £14.0m

FY Target: £14.8m
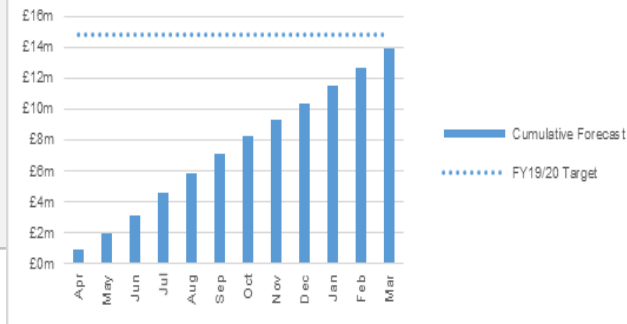
Capital Plan

- YTD Capital spend is £11.3m against a plan of £17.7m, £6.5m behind plan
- Month 10 expenditure is £0.9m, significantly below both the M8 - M9 run rate (£2.5m average) and EPMO forecast (£3.3m) putting pressure on the full year forecast.
- The Trust is forecasting to spend its full planned capital allocation of £21.9m.
- The current EPMO forecast is for spend across Feb-Mar to average £5.3m per month.

Capital Plan Breakdown

YTD: £11.3m

FY Plan: £21.9m
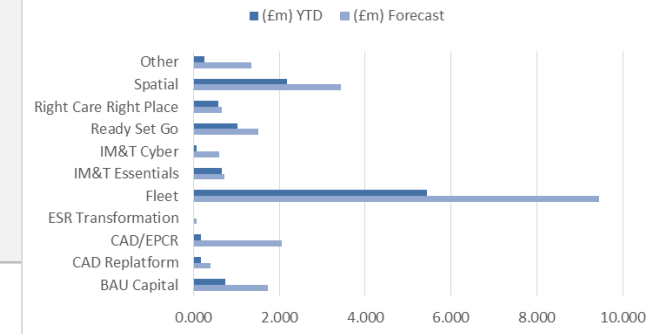
Jobs per shift (DCA)

Average jobs per 12 hour shift

Actual: 5.1

Target: 5.3
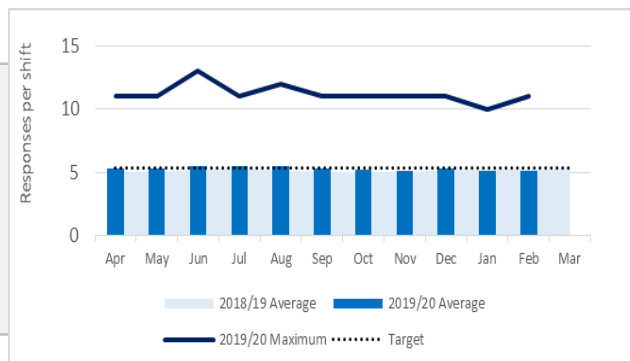
Operations are tracking the performance of jobs per shift on a monthly basis and are consistently hitting the agreed target. While there is no programme of work focusing solely on this metric, a number of our efficiency and productivity schemes will impact this number. For example success in improving Handover to Green times and reducing OOS CIPs would improve the Jobs per shift measure

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.11	We will deliver our control total and maintain our use of resources rating with NHSI.	Lorraine Bewes	🟡	Delivery of the Trust Control total remains at risk, due to a combination of factors. The Trust has developed a Financial Recovery Plan which is currently being implemented
BP.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.	Lorraine Bewes	🟢	A revised forum for consideration of future contracting / commissioning arrangements is being established. A range of potential options for discussion are being developed. In parallel the Trust has engaged with the regional regulator to realise a new model of integrated urgent care delivery
BP.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.	Lorraine Bewes	🟢	The Trust is forecasting £14.8m delivery against its £14.8m CIP target in 2019/20. This £0.8m shortfall is being mitigated through additional savings identified as part of in-year financial recovery. Of the £14.0m forecast, 81% is recurrent delivery.
BP.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.	Justin Wand	🟢	The Trust is progressing a twin approach for both operations and corporate estate. The former is being addressed by guidelines around the future Estates configuration, whilst the latter is work in progress – introducing 7:10 ratio at Waterloo and Pocock St. alongside the closure of Morley St.in year and Union St. at end of financial year.
BP.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.	Lorraine Bewes	🟢	The new Head of Commercial role is now in place. The role is developing a range of new income options, as well as supporting procurement to review how LAS can get best value from existing contracts. However, identified opportunities will need to be adequately scoped and as such only likely to deliver from 20/21 onwards
BP.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.	Justin Wand	🟢	The business case for driver safety and security system was approved in October for pilot of 40 vehicles at Fulham. Full stakeholder engagement has taken place. Project infrastructure is fully established and the fleet team are installing equipment at part of vehicle build. Pilot expected to comment Q1. Three month review will confirm delivery of benefits forecast and support the case for wider role eventually seeing installation across the whole operational fleet.

Partners Scorecard

February 2020

Benchmarking Key

| Top 3 |
| Ranked 4-7 |
| Ranked 7+ |

Please note:
999 performance data is correct as at 04/03/20 and is subject to change due to data validation processes

Indicator (KPI Name)	Basis	Data From Month	Target Status	Target and Type (Internal / Contractual / National / All)		Current Performance			Trajectory FY19/20 Trajectory	Benchmarking (Month)		
						Latest Month	Year To Date (From April)	Rolling 12 Months		National Data	Best In Class	Ranking (out of 11)
Hospital handover	minutes	Feb-20	🔴	18.5	I	22.1	20.9	20.8				
Post-handover (Handover 2 Green)	minutes	Feb-20	🟢	16.0	I	15.9	15.5	15.5				
See and Convey – to ED (Contractual Position) **	%	Feb-20	🟢	58.4%	C	55.2%	57.9%	58.0%		57.1%	51.4%	5
Hear and Treat % **	%	Feb-20	⚪	7.9%	C	8.3%	7.2%	7.2%		7.1%	9.2%	5
Hear and Treat (n) **	%	Feb-20	⚪	90,307		8,479	**85,244**					
Savings delivered to wider urgent & emergency care system through management of IUC services (£m) – Still being developed	£m			TBC		This metric has proved difficult to ascertain in a way that can be tracked on a regular basis. As part of the long term financial plan development we are refreshing our strategy modelling over July and August and the specifics for this metric will come out of that work in a way that can be tracked on a regular basis through the IPR.						
CQC rating - Overall	Annual Rating			O / S	N	TBC	Awaiting CQC Inspection					
CQC rating - Well-led	Annual Rating			G	N	TBC						
Cyber Essentials Plus Accreditation	%	Sep-19	⚪	100				TBC				

🟢 **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

Maximising safe non-conveyance to ED

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

Please note:

999 performance data is correct as at 04/03/20 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We saw a much reduced number of delays in February compared to January, with the overall number of hours lost from our arrival to patient handover over 30 mins dropping to 2,400. King Georges, Queens Romford and North Middlesex had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the had the highest number of lost hours over 30 minutes, at 354 hours for the month.

Patient Handover to Green

In February, we saw a strong handover to Green performance with 15.9. However, Over 4,250 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus as well as a cost improvement programme to recover this situation with action plans focusing on clarification of targets, improving the process and sharing good practice across sector.

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	1,623	1,568	451	29%	176.6		28.3
	North Middlesex	2,330	2,253	810	36%	243.8		28.6
	Royal Free	1,568	1,497	244	16%	78.9		22.0
	University College	1,726	1,670	177	11%	40.6		18.8
	Whittington	1,460	1,412	134	9%	24.5		17.8
North East	Homerton	1,240	1,196	24	2%	2.6		13.3
	King Georges	1,167	1,128	387	34%	57.6		27.5
	New ham	1,781	1,649	344	21%	36.4		23.3
	Queens Romford	2,548	2,453	1,149	47%	354.4		34.0
	Royal London	2,072	1,968	193	10%	19.3		18.8
	Whipps Cross	1,736	1,676	391	23%	103.6		24.6
North West	Charing Cross	1,273	1,227	29	2%	11.4		15.1
	Chelsea & West	1,381	1,329	38	3%	8.4		16.0
	Ealing	1,333	1,307	129	10%	16.3		17.7
	Hillingdon	1,845	1,803	167	9%	41.3		16.3
	Northwick Park	2,759	2,681	723	27%	300.0		26.4
	St Marys	1,832	1,762	320	18%	55.1		22.2
	West Middlesex	1,982	1,904	87	5%	14.9		16.5
South East	Kings college	2,104	2,023	728	36%	175.4		28.9
	Lewisham	1,388	1,319	222	17%	106.3		23.8
	Princess Royal	1,569	1,497	163	11%	100.7		19.7
	Queen Elizabeth II	2,325	2,257	39	2%	11.0		12.2
	St Thomas'	2,388	2,318	128	6%	17.5		17.2
South West	Croydon	1,966	1,899	518	27%	196.2		28.5
	Kingston	1,537	1,493	88	6%	16.4		19.7
	St Georges	1,922	1,854	523	28%	135.7		26.3
	St Helier	1,263	1,235	193	16%	55.0		22.9
	TOTAL	48,118	46,378	8,399	18%	**2,400**		22.1

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	2,366	1,232	52%	222.8	16.3	30.1		10.9
	Edmonton	3,468	1,827	53%	309.1	16.2	30.8		10.2
	Friern Barnet	2,224	1,210	54%	172.5	15.7	27.7		8.6
North East	Homerton	3,044	1,651	54%	254.4	15.9	28.3		9.2
	New ham	4,222	2,362	56%	425.5	16.7	30.9		10.8
	Romford	3,880	2,123	55%	294.8	15.9	27.4		8.3
North West	Brent	4,027	2,177	54%	362.8	16.4	28.8		10.0
	Fulham	2,794	1,579	57%	242.9	16.6	29.9		9.2
	Hanwell	3,147	1,671	53%	229.0	15.5	27.5		8.2
	Hillingdon	1,829	1,002	55%	168.6	17.1	30.3		10.1
	Westminster	1,774	954	54%	121.8	15.2	25.4		7.7
South East	Training	1,220	631	52%	98.1	16.0	28.7		9.3
	Bromley	2,601	1,438	55%	228.7	16.4	30.2		9.5
	Deptford	5,223	2,796	54%	418.1	15.9	28.7		9.0
South West	Greenwich	2,820	1,565	55%	198.2	16.3	29.6		7.6
	Croydon	2,361	1,423	60%	170.5	15.8	26.3		7.2
	New Malden	1,514	852	56%	127.9	16.5	29.5		9.0
	St Helier	1,523	822	54%	83.1	14.7	23.8		6.1
Other	NULL	223	104	47%	10.8	13.4	21.5		6.2
	IRO	6	5	83%	1.8	15.6	50.8		21.6
	NETS	1,455	700	48%	53.2	12.3	19.0		4.6
	Other	671	428	64%	78.8	16.1	34.7		11.0
	Training	1,220	631	52%	98.1	16.0	28.7		9.3

Max average breach value
Value >10 mins per breach

Max average breach value
Value >7 mins per breach

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Maximising safe non-conveyance to ED

See and Convey to Emergency Department

		Feb-20	Year To Date	Year-end Target
See & Convey ED %	LAS	55.2%	57.8%	
	Target			58.42%

The conveyance to emergency departments target (58.25%) was strongly delivered in February 2020 (55.2%). The metric has been steadily improving over the recent months. The Programme Manager to support the emergency department conveyance programme is working closely with a number of directorates including Operations.

Chart legend: Previous Year S&C (ED)%, Previous Year S&C(Other) %, S&C (ED)%, S&C (Other)%, ED Target
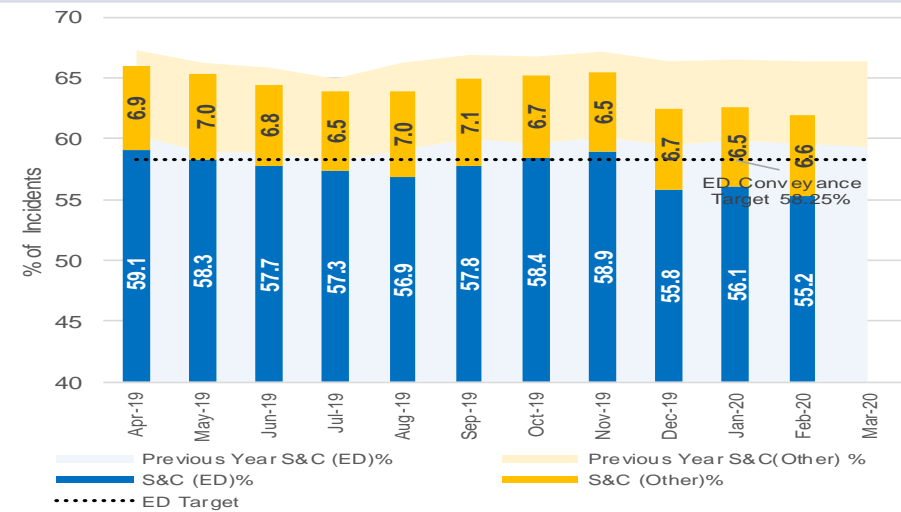
Hear and Treat %

		Feb-20	Year To Date	Year-end Target
Hear & Treat %	%	8.28%	7.3%	
	(n)		85,095	90,307

Hear and treat delivered 8.3% in February against the Trust target of 7.9%. These results are an improvement on 2018/19 rates and impending recruitment to the new CHUB structure will further help to support an improved position.

Chart legend: Previous Year H&T %, H&T%, H&T Target

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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.	Ross Fullerton	🟢	Adastra is now live in the Clinical Hub providing access to directory or services and detailed local care records. Summary care record pilot is complete. ePCR procurement is complete. The CAD replacement programme is underway.
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	Khadir Meer / Pauline Cranmer	🟢	The Director of Ambulance Services continues to meet with the regional hospital handovers lead for NHSE on a bi weekly basis to review activity of handovers at EDs, against the trajectory of eliminating 30min+ delays. National oversight of the regions most challenged sites continues on a monthly basis. Locally engagement is in place through the ADO teams. Despite this activity there is a rising trend in delays awaiting handover across a number of sites.
BP.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.	Trisha Bain	🟢	The winter programme that aims to roll-out mental health response across London has started on 13th January . Regular debriefs are being held to ensure the programme is safe and delivers the intended benefits in relation to reduction in ED conveyance. In the meantime, work with Oxleas and SLAM continues with regular meetings and agreements to roll put the programme on a permanent basis.
BP.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.	Fenella Wrigley	🟢	LAS has continued to engage with Pan London strategic leaders and LAS lead commissioners to identify opportunities for better 999 and 111 service which will better meet the health needs of patients in London. Two aspects from the Perfect Day are being implemented as part of a London Winter initiative – 999/111 integration for Cat 5 patients to ensure the access to the most appropriate further assessment and onward care and the Joint Mental Health Car Response. The mobilisation of these is being done one STP at a time and both have commenced as of week beginning 13th January with early indications of good outcomes. Work continues through the joint LAS / STP 111/999 Board on future plans.
BP.21	We will deliver the key elements in our Quality Plan for 2019/20 to improve patients' experience and quality of care for patients.	Trisha Bain	🟢	Following the receipt of the CQC reports the quality governance team are now working with relevant directorates to produce comprehensive plans to ensure that the identified 'must dos' and should dos' are delivered and monitored, and that all actions are x-referenced and included in current business planning agreements. The plans will we monitored via QOG and to the Board via QAC. In addition a review of QSIR trained staff is under way to provide further training to operational teams to ensure staff are supported in delivering their sector QI plans.

Ref	Business Plan Deliverable	SRO	Status	Comment
BP.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.	Justin Wand	🟡	The secured drugs room specification has been signed off and individual surveys at 16 sites have been conducted. Works are in progress at Waterloo, Brixton, Becontree and South Croydon complexes. Designs are complete and signed off by the Medical Directorate and Operations at the majority of sites. The ALS Bag roll out and Primary Response Bag roll outs are now complete. Vehicle--based multi-dose drug pack rollout is still in the planning phase with a trial planned for Romford, Bromley and Brent.
BP.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.	Philippa Harding	🟡	Challenges with recruitment have resulted in reduced capacity to deliver. This is being addressed through the use of additional external resource and work is being undertaken to establish the viability of the introduction of a managed service to sit alongside information security.
BP.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.	Lorraine Bewes	🟢	We continue to work with both blue light colleagues and the wider GLA family. Examples of this are the development of the London Emergency Services Coordination Centre (LESCC) the purpose of which is to facilitate and coordinate multi agency activity. It also provides a real time pan London risk and mitigation function. A table top exercise was undertaken on 20th Nov 2019 to understand if the original high level outcomes are achievable (i.e. a reduction in unnecessary deployments for all services, quicker response to incidents through shared situational awareness and shared level of risk through demand, resource availability and collation/access to each services databases). A further discovery exercise is planned for Feb 2020. With regards to working with the GLA, several working groups have come together including ICT and HR to look at greater efficiency across their respective areas.

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	Activities have focused on the Clinical Hub Transformation Pan London Winter initiative, whilst emerging data is yet to be fully validated key highlights include; • Since the January Board, Four Sectors have mobilised: NEL on 14/02, NWL and NCL on 28/01 and SEL on 18/02, however NWL, NCL & SEL STP have paused the pilot due to COVID-19 operational pressures. SWL Sector was due to go live on 25/02 but has also been paused for the same reason. • So far, outcomes are positive, with 1,709 calls* transferred from the LAS 999 CHUB to a 111 IUC CAS Provider, 27% of which resulted in an ambulance dispatch compared to 66% BAU. 28% of cases were referred to a downstream provider (compared to 13% BAU) and 45% of cases were closed on the call (compared to 21% BAU). • The LAS 999 CHUB has seen an increased Hear & Treat rate of 37% compared to 33% BAU, and has triaged 13.4% more calls than BAU. • Development of direct referral pathways for CHUB to downstream providers (GP Hubs, out of hours and UTC).	• Provide further training & clear communications for clinical staff within the CHUB and CAS on usage, availability and remit of ACPs to aid decision making. • Further Alternative Care Pathway development specific to patients being managed through remote clinical assessment. • Continue to develop ability for Clinicians within LAS 999 CHUB & 111 IUC CAS to refer patients to downstream providers to avoid unnecessary ambulance conveyances.
Pioneer Services	The Mental Health (MH) pioneer service continues to operate across London, in partnership with London's MH Trusts. Initial feedback from the paramedics and the MH nurses is that they are enjoying working on the car and are feeling like they are able to provide the right care for those patients more quickly than if this service was not running. Weekly data shows that ED conveyance rates are significantly lower for the MH car than the BAU response. The first two weeks of the full roll out had ED conveyance rates of 20.5% and 14.3% compared to BAU of 52.7% and 52.8% respectively.	• Continue to run the pan-London MH pioneer service, working with those staff to continually improve including further reducing ED conveyance rates. • Conduct a formal evaluation to identify the benefits or challenges associated with a larger scale roll out. • Continue working with SLAM and Oxleas on the work to scope the roll out from April onwards which has been funded through a successful bid for Mental Health crisis transformation monies.

Programme	Key Progress & Achievements since last IPR	Priorities for coming months
Spatial Development	• Works to HQ first Floor East and West have been completed with teams now relocated into these areas. In total, we have increased occupancy in HQ by 108% from 180 to 374, allowing us to exit Morley Street and Union Street. Works to refurbish the interior of Cody Road have started and are expected to be completed by late March. • Since January 2020, a Strategic Estates Steering Group and Operational Estates Working Group has been operational taking oversight of strategy and delivery against the LAS Estate Vision. A list of sites facing material transformation is presented to the Estates Steering Group. A provisional list of 7-10 sites for consolidation has been compiled. • We are beginning to engage with key stakeholders including NHSE/NHSI, STPs, key London hospital redevelopment sites and local authorities. • Provisional agreement to prioritise and sequence the five sectors for estate transformation has been agreed with NEL likely to be proposed as the initial focus.	• Complete works to refurbish HQ 1st Floor West and Cody Road including relocation of staff from Union Street. • Undertake additional improvements to Pocock Street - lighting and communal areas. • Continue with strategic engagement around future estates work and refine initial list of stations that we might exit from in the coming year. This will be based around current urgent issues, opportunities as they arise and leases coming to an end.
Digital 999	• ePCR procurement has now been completed with 'Cleric' set to be rolled out to all staff over the next few months. Cleric has been successfully rolled out in South East Coast, West Midlands and North East ambulance services. • The ePCR system will help staff with clinical decision making, allow for wider access to patient notes, integrate with other LAS systems and eventually will allow for more seamless, joined up patient care across different care settings. • We are now out for tender for a new CAD system via the European Journal. A new CAD system will integrate better with medical records and existing databases. We will also be able to identify patients, and their individual needs, at an earlier point in the patient journey to improve care and clinical decision making. • The Summary Care Records (SCRa) continues to be rolled out, however this has been delayed due to priorities around Covid19.	• Working with Cleric on specification and configuration of ePCR and commence initial testing of LAS specific system • Complete CAD tender and commence configuration of system with successful provider with the following milestones • Design phase complete 18 May 2020 • Deploy phase complete 23 October 2020 • Go-Live phase complete 27 November 2020 • Communications and engagement with staff, including required training to ensure staff are ready and confident in the se of ePCR • Develop and agree KPIs to allow for monitoring of ePCR usage and benefits that it delivers.
Ready, Set, Go (Medicines Management)	• **Advanced Life Support Bags - Trust wide rollout complete.** The ALS bag replaces the personal issued paramedic bag which is now being withdrawn from the service and have not been ordered since April 2019. • **Primary Response Bags – Trust wide rollout complete.** The primary response bag replaces the existing oxygen barrel bag, first responder bag and consumable bag. There continues to be issues with some missing equipment (predominantly BM kits and Tympanics) and work is underway to rectify this situation. Oxygen barrel bags are being withdrawn from service as each sector goes live. This project will be completed in April 2020. • **Multi Dose Pack -** Delivery to commence in 20/21. • **Kit Prep** - User Acceptance Testing (UAT) for Kit prep Depot app commenced November 19 and was completed January 2020. One major incident reported during the UAT which has been escalated to the supplier and IMT to resolve asap. Agreed decision to proceed with the development of Kit Prep app 2. Build commenced February 2020.	• Continue with the action plan to withdraw personal issue paramedic bags • Kit Prep 1 (Depot App) Go live. • Build, test and implement Kit Prep 2 (Clinician App). • Commence Multi dose pack delivery.

Programme	Key Progress & Achievements since last IPR	Priorities for coming months
Contracting and contractual form	Development work with commissioners is currently underway for the future LAS Contract; • Started negotiations for 2020/21 999 core contract. Currently highlighting a shortfall in the financial envelope. • Opened discussions on increasing the financial envelope for SEL/NEL IUC contracts. • Opened discussions regarding the focus areas for 20/21 CQUINs • A recruitment offer has been made for Service Line Reporting (SLR) & Costing Manager post which enable us to progress our ambition to move to SLR	• Liaison with NHSI to determine LAS commissioning arrangements for 2020/21 onwards. • Negotiation of appropriate financial envelopes for current Core and IUC contracts. • Formalising procurement of costing system.

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 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

A key change since the last IPR has been the change to who attends STP Level meetings with Sector ADOs now attending all STP/ICS level forums representing the LAS. ADOs are supported by both the Communications and Engagement Team and also the Strategy Function. Where appropriate, Directors as well as the CEO are also available to attend and support.

• NWL Provider Board (ADO)

• SEL ICS Board (ADO)

• SWL STP Healthcare Programme Board SWL (ADO and Strategy)

• SWL UEC Programme Board (ADO and Strategy)

Progress since the last IPR

• The **Chair appointments for the 5 'emerging' ICS** have been made and while some have commenced their positions others have not yet but are due to over March and April (e.g. the Chairs for NWL and NEL).

• **NWL Provider Board** continues to focus on the financial challenges faced by the local health economy.

• **SEL colleagues** are developing and embedding governance for the ICS.

• The **SWL STP Programme Board** assessed their readiness to become an ICS via the NHSE ICS development maturity matrix and proposed governance arrangements for any future potential ICS arrangement. The outcome for SWL's STP's application to become an ICS will be confirmed by NHSE in March 2020.

Key priorities for the coming months

• We will continue to support the ADOs to undertake their relatively new roles engaging with STPs/ICSs e.g. a seminar will be held on 31 March on the STPs/ICSs/NHS Long Term Plan. The LAS Strategy Team will deliver quarterly strategy updates for ADOs.

• We will engage the new 'emerging' Chairs for the 5 ICSs as they commence their positions.

• We will strengthen partnership working and collaboration with NEL and NCL STPs. Meetings have been arranged for March 2020.

PUBLIC BOARD OF DIRECTORS MEETING

Executive Director Report: Quality & Clinical Care Q2

1. Hot Topic Updates

- Vaccination and Immunisations programmes – the organisation is enlisting the support of a bespoke vaccination organisation to ensure that the backlog of general immunisations is resolved and to support the flu vaccination programme. This will ensure all staff have all required vaccinations by the end of the year.
- The clinical directorate are working closely with regional and local stakeholders to ensure patients are assessed and treated in the right place, maximising referral to local pathways where clinically appropriate, and minimising the risk of nosocomial infection.
- The Trust has taken forward a comprehensive assessment and relevant actions to ensure all areas are 'Covid Secure'. This compliance will be monitored via the regular health and safety compliance checks.

2. Patient Safety Themes

Patient Safety Incident Response Framework:

In line with the national decision, the Patient Safety Incident Reponses Framework (PSIRF) programme was put on hold in March 2020 due to the COVID-19 Pandemic. Whilst this was put on hold, the pandemic presented an opportunity to develop further and test the Trust's PSIRF model.

The Trust is an earlier adopter which will see the service move away from the two tiered Serious Incident Framework to the risk-based approach of PSIRF. This approach provides a boarder proactive response to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

COVID-19 presented a unique situation where there was the need to review the delays that occurred to both call answering and dispatch in resources. The PSIRF allowed the Trust to apply a thematic review using methodology of a systems-based approach to the investigation which included the development of a detailed delay Structured Judgement review (SJR).

This has led to the identification of key learning which includes the need to work with our commissioners and through them care and nursing homes to ensure, should there be a second wave, they are accessing the ambulance service appropriately.

The Integrated Urgent Care 'After Action Review' which also used a similar approach to evaluate IUC's response to COVID-19 has also produce lessons learnt in case of further peaks in demand. Positive themes found include 999 – 111 warm transfers, emergency calls being managed through NHS Pathways and redeployment of frontline clinicians to support CAS operations.

Positively, a meeting has been held recently with NHS E/I's patient safety team. This meeting was to check in with early adopters and check if the programme can be re-started. During this meeting, our COVID-19 review was shared which was received with great interest and compliments. The Trust have seen its position on the early adopter programme were affirmed with the team working towards full sign off and implementation in the coming months.

Delayed Ventricular Defibrillation (VF) Thematic Review:

A recent Coroner's case saw Association of Ambulance Chief Executives and other key stakeholders in the UK receive a Regulation 28 Prevention of Future Death regarding the design and future procurement of defibrillators. The Trust's Delayed VF Defibrillation Thematic review was commissioned after several Serious Incidents was positively received by the Coroner. Since the thematic the Trust has had no further Serious Incidents declared for this issue and there is further review planned to build in the findings of this thematic analysis and to continue to monitor the effective of the actions that were identified and out into place.

3. Health, Safety and Security

Body Worn Video Cameras (BWVC):

Funding of £190K for the Body Worn Video (BWV) trial has been received from NHSE/I via LAS lead Clinical Commissioning Group. The BWV trial programme was suspended during the Covid-19 pressures experienced by the Trust and is due to be restarted with pilots in selected areas starting in September following tender sign off. The Statement of Requirements to support the tender for BWV have been drafted and are with IM&T for final comment before being presented to Procurement. NHSE/I are drafting Violence Reduction Standards for organisations to assess themselves against.

Violence and Aggression:

The new Violence Reduction Policy will be approved at the Health and Safety Committee on 30th July 2020. This will then be ratified at EXCO and disseminated accordingly. Two, 1 day per week, Violence Reduction Officers have joined the Health, Safety & Security Department to monitor incidents of violence and aggression and help provide support, with positive feedback from staff. A total of 133 Physical Assaults on Staff have been reported for current year 2020/21, to 30th June'20. (Total of 625 for last year -1st April 2019 to 31st March 2020). This is a decrease on the numbers reported for the same quarter last year which had 150 physical assaults reported (11.3% decrease).

The greatest number of reported physical assaults (55%) occur due to the clinical condition of the patient; Police attended 70% of physical assault incidents. Ten successful prosecutions for assault have been recorded since the focused support has been in place and the team continue to liaise with the Metropolitan Police Service (Operation Hampshire team) regarding police investigations.

COVID-19 Secure Compliance:

The HS&S Team have worked closely with local operational management team and the Unions to undertaking Covid-19 secure compliance assurance assessments across the trust. The Trust has completed and displayed LAS Covid-19 Secure Risk Assessment in line with the Government Guidance document: Working Safely during Covid-19 in Ambulance Service across all areas following assurance checks ending on 10th July.

The 14 satellite sites that were visited in week beginning 6th July have been completed and have been processed. The Assurance & Governance Team are currently checking these sites for assurances by the end of next week beginning 13th July.

Status of Covid-19 RIDDOR Investigations:

Sadly, the organisation has had 3 COVID-19 related staff fatalities in the year to date. Investigation reports have been drafted, pending panel review for agreement as to the need to report to RIDDOR. The number of staff who have been hospitalised due to Covid-19 is 18 (including the 3 fatalities). All of these cases are being individually investigated. The investigation process of Covid-19 related cases is based on the risk assessment tool developed by NWAS and agreed at QGARD. It follows a 2 stage approach.

Stage 1 assessment patient facing activities to identify likelihood of any specific incident causing infection. This generates a low, medium or high likelihood of the case being RIDDOR reportable. 66 stage 1 investigations complete. Of these 20 are rated moderate requiring further investigation.

Stage 2 involves a deep dive into the case to look at controls and circumstances surrounding possible infection. Investigations complete for 3 and in progress for 2.

4. Research, Audit and Clinical Information

Current Research Trials

In line with national decisions, several research trials were suspended in March 2020 due to COVID-19 and we are currently working with our partners to restart these trials.

COVID-19 has provided opportunity for new areas of research and LAS was invited to participate in a range of research trials. Each research trial proposal was assessed by the Head of CARU as to its suitability for London Ambulance Service participation and then a recommendation made to the Chief Medical Officer and Clinical Non-Executive Directors for their clinical opinion. If all parties agreed that the research trial was one which LAS wanted to participate in then it was taken to the Executive-Led Covid Operational Leadership Team meeting for approval. To date the research trials LAS is participating in are:

- **CARA,** a collaboration with the College of Paramedics on this survey study to determine the impact of the COVID-19 pandemic on ambulance service personnel's wellbeing,
- **PRINCIPLE**, this study is being run by the University of Oxford and funded by UK Research and Innovation (UKRI) / National Institute for Health Research (NIHR) is currently open in our SEL and NEL IUCs. Older patients, who are suspected of having COVID-19, are referred to the team at the University of Oxford by IUC clinicians and if eligible, may be randomised into this trial a study
- **SWAP -** Promoting Staff Wellbeing in UK NHS Ambulance Personnel – What Works and How Can We Do Better? This study aims to establish characteristics of successful employee mental wellbeing services within UK ambulance services. The study was amended in response to COVID-19 to take into account the impacts of responding to the pandemic.
- **PROTECTED:** Exploring and Improving Resuscitation Decisions in Out of Hospital Cardiac Arrest**.** We are working with the University of Warwick on this NIHR HS&DR funded study which will explore and aim to improve the guidelines related to resuscitation decisions used by ambulance service staff in the UK. This project will also consider the effects of COVID-19 on resuscitation decisions.

Clinical Audit

The final maternity emergencies audit report has recently been concluded. This re-audit aimed to determine whether actions implemented following the original clinical audit have led to improvements in care for babies born before arrival at hospital (BBA), postpartum haemorrhage (PPH) and neonatal resuscitation. This re-audit also looks at eclampsia for the first time to assess seizure management following updated national guidance on the administration of diazepam. Results from this re-audit have shown that although improvement has been made for the care given to mothers and babies, and that many elements of care delivered were of a very high standard, there are areas requiring significant improvement. Due to the relatively small number of patients each year that the LAS attends with eclampsia, PPH or requiring newborn life support, there is a risk of skill decay. The LAS Consultant Midwife and Practice Leads for Pre-hospital Maternity Care are progressing a care bundle for PPH and further educational tools using the QI methodology.

Throughout the COVID-19 peak the continuous recontact audit has continued to be undertaken to ensure that the care provided to any patients who needed to recontact LAS within 24 hours was reviewed. As part of the Service's response to Covid-19 paramedic volunteer involvement was necessarily suspended in order to maximise our patient facing capacity however we have been able to work with paramedics who are shielding or otherwise unable to undertake frontline duties were trained to undertake re-contact reviews.

Other audit activity

The Clinical Performance Indicators (CPI) were temporarily suspended on the 25th March and restarted on the 1st July. A total of 51 paramedics, who are shielding or otherwise currently unable to undertake frontline duties, have been trained to undertake CPI audits. These paramedics will now be able to support their local operational teams and Clinical Team Managers (CTMs) in undertaking CPIs.

Reporting by NHS England of the Ambulance Quality Indicators (AQI) was suspended due to the COVID-19 pandemic and has just re-opened for submissions starting with December 2019 data. There will be an even larger time lag than usual as things return to normal, but we should be able to provide validated data for Trust reporting from the 13th August and moving forward.

5. Clinical development and pathways

The Clinical Directorate continues to lead on the development of the Trusts future clinical model. The proposed model that sees a greater integration of the 999 Clinical hub and 111 IUC, building on the success seen in the Perfect Day collaboration initiative led by the Trust in September 2019. This incorporates development of the optimal approach to ensure safe and effective deployment of specialist assets such as mental health practitioners and advanced paramedic practitioners (Urgent and Critical Care) alongside maximising the availability and use of out of hospital appropriate care pathways.

The Chief Medical Officer is a core member of the NHSE London Clinical Advisory Group (LCAG), which has been meeting daily through the COVID-19 peak. This has ensured LAS is embedded in the future developments of Healthcare Delivery for London and is able to support changes and new pathway development. Local ownership of pathway development within each ICS /STP is fundamental to the success of the delivery of the post COVID-19 plans and to support this the Senior Sector Clinical Leads are starting to be involved with their respective ICS / STP CAGs external Clinical Advisory Group. Whilst this is in the early stages of development, the clinical leadership team are having positive conversations with their

respective colleagues across the healthcare sector with the aim of them being a key integrator in the group.

NCL Stroke Pathway

The trial of pre-conveyance video conferencing for suspected stroke patients in North Central London has begun and shown some early patient benefits. Fully endorsed by the NHSE LCAG and NCL CAG the project has been running for an initial period with a number of patient being able, after consultation with a stroke specialist, to be referred to other health care pathways rather than being conveyed to a more distant Hyper Acute Stroke Unit. So far, 121 of our ambulance clinicians have been trained in the process and 51 patient video conferences have occurred. This initiative has seen 27 of the 51 patients conveyed to a HASU while 6 of them were diverted to an outpatient TIA clinic, 6 referred to their GP and 12 diverted to a local ED. Just under a quarter (24%) have been treated in their community. The trial, which has been in a collaboration with UCLH, is set to expand to Barnet hospital later this month.

Clinical Development and Governance

During 2019/2020 the APP team have continued to embed the governance culture within the team. Including fortnightly case review sessions assist in the critical review of cases, with learning shared across the entire programme.

The LAS is the first ambulance service to introduce Alteplase, a fibrinolytic, for use by the Critical Care Advanced Paramedics (APP-CC) under a Patient Group Direction (PGD), for patients in cardiac arrest where the most likely cause of the cardiac arrest is a pulmonary embolism. This service development has been approved internally by Patient Safety and Clinical Effectiveness Group and Quality Oversight Group and externally by the National Ambulance Medical Directors Group who will be providing peer review.

We are continuing to lead the way with clinical innovation in the ambulance sector. In collaboration with Bart's Health NHS Trust and London's Air Ambulance, the SUB30 Feasibility study aims to establish the feasibility of undertaking prehospital Extra Corporeal Membrane Oxygenation (ECMO) in London and is the first study of its kind nationally. The study was suspended in March due to COVID-19 and discussions are underway to assess the capacity to restart.

Additionally, the LAS developed Major Trauma Triage Tool triage tool is now the feature of a study by the University of Sheffield and National Institute for Health Research (NIHR); to identify patients who will benefit most from MTC care, and optimise over/under-triage. The study was suspended this study in March and reopened on 10th June 2020.

6. Medicine Management

Station based controlled drug audits are being undertaken by the interim pharmacy technicians and local feedback is being provided as required.

Two new Patient Group Directions were issued in June - currently, diazepam for injection comes in the form of an emulsion (Diazemuls). Paramedics administer this specific medication formulation under exemptions within Schedule 17 of the Human Medicines Regulations, 2012. The Trust is aware of potential supply shortages of the Diazemuls formulation. To mitigate this the Trust has approved a PGD for the use of an alternative formulation. The PGD for Tranexamic Acid (TXA) has been updated to incorporate changes in national guidelines and evidence based practice. These include the administration of Tranexamic Acid (TXA) for

Head Injuries and Post-Partum Haemorrhage (PPH) and in paediatric patients. Further PGD's have been developed for use by Advanced Paramedic Practitioners to extend the range of treatments available to patients in the community.

Work is ongoing, in collaboration with estates and logistics, to identify a suitable location and design a bespoke medicine packing unit. The primary objective is to ensure best practice in all aspects of the handling and use of medicines that consequently maintains the quality and the integrity of medicinal products

7. Infection Prevention and Control (IPC)

London Ambulance Service has welcomed our new substantive Head of Infection Prevention and Control Claire Brown to the service. Claire joins us from Kings College Hospital. Sharon Egdell, the interim Head of Infection Prevention and Control (IPC), leaves the organisation on 2nd August and we would like to formally thank her for all her work over the past two years and in particular for her work over the COVID-19 pandemic providing expert guidance internally and representing the LAS externally. We wish her well in her next role.

COVID-19 work continues and the IPC team are working closely with all directorates, in particular health and safety, estates, logistics and operations, to ensure that we continue to protect our staff and patients. As at 10th July 2020 the LAS trusts current Personal Protective Equipment (PPE) stockpile provision was reported by procurement as sufficient, with some specific challenges where different models of FFP3 masks are provided from the national stockpile which then require new Fit Testing. Whilst we have mitigated this risk by purchasing and supplying reusable face-masks for clinicians there remains a risk if a clinician needed to don a disposable mask. There is on-going work to ensure that we maintain the supply chain for FFP3 disposable respirators and disposable gowns – PPE is not just for COVID-19 patients but all infectious diseases and, in particular, respiratory illnesses.

The IPC annual report has been completed and shared with the Quality Assurance Committee. Despite the COVID-19 pandemic impacting on Q4 achievements, 46/55 (84%) of the work programme objectives have been achieved. The 9 objectives not met related to Q4 A&E audits, clinical ride out audits and production of a real time simulation training video. Key points of note were the successful introduction and roll out, in October 2019, of the My Assurance app audit tools for Operational Workplace Review (OWR) hand hygiene and premises cleaning. This app enables staff to input data onto their hand held device and review their audit data in real time. A quarterly Infection Prevention and Control link Practitioner (IPCLP) educational development programme was completed.

8. Clinical Education and Standards

Over the past two months we have welcomed the Emergency Operations Centre (EOC) and Non-Emergency Transport education teams into the Clinical Education and Standards department – these moves, along with some further planned moves later in the year, aligns all clinical and patient facing education into one department. The Chief Medical Officer and Deputy Director of Education and Standards opened a new education suite at Barking for the Emergency Operations Centre (EOC) team which sees a purpose built environment with digital capability. During the COVID-19 period the clinical tutors and wider clinical directorate have continued to provide education at ambulance stations and remotely using technology – there have also been bespoke sessions for clinicians shielding which has been well received. There is on-going and positive work with our Partner Universities to facilitate students returning and so that placements recommence in line with social distance guidance.

9. Safeguarding

The annual safeguarding report was presented and approved at the Quality Assurance Committee (QAC) in July 2020. The committee commended the work of the team in taking forward significant programmes of work including:

- Introduced Twiddle Mitts onto all ambulances to support dementia patients
- Developed Safeguarding Star badge and certificate to recognise good and outstanding safeguarding practice.
- First Ambulance Trust to introduce contextual safeguarding pilot
- Maintained safeguarding focus and practice during Covid-19, this included domestic abuse stickers which were issued to all staff to raise public awareness due to the lockdown situation and the impact this had on families.

All regulatory standards were met alongside the Level 3 Safeguarding training trajectory. However, due to COVID19 social distancing guideline, the way in which training and education will need to be delivered is being reconsidered. This means re-setting the trajectory for 2021/22 and utilising video conferencing and e-learning methods to meet training compliance. A task and finish group is currently reviewing this situation to identify solutions.

10.   Quality Account Priorities

The quality priorities have now been set and included in the annual quality account for 2020/21which will be signed off at the Board in July. Progress against the priorities will be monitored via Quality Oversight Group (QOG) and Quality Assurance Committee (QAC) and to the Board via the Quality report.

11.   Quality Regulatory Standards

The London Ambulance Service station/service accreditation programme is being developed to bring together key measures of quality standards to enable a structured approach to assessing the quality of care at station/service level. The programme is aligned to the Trust's quality strategy and is sponsored by the Chief Quality Officer (CQO). The LAS will be the first ambulance service to implement this type of approach and builds upon the success of HealthAssure, which monitors the Care Quality Commission (CQC) standards at stations/services level to identify areas of excellence and also areas for improvement.

The programme sets specific standards that have to be met by a station/service for it to achieve accreditation status and it is underpinned by staff engagement to ensure sustained improvement. The programme is different from the routine quality reviews in that it is owned, led and driven by local management teams. The ambition is to drive quality standards by empowering staff to make improvements in line with the Care Quality Commission's (CQC) fundamental standards.

Benefits
- Safe care and improved patient experience
- Improved staff engagement, staff morale, a sense of collective leadership & pride in care delivered
- Clear expectations in terms of staff & patient experience as well as standards of care
- Standardised approach to quality assurance
- Accelerated quality improvement and shared learning

The Quality Governance & Assurance team will identify specific key lines of enquiry based on the Care Quality Commission (CQC) fundamental standards. The team will establish target parameters for each key line of enquiry and this will be discussed with relevant subject matter experts. For example, the Infection Prevention and Control standards will be signed off by the IPC lead, Medicines standards by the Medicines Safety Officer and so on. The tool will be signed off at the Quality Oversight Group by the Chief Quality Officer & Chief Medical officer.

1. Joining the accreditation programme.

Assistant Directors of Operations (ADOs), Locality Group Manager (LGMs), Heads of Service & Quality Governance & Assurance Managers (QGAMs) will identify a station/stations to participate in the programme. The relevant Locality Group Manager (LGMs) and their teams will work with their sector Quality Governance & Assurance Manager (QGAM) to put together evidence for each individual standard for a baseline Assessment.

2. Baseline assessment

The baseline and subsequent assessment will be based on a mixture of data, observation and triangulation of staff & where possible patients experience. The station accreditation tool will be completed for each Station. The baseline assessment will result in either of the following status.

- Supported Station (Meeting basic standards)
- Good station(Meeting all standards expected with clear plans for improvement)
- Excellent (Meeting all standards and is deemed excellent)

A station will be deemed Outstanding if it sustains the "Excellent" status for at least 1 year and has innovative and transformational goals.

Frequency of assessments will be guided by award achieved by each station as illustrated below

AWARD TYPE	FREQUENCY OF ASSESMENT	DEFINATION OF AWARD
Bronze	1 Month	Supported Station
Silver	3 months	Good station
Gold	6 months	Excellent
Platinum	1 year	Outstanding

3. Subsequent Assessment

Assessment will be led by the Quality Compliance Manager who will work with Quality Governance & Assurance Managers (QGAMs) to put together an assessment team. The team should include the following:

- One Quality Governance & Assurance Manager (from another Sector)
- Non-Executive Director (TBC)
- Commissioner
- Public/patient representative
- Operational lead (ideally Locality Group Manager or Clinical Team Manager from another Sector)
- People and Culture representative if available

The programme will provide a step change in terms of operational ownership and accountability for the quality agenda and give recognition to the efforts of our staff in delivering high quality care.

12. <u>Looking forward</u>

- The referrals to out of hospital pathways has begun to reduce – we are working internally and with stakeholders to understand this and ensure that we maintain accessibility
- We are working with partners to develop a number of future research projects, including Imperial College London, University of Warwick, London School of Hygiene and Tropical Medicine and University College London
- Recruitment is in progress for Advanced Paramedics Critical Care and Urgent Care and assessment centres are planned for the next month.
- Ensuring that we have robust quality assurance frameworks for any new service ie. Patient Transport Service, Integrated Urgent Care expansion, is critical and work is underway to develop these with key stakeholders.
- Clinical Team Manager training being planned between operations and clinical. All future training programmes and mode of delivery need to be agreed to ensure we meet the statutory and mandated training requirements and that are staff are confident in delivery high quality care.

The Board is asked to note and discuss the report.

London Ambulance Service NHS Trust

Assurance report:	**Quality Assurance Committee**	**Date:**	**07/07/2020**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/07/2020**
Presented by:	**Mark Spencer, Chair of Quality Assurance Committee**	**Prepared by:**	**Mark Spencer, Chair of Quality Assurance Committee**

Matters for escalation:	Flu vaccination for all staff remains a concern following a disappointing rate last year and the impact this could have with Covid-19 in addition.
	There is ongoing investigation into LAS staff who contracted Covid-19 infections. This appears to mostly affect support staff (eg vehicle cleaners) rather than front-line staff with issues from PPE.
	The Committee reviewed its terms of reference and ask the Board to ratify the proposed amendment to Data Quality reporting which will now be directed through the Quality Assurance Committee
	The Annual Quality Report was recommended to the Board for Approval.

Other matters considered:	The Committee noted and thanked the LAS team for the immense effort and thoroughness that they have shown in investigating using Structured Judgement Reviews for each patient who had suffered delays in call answering or responding in both the 999 and IUC services. As a result of the reviews a small number (2-6) of Sis have been identified and declared.
	The Quality Report, Safeguarding Report and Infection, Prevention and Control Annual Reports were considered and show good progress.
	A thematic review of delays as common factor in 31% of SI declared was discussed. Multiple factors contribute to the delay. Members considered the COVID decision making process and rapid decision making tool. This tool provided users guidance in respect of decision making processes, required approvals and reporting to be applied throughout the pandemic response members noted its successful implementation.
	The Committee received detail in respect of progress against delivery of COVID related risk assessments particularly those in respect of Trust BAME staff and of the Trust estate and recognised the positive progress that had been made.

| **Key decisions made / actions identified:** | The Quality Report, Safeguarding Report and Infection, Prevention and Control Annual Reports are recommended to the Board.

Medicines Modernisation project update will be presented to September Committee.

111/IUC internal Audit Report to be presented to September Committee. |
| --- | --- |

| **Risks:** | BAF risk 61 was reviewed and subcategories of clinical risk were reduced because of actions undertaken.

BAF Risk 54 was reviewed and there were no required adjustments. |
| --- | --- |

Assurance:	The ongoing work of the Quality Assurance team is demonstrating through review of the 999 and IUC services that delays caused by the Covid-19 pandemic are being well investigated and further learning will follow.

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Quality Assurance Committee Terms of Reference
Agenda item:	8.1
Report Author(s):	Syma Dawson, Director of Corporate Governance
Presented by:	Mark Spencer, Chair Quality Assurance Committee
History:	These are presented to the Trust Board when proposed changes required ratification. Quality Assurance Committee 7 July 2020

Purpose:	☐	Assurance	☒	Approval
	☐	Discussion	☐	Noting

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

Following discussion with the Chair of the Quality Assurance Committee, Logistics and Infrastructure Committee and Audit Committee, it was proposed that the reporting of data quality to Board Assurance Committees is amended.

It has been collectively agreed by the Chairs that data quality should be reported to the Quality Assurance Committee as it has direct impact on the quality of care and monitoring.

The Committee terms of reference have been updated accordingly and proposed changes marked in red. These changes were presented 7 July Quality Assurance Committee who endorsed the recommendation.

Recommendation(s) / Decisions for the Board / Committee:

The Trust Board is asked to review and approve the proposed changes.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed			Relevant reviewer [name]
Quality	Yes	x	No	Chair of the Quality Assurance Committee
Finance	Yes		No	
Chief Operating Officer Directorates	Yes		No	
Medical	Yes		No	

Communications & Engagement	Yes		No		
Strategy	Yes	x	No		Chair of the Logistics and Infrastructure Committee
People & Culture	Yes		No		
Corporate Governance	Yes	x	No		Chair of the Audit Committee Director of Corporate Governance

Quality Assurance Committee
Terms of Reference (effective April 2020-March 2021)

1. Purpose

1.1 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.

1.2 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 Committee of the Trust (including the Chief Medical Officer 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 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, with Non-Executive Directors being in the majority;

8.1.1 The Chair or nominated Chair of the Committee; and
8.1.2 At least two Executive Committee members, one of whom must be the Chief Quality Officer or Chief Medical Officer, 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.
- A report on the Trust's Data Quality and information management/governance activities (frequency will be set out in the forward planner accordingly)
- 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 (at least 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.

PUBLIC BOARD OF DIRECTORS MEETING

Executive Director Report: People and Culture Q2

1. **Hot Topic Updates**

- Black Lives Matter and our BAME action plan: Three years ago the Trust engaged with staff to identify the values and associated behaviours that were expected of everyone. Given the experience of staff from BAME groups following the death of George Floyd, static (negative) survey scores for bullying and harassment and discrimination, and an increase number of grievances and disciplinary actions from the previous year, there is much work to do with our leaders and staff in relation to the Trust value of 'Respect'. An action plan is in place for addressing the workplace experience of BAME staff which is also reflected in our focus on BAME staff risk assessments regarding COVID which as at 13 July 2020, 93% of BAME colleagues had a risk assessment undertaken. The Trust Board has been wholly supportive of our efforts in this area as two Board sessions recently took place to discuss the Black Lives Matter campaign as well as consider our future Equality and Diversity approach and how to tackle racism.

- Cultural transformation: closely linked to the above is the opportunity to re-start the discussion on the Trust's desired culture. The Trust is very clear about what is not acceptable and which elements of undesired culture exist but has yet to clearly define what the culture of the world's leading ambulance service looks like for staff and patients. The People & Culture Director will initiate a conversation with the Chair and Chief Executive Officer leading to agreed next steps for the Trust's cultural transformational programme.

- Staff Wellbeing: We have always seen our staff's health and wellbeing as a priority but the 2020 COVID Pandemic has thrown into sharp relief the requirement to respond to our staff's health and wellbeing needs both now and for the future. As such, we have established the "Wellbeing Hub" which consolidates a range of welfare and wellbeing support streams so staff have a single point of access to these important services. Please see further information in section 3.

2. **Regional updates**

- There is a newly formed 'London People Board' which the Trust's Director of People and Culture is a member of and will consider priorities for the NHS in London under the sponsorship of Sir David Sloman. This approach is set out in the NHS Interim People Plan.

- At the regional level, there is also a London COVID-19 Workforce Clinical Expert Group which is chaired by John Brouder. The focus of this group is to oversee the provision of end-to-end mental health support to NHS staff post COVID given the impact in terms of psychological trauma in relation to COVID.

3. Wellbeing Hub

Staff wellbeing is not just a priority at the regional level but also at our local Trust level. We were delighted to launch our "Wellbeing Hub" on the 6 July 2020 which is being led by the Head of Health and Wellbeing and will shape our new Health and Wellbeing Strategy. The Wellbeing Hub will focus on all key areas as set out below:

4. Highlights

In addition to the launch of our Wellbeing Hub, we are proud to report that:

- 250 members of staff from predominantly non-BAME backgrounds have participated in a series of workshops to explore what it means to become an ally of BAME staff.

- 700 line managers will be invited to participate in "fish bowl" exercises to discuss racism at the Trust. Sessions will be hosted virtually and provide a safe environment for leaders at Band 6 and 7 to learn more about the experiences of BAME staff and reflect on their personal experiences in relation to racism.

  This approach was successful piloted with 75 of the Trust's most senior managers.

- Over 5,500 of the Trust's staff and volunteers have taken part in COVID antibody (serology) testing.

- An updated Diversity & Inclusion Strategy that reflects the aspirations of the Trust is being drafted. The Strategy is expected to be reviewed in September for launch in Q3.

5.   Resourcing risks and issues

- To meet current and future organisational requirements, the People & Culture Director is finalising the restructuring of the directorate. The completed plan will be routed through the required governance and consultation pathways.
- There is a need to consider and report back to the People and Culture Committee on the Trust's training capacity to implement the Resolution Framework which will replace the traditional Grievance Policy, Dignity at Work Policy and Disciplinary Policy and Procedure. KPIs also to be developed. The Trust will also focus on its compliance rate regarding appraisals which was put on hold during the COVID pandemic as per the national team's instruction.
- Across the Trust, People & Culture are working with Ambulance Operations to deliver revised recruitment plans to fill the anticipated gap in clinical staff. New interventions will include recruiting 240 additional staff into a new Band 4 role, confirmation of visa extensions and right to remain arrangements for international Paramedics and targeted 1:1 retention interviews with potential leavers which have been significantly effective in reducing attrition in previous years.
- The Trust is preparing for a pilot Paramedic Primary Care Network (PCN) placement in Merton for 12 staff. This provides us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021.

6. Looking forward

- The Trust will continue to focus on its work around risk assessments for BAME staff as well as focus on all other vulnerable staff groups;
- Preparation is underway for the second "How are you Doing?" survey which will be repeated in August. An infographic with key messages and follow up activities from the first survey is being prepared for publication at the end of July;
- 2020 Flu plan is in place and monitored through the Executive Committee. 7,000 flu vaccines have been ordered and the communication campaign for Flu 2020 will launch in September; and
- A "Stamp Out Racism" campaign is being created in collaboration with the Trust's Communications directorate. It is hoped that the campaign will also be utilised by other Ambulance services.

The Board is asked to note and discuss the report.

Assurance report:	People and Culture Committee	Date:	16/07/2020

Summary report to:	Trust Board	Date of meeting:	28/07/2020
Presented by:	Jayne Mee, Non-Executive Director, People and Culture Committee Chair	Prepared by:	Jayne Mee, Non-Executive Director, People and Culture Committee Chair

Matters for escalation:	**Workforce Operational Modelling and Resourcing** • Members received a paper which demonstrated the current operational recruitment position of the Trust. This was as reported to the Daily Senior Leadership Team (DLST) 8 July 2020. The paper outlined the current position, current approach, impact on headcount, action plan, risks, identified next steps and further support required. • The Committee focused on the recruitment gap of 520 FTE's by April 2021 including the anticipated PCN requirement of 200. It was noted that a pilot is under way with Merton CCG to test the proposed model. • Proposals to recruit 497 ambulance staff in 2020/21 from existing recruitment and a new Band 4 role, supplemented by LFB resource over winter were discussed. • Assurance was sought that the skill mix had been considered and that there was no anticipated impact on patient safety. This assurance was provided. • Recruitment of UK graduates had gone well with 96 starting in August, 23 in September and 7 are still completing pre-employment checks. This gives a net additional 6 overall. • Training is a key enabler of the recruitment programme. The Committee discussed the anticipated challenges if individuals are unable to commence training when expected as there is not sufficient estates capacity to deliver additional courses. This position will be closely monitored. • Members sought assurance as to whether there was sufficient resource in Operations and People & Culture to drive the recruitment of 240 Band 4, in addition to all other recruitment.
Other matters considered:	**Investigation, Disciplinary and Conflict Resolution** • The Committee received a detailed presentation on the proposed Resolution Framework which will replace the traditional Grievance Policy, Dignity at Work Policy and Disciplinary Policy and Procedure. This will offer a timely, supportive and proactive approach for resolving workplace issues. • Concern was raised in respect of training capacity as cultural change is required to implement the resolution framework successfully. The training of Line Managers was discussed, and in addition, there would be a training and cultural change requirement for HR Business Partners and HR Managers who have not been used to working in this way to gain resolution, rather than implementing a procedure. • The positive work was acknowledged and assurance was sought that KPIs and key outputs would be established to measure the success of

implementation. There is a dedicated workstream established to consider these measures and ensure they are embedded in the delivery plan.

Internal Audit activity Report, Statutory and Mandatory Training

- Members received a report which outlined the current status of internal audit activity from the 2018/19 and 2019/20 Internal Audit Programmes including progress with implementing recommendations and the reviews planned from 2020/21 relating to People and Culture.
- The workforce planning audit was discussed, and members raised caution in respect of the scheduling recognising the volumes of work being conducted in that area currently. Members requested that the appropriate scheduling was given further consideration.

People Integrated Performance Report

- The Committee considered vacancy levels and abstraction rates noting the improvement in 111. Caution was raised in respect of the numbers noting that people had been working relentlessly with a sense of loyalty and commitment and now that the pressure is reducing fatigue may influence abstraction levels more. The committee sought assurance that staff are being encouraged to take leave. This has been the case but various influencing factors, including inability to go on holiday have meant that it has not been taken. The Committee suggested that positive action is taken to encourage the taking of annual leave.
- BAME risk assessments to 8th July 2020 were at 87% complete, the next steps are to risk assess other staff in vulnerable groups, including over 70's and those staff on maternity leave.
- The low level of Appraisal completion at 64% was discussed, and the committee sought assurance that the programme had been reinstated and clearly communicated. It was agreed that upon return to REAP 2 these functions should have been reinstated, but communication could be improved to ensure the message has been received.

Freedom to Speak Up / Dignity at Work

- The detail of the report was considered, and concern was raised that 9 staff reported detrimental treatment after raising concerns. It was agreed that the next report should provide some additional context to allow members to have a clearer overview of such issues.
- In line with this, 'process' and 'Management' were recognised as nebulous terms and members felt there would be a benefit to understanding some context, this would be considered for provision in future reporting

Board E&D development session

- Members discussed the actions and results in detail acknowledging the opportunity to drive positive change in the organisation and focus on the cultural change required.
- It was acknowledged that substantial work is being progressed and the Trust should be commended for the enlightened approach it is taking to the issue of equality and diversity.

Health and safety update

- The committee received a paper which detailed key areas of focus from the health and safety department and members noted that some projects had been paused due to COVID response including body worn cameras, although this has now resumed and is being progressed through procurement.
- It was noted that there had been a drop in violence and aggression, however the levels are now increasing again as the lockdown releases. Further to this, members were notified that improved prosecution rates had been achieved with 10 this year as opposed to 2 last year.

Flu Update

	• The committee were informed that 115 peer vaccinators had been identified and 7000 vaccines had been ordered with no anticipated supply chain issues. The Flu and immunisation steering group will progress the plan to completion. • Members raised concern that vaccination had not been mandated and felt that it if this was not possible for existing staff it could be written into the contracts of new starters. This approach would be considered.
Key decisions made / actions identified:	• As above
Risks:	• Staff fatigue • Operational Recruitment Programme • Availability of Training rooms • Appraisal Compliance
Assurance:	• Partial assurance was received for the Workforce Operational Modelling and Resourcing Programme. The numbers are now clearly defined and there is a plan to deliver in place. The Committee cannot be entirely assured that the plan will be delivered to the timescales required. It is prepared to accept that this is currently work in progress and mitigations have been identified. • The Resolution Framework requires extensive cultural implementation. Members requested that the resolution framework implementation plan be presented to the September Committee for further monitoring and assurance. • The Committee wanted greater assurance that staff were being encouraged to take Annual Leave. • Majority completion of BAME Assessments provided the Committee with assurance that this had been achieved effectively. • The Committee received little assurance that Appraisals were now being completed in order to achieve the target of 85%. • The Committee received substantial assurance around Freedom to Speak Up, Equality and Diversity Plans, Health and Safety and Flu • Members concluded that the meeting had been well chaired and had considered a large agenda effectively in good time. • The improved quality of papers was recognised which allowed discussion of key points rather than re-reporting the paper.

PUBLIC BOARD OF DIRECTORS MEETING

Director Report: Finance Q1

- **Hot Topic Updates**
  - Interim national financial arrangements have been extended until end August and likely end September resulting in high likelihood of breakeven for half year1, though uncertainty remains for half year2.

  - As referenced in the CEO report, North West London (NWL) Health & Care Partnership (HCP) CFOs have agreed a capital plan of £335m which has prioritised the Trust's urgent schemes for wave 2 preparedness, brokering £6m Capital Resource Limit (CRL) from other NWL providers and a total Trust capital plan (including nationally funded and prior Covid schemes) of £44m. Subject to formal notification, this will be nearly double last year's plan and is a very welcome recognition by the system of the priority of the Trust's recovery plans.

  - The Trust has been selected for a Covid-19 cost reimbursement audit by Deloitte on behalf of NHSE/I as part of the first wave of a rolling programme during 20/21, starting with 2 organisations in each of 7 regions. The scope is to check that Covid claims were made in accordance with the NHSE/I guidance and supported by evidence. The audit is under way and expected to report findings next month.

  - London CFOs have recognised that the Covid impact has been an extremely stressful time for our staff, who have had to support accelerated budget decision procedures whilst maintaining control and value for money and in most cases, doing this remotely. This has particularly been the case for the LAS teams whose space was necessarily taken over for the expansion of call-taking services. Notwithstanding this, the 19/20 underlying control total was met and the final audited accounts for 19/20 were delivered in line with the June deadline with an unqualified opinion. I would like to take this opportunity to put on record my thanks to the team for this significant achievement.

- **Q1 Finance Position**
  - The Trust has a breakeven position as at the end of June 2020 in line with the interim financial framework established by NHS England.

  - £27m of Covid-19 revenue expenditure has been incurred for quarter 1 and retrospective claims to month 2 have all been funded in full.

  - The Trust has a cash balance of £57m at the end of June.

- **2020/21 Finance Position**
  - The extension of top-up arrangements means there is continued uncertainty over the affordability of the business plan for the remainder of the year due to the difficulty in setting a clear budget and risk of a revenue gap when retrospective arrangements stop. Consequently a new Board Assurance Framework (BAF) level finance risk has been raised.

  - The Trust is working at pace in partnership with NWL HCP to agree its revenue envelope for 20/21 on an open book basis and we are inviting independent ambulance expert assistance to help broker this with the London-wide system.

- **Looking forward**
  - National Ambulance Directors of Finance have provided a response to an informal consultation by NHSE/I on payment and contracting options for 2021/22 and the Association of Ambulance Chief Executives (AACE) is developing a position statement to support development of a commissioning blueprint for integrated 999 and 111 call handling, clinical assessment and triage, out of hours access and ambulance services.

  - Internally, the key look ahead and priorities for the Finance directorate teams are supporting the development of Trust business plan for 20/21 and development of the strategic outline case for the longer term investment. Other priorities include supporting readiness for an early pilot for providing paramedics in Merton Health Primary Care Network (PCN) in advance of the roll out of PCN paramedics in 21/22 and reinstating work programmes including the procurement transformation plan which forms a key part of the wider medium term efficiency programme for the Trust.

  The Board is asked to note and discuss the report.

Finance Report

Month 3: June 2020

Key Headlines

This paper updates on the financial position as at the end of June 2020 (month 3, financial year 2020-21).

The Trust is operating under an adjusted financial framework for the period April to July 2020 which has involved pausing business planning (including Cost Improvement Programmes) and contracting and commissioning processes (including CQUIN).

The framework involves the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions. This allows expenditure on the Trust's response to the COVID-19 pandemic to be funded.

In line with the revised financial framework issued by NHS England the Trust reported a breakeven position on an adjusted financial performance basis in month 3 (£14k deficit before measurement adjustments in relation to donated assets).

The amount of additional M3 retrospective top up requested to balance the Trust's position was £7.59m (YTD: £26.434m M1: £10.734m, M2: £8.110m). This is higher than the Trust's M3 reported COVID costs of £6.807m (YTD: £27.068m M1: £12.915m, M2: £7.345m).

Month 3 YTD expenditure incorporates:

1. Pay expenditure of £90.3m YTD, £10.2m higher than the pre-COVID business plan. It is also £10.1m higher than expected in NHSI planning primarily due to COVID-19 costs (£3.9m YTD), with the remainder due to higher than expected increases in AfC costs (£1.1m) and higher current WTE compared to the reference period used for the plan (approximately £2m).
2. Non pay expenditure including depreciation but excluding finance costs is £45.3m YTD, £13.4m higher than the pre-COVID business plan. Compared to central NHSI planning expectations this is £17.1m higher than expected due primarily to COVID-19 costs (£20.1m YTD), and higher depreciation than expected (£0.9m YTD) due to one off adjustments for the reassessment of the useful lives of Trust assets in the prior year reference period used to calculate the expected costs. These were offset by underspends in non-pay spend for non COVID-19 activity (£3.9m YTD) due to reduced focus on non-COVID areas and the use of a peak period run-rate in calculation of the expected costs.

The Trust finished the month with a cash position of £57.0m.

Capital spend was £7.2m YTD (primarily on COVID-19 response requirements which amounted to £5m) and is currently forecasting to spend £44.2m in line with its June 2020 revised capital plan.

Key Financial Indicators

Surplus / (Deficit)

Legend: In Month Surplus / (deficit) — Cumulative Forecast Surplus / (deficit) — Cumulative Pre COVID-19 Plan

Chart values: 0.115, 0.110, (0.324), 0.329, 0.068, (0.005)
Y-axis: 0.500, 0.000, (0.500), (1.000), (1.500), (2.000), (2.500)
X-axis: Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21

	M3	YTD	Forecast
	GREEN	GREEN	GREEN

- The month 3 in-month position was a £115k surplus (breakeven on an adjusted financial performance basis) in line with NHSI requirements
- The month 3 YTD position was a £110k surplus (breakeven on an adjusted financial performance basis) in line with NHSI requirements
- The full year forecast position at month 3 is a £68k surplus (breakeven on an adjusted financial performance basis) in line with NHSI requirements
- The Trust is operating under an adjusted financial framework for April to July 2020 which has involved the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions. This allows expenditure on the Trust's response to the COVID-19 pandemic to be funded.
- The YTD position incorporated £27.1m of costs in relation to the Trust's response to COVID-19, and a retrospective income top up to balance the Trust's financial position of £26.4m.

Use of Resources Rating

	YTD		Full year	
	Plan	Actual	Plan	Actual
Capital service cover rating				
Liquidity rating				
I&E margin rating				
Variance from control total				
Agency rating				
Overall rating				

	M3	YTD	Forecast
	N/A	N/A	N/A

- NHSI rates Trust's on a Use of Resources rating. The scoring system ranks from '1' (low risk/best score) to '4' (high risk/worst score). The table left shows the Trust's current Use of Resources rating for YTD and full year position.
- The overall rating is a weighted risk rating across five financial metrics. The overall rating includes an override where if any one metric is a 4, the highest overall rating that can be achieved is a 3
- **No use of resources scores are currently available under the interim financial framework arrangements.**

Key Financial Indicators
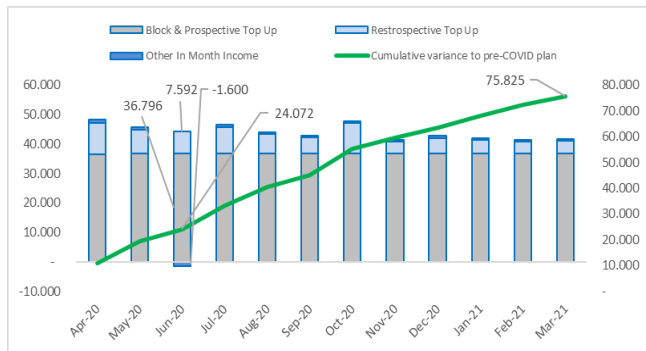
Income
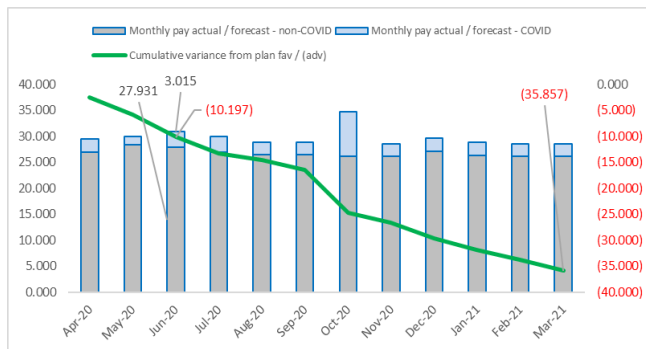
M3	YTD	Forecast
GREEN	GREEN	GREEN

- YTD and forecast income assumptions are in line with the current financial framework for April to July 2020. This involves the Trust receiving block contract income in advance (£34.084m per month) as determined by NHSE/I, along with a standard monthly top-up amount (£2.657m per month) and retrospective top ups to breakeven financial performance positions (£18.843m YTD, FY forecast £30.1m).
- Other Operating Income is £36.3m YTD (FY forecast £116.7m) which is comprised mainly of top up and retrospective top up income £34.4m YTD (FY forecast £113.1m) and Education & Training Income £1.5m YTD (FY forecast £3.1m).
- The total income position is £24.1m higher than pre-COVID plan YTD (FY forecast £75.8m higher than pre-COVID plan).

Pay Expenditure

M3	YTD	Forecast
AMBER	AMBER	AMBER

- Pay expenditure is £90.3m YTD, £10.1m higher than expected in NHSI planning due primarily to COVID-19 costs (£6.95m YTD), with the remainder due to higher than anticipated increases in AfC costs (£1.1m) and higher current staffing compared to the reference period used for the plan (approximately £2m).
- The total pay expenditure position is £10.2m higher than pre-COVID plan YTD and is currently forecast to be £35.9m higher than pre-COVID plan across the financial year.

Key Financial Indicators

Non-Pay Expenditure
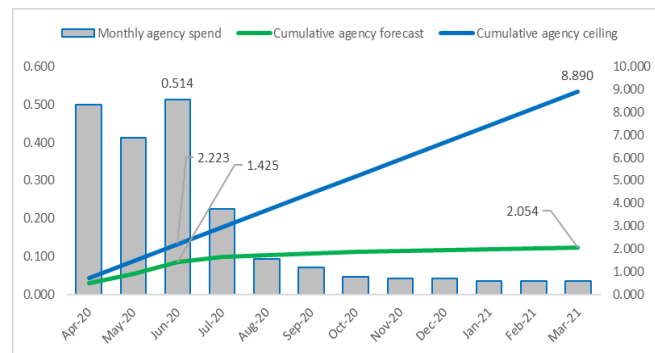
	M3	YTD	Forecast
	AMBER	AMBER	AMBER

- Non pay expenditure including depreciation but excluding finance costs is £45.3m YTD, £13.4m higher than the pre-COVID business plan.
- Non pay COVID-19 costs are £20.1m YTD in relation to increased 111 IUC resourcing through external providers, increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning, personal protective equipment, medical equipment and operational consumables, and in relation to IT equipment and IT services to enable home working and expand the capacity and capability of systems and telephony.
- This was offset by underspends in non-pay spend for non COVID-19 activity (£6.6m YTD) due to reduced focus on non-COVID areas and lower than pre-COVID budgeted depreciation.

Agency Ceiling

	M3	YTD	Forecast
	GREEN	GREEN	GREEN

- YTD agency spend is £1.4m compared to the cumulative YTD agency ceiling of £2.2m.
- Full year agency spend is currently forecast to be £2.1m, which is £6.8m below the agency ceiling of £8.9m.
- The Trusts limited agency forecast reflects the implementation of alternative resourcing models within the IUC Clinical Triage service.

Key Financial Indicators

	M3	YTD	Forecast
Cost Improvement Programme	GREEN	GREEN	GREEN

- **The Trust is operating under an adjusted financial framework for April to July 2020 in response to the COVID-19 pandemic.**
- **This has involved pausing business planning and Cost Improvement Programmes and as such no CIP data will be available across this period.**

	M3	YTD	Forecast
Capital Expenditure	GREEN	GREEN	GREEN

- YTD capital expenditure is £7.2m YTD compared to planned capital expenditure of £7.5m (£0.3m behind plan)
- Full year forecast capital expenditure is £44.2m in line with the Trust's latest capital plan submitted to NHSI.
- The majority of the Trust's YTD capital spend relates to its phase 1 response to the COVID-19 pandemic with £5m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment.
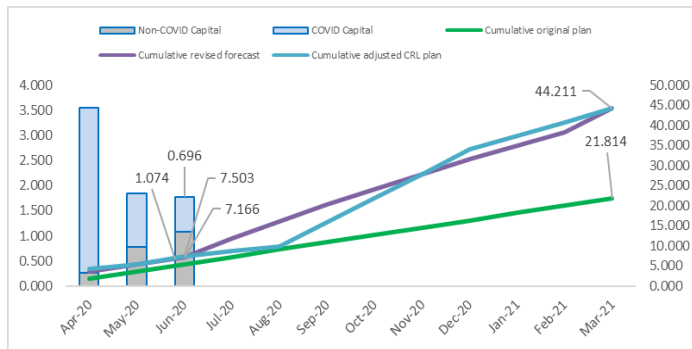
Key Financial Indicators

Cash

	M3	YTD	Forecast
	GREEN	GREEN	GREEN

Actual Cash at end of June 2020
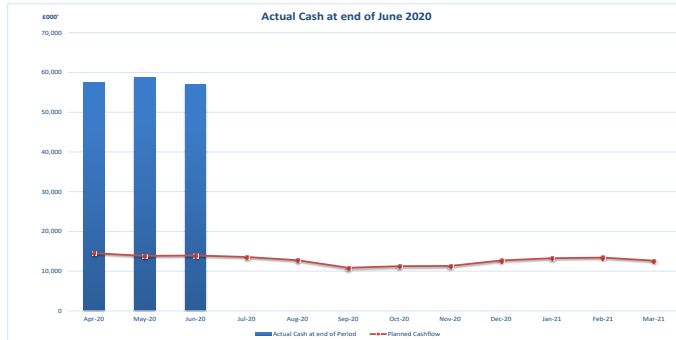
- Cash was £57.0m as at 30 June 2020, £45m above pre-COVID plan.
- The main reason for the favourable position was the payment in advance of one month's block contract income between April and June. Our cash balances are expected to reduce in July onwards as this arrangement ceases at the end of June.

Better Payment Practice Code
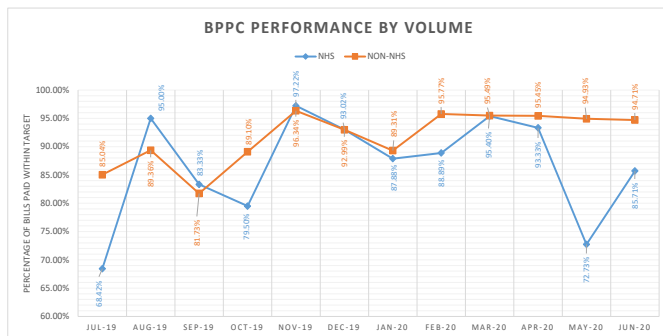
	M3	YTD	Forecast
	AMBER	AMBER	AMBER

BPPC PERFORMANCE BY VOLUME

- The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days.
- The NHS and Non-NHS performance by volume for June 2020 was 85.7% and 94.7% respectively
- The Trust has a high volume of overdue invoices waiting to be approved
- Directorate managers and staff have been sent lists of invoices that are outstanding that require approval.
- During the COVID period there has been a focus on paying invoices within 7 days and performance against this will be reported going forward.

COVID-19 Response Expenditure

	Actual £000 YTD Month 3 2020-21	Actual £000 Apr-20	Actual £000 May-20	Actual £000 Jun-20
Additional Staff Costs (EOC and Ambulance Services)	4,371	1,677	801	1,894
NHS 111 Additional Capacity - Staff	1,714	297	527	890
NHS 111 Additional Capacity - External Contracts	4,158	979	1,849	1,330
Decontamination Services - Premises	305	116	206	- 16
Defibrillators, Medical and Ambulance Equipment	739	1,229	191	- 681
IT Support	909	370	496	43
Private Ambulance Services	1,789	558	638	593
Vehicle Leasing	93	26	29	38
Telephony, Radio and IT Systems Expansion	1,867	906	112	848
Accommodation	985	400	344	241
Personal Protective Equipment	3,380	3,639	905	- 1,165
Fleet Maintenance and Preparation	3,687	1,531	621	1,535
Critical Care Transfer Service	933	524	242	167
Property Adjustments and Expansions	320	148	48	123
Other	1,817	516	336	965
Total COVID-19 Expenditure	27,068	12,915	7,346	6,807

The Trust has incurred £27.1m of COVID 19 incremental costs YTD (M1 12.9m, M2: £7.3m, M3: £6.807m) in order to provide significantly expanded resourcing, vehicle, vehicle and technical capacity.

PPE requirement for the Trust has increased significantly compared to BAU and the Trust has supported the wider health system through mutual aid for single use PPE (in excess of 0.6m items provided).

Vehicle deep cleans have continued to be required at a significantly increased level and Critical Care Transfer support continues for hospital transfers after being mobilised for the Nightingale Hospital.

Estate consolidation has been undertaken including temporary closure of 33 ambulance stations to consolidate operations and enable a flexible deployment model and improve efficiency across supply chain management.

Significant items of spend are summarised in the table to the left and include:
- Additional Staff Costs Ambulance Services and EOC (£4.4m YTD) reflecting the cost of additional resourcing to cover increased abstractions, additional resourcing impact of higher time off the road for cleaning vehicles and to provide increased resource capacity on the frontline and in control rooms.
- Personal Protective Equipment (£3.4m YTD) for items such as gowns, coveralls and protective face visors and glasses (£1.8m) and Masks & Filters (£1.55m).
- Accommodation (£1m YTD) for accommodation for staff to support isolation requirements.
- NHS 111 Additional Capacity Staff (£1.7m YTD) for additional resourcing through

internal sources.
- NHS 111 Additional Capacity External Contracts (£4.2m YTD) £1.2m for additional clinician resources (GPs, nurses and advanced practitioners) and £2.84m for additional non-clinical call handling resource support.
- Fleet Maintenance and Preparation (£3.7m YTD) additional external fleet maintenance support and preparation resources for cleaning higher numbers of vehicles more frequently
- Defibrillators, Medical and Ambulance Equipment (£0.7m YTD) for additional defibrillators for vehicles (£0.3m) and ambulance and medical equipment for expanded fleet (£0.4m)
- Private Ambulance Services (£1.8m) for additional private ambulance resources
- Telephony & IT Systems Expansions (£1.9m YTD) expanding the capacity of telephony and technical systems and equipment
- IT Support (£0.9m YTD) IT support resources
- Critical Care Transfer Service (£0.9m YTD) which was stood up in conjunction with London Nightingale Hospital and now supports hospital transfers. Staffing (£561k), consumables, equipment and support services (£405k).
- Decontamination Services - Premises (£0.3m YTD) for increased frequency of premises cleaning.

The Trust is actively reviewing its COVID-19 response to reduce cost whilst maintaining resilience and resource capacity.

Supporting Information

SOCI

	Month 3 2020-21 £000			YTD Month 3 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance to budget fav/(adv)
Income									
Income from Activities	36,863	31,825	(5,039)	111,149	100,572	(10,577)	445,785	410,822	(34,963)
Other Operating Income	1,133	10,963	9,830	1,632	36,281	34,649	5,933	116,721	110,788
Total Income	37,996	42,788	4,791	112,781	136,853	24,072	451,717	527,542	75,825
Operating Expense									
Pay	(26,637)	(30,946)	(4,309)	(80,098)	(90,295)	(10,197)	(320,747)	(356,605)	(35,857)
Non Pay	(9,215)	(10,380)	(1,165)	(27,891)	(42,411)	(14,521)	(109,546)	(149,722)	(40,176)
Total Operating Expenditure	(35,852)	(41,326)	(5,474)	(107,988)	(132,706)	(24,718)	(430,293)	(506,327)	(76,034)
EBITDA	2,144	1,461	(683)	4,793	4,146	(646)	21,424	21,215	(209)
EBITDA margin	5.6%	3.4%	(2.2%)	4.2%	3.0%	(1.2%)	4.7%	4.0%	(0.7%)
Depreciation & Financing									
Depreciation & Amortisation	(1,310)	(955)	354	(3,932)	(2,853)	1,079	(16,356)	(15,770)	586
PDC Dividend	(388)	(388)	0	(1,164)	(1,164)	0	(4,656)	(5,340)	(684)
Finance Income	8	0	(8)	24	(4)	(28)	100	(4)	(103)
Finance Costs	(15)	(3)	12	(45)	(15)	30	(182)	(34)	148
Gains & Losses on Disposals	0	0	0	0	0	0	0	0	0
Total Depreciation & Finance Costs	(1,705)	(1,346)	359	(5,117)	(4,036)	1,081	(21,095)	(21,148)	(53)
Net Surplus/(Deficit)	440	115	(324)	(324)	110	434	329	68	(262)
NHSI Adjustments to Fin Perf									
Remove Donations I&E Impact	3	(115)	(119)	10	(110)	(120)	38	(68)	(106)
Adjusted Financial Performance	443	(0)	(443)	(315)	0	315	368	0	(368)
Net margin	1.2%	0.3%	(0.9%)	(0.3%)	0.1%	0.4%	0.1%	0.0%	(0.3%)

Year to Date Position

The YTD position is a £110k surplus (breakeven on an adjusted financial performance basis) in line with NHSE/I requirements.

Forecast Full Year Position

The full year position is forecast to be a £68k surplus (breakeven on an adjusted financial performance basis) in line with NHSE/I requirements. The forecast position previously included only phase 1 COVID response costs, but now incorporates extended COVID response requirements expected for phase 2 over the remainder of the financial year.

Key items to note in the positions are:
- Income from activities is primarily comprised of the Trust's block contract income under the current interim financial arrangements with £34m being received each month – lower than pre-COVID plan by £10.6m YTD and £35m FY forecast.
- Other operating income is favourable to pre-COVID plan due to the inclusion of monthly top up and retrospective top up income under the current interim financial arrangements (£34.4m YTD and £113.1m full year forecast which covers the Trust's COVID response related expenditure and ensures a breakeven position.
- Pay expenditure is currently £10.2m adverse to pre-COVID plan YTD, and forecast to end the year £35.9m adverse to pre-COVID plan primarily due to COVID-19 response costs (£6.95m YTD and £35.3m FY forecast).
- Non pay expenditure is £14.5m adverse to pre-COVID plan YTD, and forecast to end the year £40.2m adverse to pre-COVID plan primarily due to COVID-19 response costs (£20.1m YTD and £44.1m FY forecast).
- Depreciation and finance costs are £1.1m favourable YTD (£0.1m unfavourable FY forecast) due to the impact of asset life reassessment not incorporated in the business plan and depreciation plan phasing differences YTD, with the forecast impacted by depreciation on COVID-19 response related asset purchases (£0.8m).

Financial Position by Directorate

Directorate	Month 3 2020-21 £000					YTD Month 3 2020-21 £000					Full Year 2020-21 £000				
	Budget	Actual	COVID	Actual excl COVID	Budget Variance (excl COVID) fav/(adv)	Budget	Actual	COVID	Actual excl COVID	Budget Variance (excl COVID) fav/(adv)	Budget	Forecast	COVID	Actual excl COVID	Budget Variance (excl COVID) fav/(adv)
Chief Executive	(236)	(211)		(211)	25	(706)	(621)		(621)	85	(2,718)	(2,556)		(2,556)	162
Chairman & Non-Executives	(13)	12		12	25	(39)	(9)		(9)	30	(157)	(114)		(114)	43
People & Culture	(714)	(450)		(450)	264	(2,114)	(919)		(919)	1,195	(8,937)	(8,066)		(8,066)	871
Communication & Engagement	(256)	(102)		(102)	154	(762)	(531)		(531)	231	(3,175)	(2,454)		(2,454)	721
Ambulance Services	(18,075)	(22,358)	(2,396)	(19,962)	(1,887)	(53,945)	(64,649)	(5,556)	(59,094)	(5,149)	(218,020)	(253,733)	(29,047)	(224,686)	(6,657)
999 Operations	(2,995)	(3,705)	(117)	(3,589)	(594)	(8,789)	(11,871)	(787)	(11,084)	(2,295)	(35,573)	(44,211)	(3,493)	(40,718)	(5,145)
IUC Services	(5)	(4,663)	(2,298)	(2,365)	(2,360)	100	(13,192)	(6,010)	(7,182)	(7,282)	450	(43,154)	(15,046)	(28,108)	(28,558)
Performance	(138)	(112)		(112)	26	(407)	(330)		(330)	76	(1,593)	(1,317)		(1,317)	276
Programmes & Projects	(222)	(351)		(351)	(129)	(663)	(479)		(479)	184	(2,685)	(3,803)		(3,803)	(1,119)
COO Management	(89)	(134)		(134)	(46)	(266)	(294)		(294)	(28)	(1,118)	(1,219)		(1,219)	(102)
Corporate Governance	(71)	(83)		(83)	(12)	(213)	(192)		(192)	21	(860)	(660)		(660)	200
Finance	(363)	(265)		(265)	98	(1,091)	(884)		(884)	207	(4,319)	(3,609)		(3,609)	710
Strategy, Tech & Development	(90)	(29)		(29)	61	(272)	(224)		(224)	48	(1,004)	(1,180)		(1,180)	(176)
IM&T	(1,239)	(1,401)	(460)	(941)	297	(3,693)	(5,818)	(2,348)	(3,470)	224	(14,761)	(18,330)	(4,037)	(14,293)	468
Medical	(2,051)	(1,546)	(167)	(1,379)	673	(6,128)	(5,247)	(933)	(4,314)	1,814	(24,986)	(22,242)	(1,127)	(21,115)	3,871
Quality & Assurance	(939)	(907)		(907)	32	(2,815)	(2,633)		(2,633)	182	(11,301)	(10,862)		(10,862)	440
Strategic A&P Management	(31)	(11)		(11)	20	(92)	(45)		(45)	47	(367)	(160)		(160)	207
Property	(900)	(1,199)	(173)	(1,026)	(126)	(2,719)	(3,508)	(549)	(2,959)	(241)	(10,590)	(13,327)	(1,421)	(11,905)	(1,316)
Fleet & logistics	(3,384)	(2,092)	(209)	(1,883)	1,501	(10,022)	(17,018)	(8,748)	(8,269)	1,753	(39,317)	(59,693)	(22,538)	(37,156)	2,162
Directorate Sub-Total	**(31,808)**	**(39,606)**	**(5,820)**	**(33,786)**	**(1,978)**	**(94,635)**	**(128,464)**	**(24,931)**	**(103,532)**	**(8,897)**	**(381,041)**	**(490,690)**	**(76,708)**	**(413,982)**	**(32,940)**
Central Income	35,007	42,031	7,108	34,924	(83)	103,545	134,356	27,369	106,987	3,442	415,459	520,414	80,711	439,703	24,244
Central Corporate	(2,759)	(2,310)	(1,287)	(1,023)	1,736	(9,233)	(5,782)	(2,437)	(3,344)	5,889	(34,088)	(29,656)	(4,003)	(25,653)	8,435
Total	**440**	**115**	**0**	**115**	**(324)**	**(324)**	**110**	**0**	**110**	**434**	**329**	**68**	**0**	**68**	**(262)**

Fleet & Logistics
- Underspend excl COVID of £1.7m YTD (£2.2m FY forecast) driven by reduced underlying transport costs primarily in relation to fuel underspends due to discounting (£0.9m YTD, £0.8m FY forecast) and fleet maintenance and insurance costs (YTD underspend £0.5m, FY forecast underspend (£1.2m)).
- COVID-19 costs of £8.7m YTD (full year forecast £22.5m) relate primarily to increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle cleaning, and increased purchases of personal protective equipment, medical equipment and operational consumables.

IM&T
- Full year forecast underspend excl COVID of £0.5m driven by planned recruitment to vacancies and reduced managed service costs.
- COVID-19 costs of £2.3m YTD (full year forecast £4m) relate primarily to IT equipment and IT services to enable home working, and systems and telephony expansions.

Medical
- Favourable variance excl COVID of £1.8m YTD (forecast full year £3.9m favourable) driven by net vacancies (£1.4m favourable YTD, £3.2m favourable FY forecast) primarily re APPs, lower than planned trainee costs and Clinical Education & Training vacancies.
- COVID-19 costs of £0.9m YTD (FY forecast £1.1m) relating to the Critical Care Transfer Service.

Property
- Full year forecast overspend of £1.3m excl COVID driven by building maintenance (£0.7m), utilities (£0.3m) and rent, rates and service charges (£0.3m).
- COVID-19 costs of £0.5m YTD (FY forecast £1.4m) relate primarily to increased premises cleaning and facilities adjustments to facilitate new operating models.

IUC Services
- Overspends excl COVID of £7.3m YTD (£28.6m FY forecast) are due to change in income structure which means that income is only received via the block and top-up arrangements and not specifically for 111 IUC Services.
- COVID-19 111 IUC costs are £6m YTD (£15m FY forecast) primarily in relation to increased call handling and clinical resourcing in response to activity levels that are 50% higher than pre-COVID planning.
- YTD expenditure excl COVID is £0.2m higher than pre-COVID plan, and forecast to be £0.1m higher for the full year.

Ambulance Services
- Overspends excl COVID YTD (£5.1m) and FY forecast (£6.7m) are due primarily to overtime and incentives covering vacancies (the forecast for which has been extended to cover phase 2 response requirements over the remainder of the financial year).
- COVID-19 costs are £5.6m YTD (full year forecast £29m) primarily in relation to increased resourcing levels in preparation for higher absence rates and longer out of service.

999 Operations
- Overspends excl COVID YTD (£2.3m) and FY forecast (£5.1m) are due primarily to overtime and incentives (£1.8m YTD and full year forecast £2.7m adverse variances) and over-establishment in the 999 Quality & Continuous Improvement area (£0.5m YTD and full year forecast £1.6m adverse variances).
- COVID-19 costs are £0.8m YTD (full year forecast £3.5m) primarily in relation to increased resourcing levels (the forecast for which has been extended to cover phase 2 response requirements over the remainder of the financial year).

Programmes & Projects
- Full year forecast overspend of £1.1m excl COVID driven by Digital 999 (£0.8m), HSCN (£0.1m) and central project management overspends (£0.2m).

Income

Income by Type	Month 3 2020-21 £000			YTD Month 3 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Patient Care Income									
Commercial Service Income	212	86	(126)	635	248	(388)	2,541	1,172	(1,370)
Emergency & Urgent Care Income	33,571	31,639	(1,932)	101,050	99,583	(1,467)	405,710	405,832	122
Emergency Bed Service Income	8	0	(8)	23	0	(23)	93	0	(93)
Injury Cost Recovery Income	111	92	(19)	385	255	(130)	1,257	1,021	(236)
Neonatal Service Income	40	12	(28)	125	20	(105)	491	130	(361)
Non-Contract E&UC Income	20	21	1	55	19	(35)	229	110	(119)
Other Patient Care Income	33	(275)	(308)	100	(162)	(262)	264	123	(140)
Patient Transport Service Income	0	0	0	0	0	0	0	0	0
Specialist Service Income	560	250	(311)	1,681	609	(1,072)	6,720	2,433	(4,287)
Telephone Advice Service Income	2,308	0	(2,308)	7,095	0	(7,095)	28,481	0	(28,481)
Total Patient Care Income	**36,863**	**31,825**	**(5,039)**	**111,149**	**100,572**	**(10,577)**	**445,785**	**410,822**	**(34,963)**
Other Operating Income	**1,133**	**10,963**	**9,830**	**1,632**	**36,281**	**34,649**	**5,933**	**116,721**	**110,788**
Total Income	**37,996**	**42,788**	**4,791**	**112,781**	**136,853**	**24,072**	**451,717**	**527,542**	**75,825**

The Trust is currently operating under an adjusted financial framework for the period April to July 2020 which has involved pausing contracting and commissioning processes (including CQUIN), the Trust receiving block contract income in advance as determined by NHSE/I, along with a standard monthly top-up amount and retrospective top ups to breakeven financial performance positions.

Patient Care Income

Emergency & Urgent Care Income
- The Trust's block contract income is predominantly reported under the emergency and urgent care heading with £34m

being received each month.
- The full year forecast has assumed this continues to the end of the financial year.
- This has been offset in the position by the crediting of invoices issued in relation to the Flowers case (£2.5m).

Telephone Advice Service Income
- As described above the adjusted financial framework the Trust is operating under has involved pausing contracting and commissioning processes. As such, no income is currently recorded against Telephone Advice Services as funding is being received through the block and top-up arrangements.

Commercial Service Income
- Due to the COVID-19 pandemic, no stadia income is expected across the year and Heathrow contract income has been reduced temporarily. As such, the YTD and full year forecast positions are behind budget by £0.4m and £1.4m respectively.

Specialist Service Income
- £1.1m adverse YTD and £4.3m adverse full year forecast due to MTFA income (£5.4m full year) being covered by block and top up arrangements offset by £0.8m favourable variance in relation to project income for the renegotiated BARTS PRU service.

Other Operating Income

Top Up Income
- Standard monthly top up income of £2.657m has been recognised monthly in the YTD and full year forecast positions, along with retrospective top up income to breakeven (on an adjusted financial performance basis) of £26.4m YTD and full year forecast of £81.2m.

Education & Training
- Training and Development funding is £0.9m favourable YTD and forecast to be £1.2m favourable full year due to increased allocations from HEE.
- YTD and full year forecast apprenticeship income is on plan.

Pay Expenditure

Pay Expenditure by Type	Month 3 2020-21 £000			YTD Month 3 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Substantive									
Corporate & Support Staff	(3,261)	(2,708)	553	(9,596)	(7,899)	1,697	(38,844)	(32,681)	6,163
Directors And Senior Managers	(1,553)	(1,158)	395	(4,651)	(3,547)	1,105	(18,363)	(14,635)	3,728
Frontline Control Staff	(2,166)	(2,178)	(12)	(6,385)	(6,173)	212	(26,026)	(28,102)	(2,077)
Frontline Ops Staff	(15,094)	(14,861)	233	(45,470)	(43,826)	1,644	(183,843)	(179,989)	3,854
Med, Nursing & Clin Adv Staff	(561)	(679)	(118)	(1,619)	(1,963)	(345)	(6,436)	(8,022)	(1,586)
Non-Emergency Control Staff	(36)	(13)	23	(105)	(44)	61	(424)	(164)	260
Non Emergency Ops Staff	(433)	(450)	(17)	(1,178)	(1,365)	(187)	(4,712)	(5,448)	(736)
Ops Management & Team Leaders	(2,867)	(2,633)	234	(8,185)	(7,935)	251	(33,077)	(31,327)	1,750
Other Pay Costs	(158)	(125)	33	(1,367)	(360)	1,007	(2,528)	(1,484)	1,044
Overtime & Incentives	(283)	(4,667)	(4,384)	(864)	(13,436)	(12,572)	(3,747)	(47,259)	(43,512)
Total Substantive	**(26,412)**	**(29,473)**	**(3,060)**	**(79,421)**	**(86,548)**	**(7,127)**	**(317,999)**	**(349,112)**	**(31,112)**
Agency	(17)	(514)	(497)	(52)	(1,425)	(1,374)	(207)	(2,054)	(1,848)
Bank	(197)	(934)	(737)	(595)	(2,227)	(1,631)	(2,421)	(5,170)	(2,748)
Seconded	(10)	(25)	(15)	(30)	(95)	(65)	(120)	(269)	(149)
Total Pay Expenditure	**(26,637)**	**(30,946)**	**(4,309)**	**(80,098)**	**(90,295)**	**(10,197)**	**(320,747)**	**(356,605)**	**(35,857)**

Pay Expenditure by Directorate	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	(123)	(198)	(74)	(1,263)	(486)	776	(2,095)	(1,718)	377
Chief Executive	(187)	(175)	12	(560)	(530)	30	(2,198)	(2,155)	43
People & Culture	(422)	(356)	66	(1,229)	(990)	240	(5,023)	(4,462)	561
Communication & Engagement	(225)	(213)	12	(663)	(612)	50	(2,812)	(2,368)	444
Ambulance Services	(17,355)	(21,179)	(3,824)	(51,777)	(60,465)	(8,688)	(209,335)	(240,906)	(31,570)
999 Operations	(3,028)	(3,656)	(628)	(8,892)	(11,572)	(2,680)	(35,967)	(43,131)	(7,165)
IUC Services	(985)	(1,764)	(779)	(2,918)	(4,908)	(1,991)	(12,164)	(17,295)	(5,132)
Projects & Programmes	(148)	(50)	98	(440)	(91)	349	(1,744)	(1,139)	605
COO Management	(89)	(81)	7	(266)	(231)	35	(1,087)	(962)	125
Corporate Governance	(36)	(35)	1	(107)	(101)	6	(437)	(275)	161
Finance	(277)	(211)	66	(833)	(663)	170	(3,287)	(2,750)	538
Performance	(135)	(73)	62	(399)	(216)	183	(1,555)	(861)	695
Strategy, Tech & Development	(51)	(58)	(7)	(157)	(171)	(14)	(545)	(748)	(204)
IM&T	(512)	(305)	208	(1,514)	(1,004)	510	(6,019)	(4,259)	1,760
Medical	(1,846)	(1,351)	495	(5,496)	(4,661)	835	(22,175)	(19,872)	2,302
Quality & Assurance	(476)	(435)	41	(1,424)	(1,317)	106	(5,621)	(5,384)	237
Strategic A&P Management	(30)	(11)	20	(91)	(32)	59	(364)	(144)	221
Property	(66)	(108)	(42)	(198)	(300)	(102)	(793)	(767)	26
Fleet & logistics	(645)	(689)	(44)	(1,870)	(1,943)	(73)	(7,526)	(7,407)	119
Total Pay Expenditure	**(26,637)**	**(30,946)**	**(4,309)**	**(80,098)**	**(90,295)**	**(10,197)**	**(320,747)**	**(356,605)**	**(35,857)**

YTD Position

Pay expenditure is currently £10.2m adverse to pre-COVID plan YTD. Key items include:

- COVID-19 response costs of £6.95m primarily in relation to additional resourcing across Ambulance Services, IUC Services, 999 Operations and Critical Care Transfer Services.
- YTD overspends in Med, Nursing & Clin Adv Staff (£0.3m) and Non Emergency Service staff (net £0.1m) excluding COVID due to staffing over budget levels (37 WTE and 9 WTE respectively) to support frontline vacancies.
- Corporate and frontline operations and control staff underspend in relation to vacancies excluding COVID (£6.8m net positive variance YTD) has been more than offset by increased overtime and incentives spend (£8.1m negative variance YTD), agency, bank and secondee spend (£1.5m negative variance YTD) and non-pay spend on professional fees and managed services.

Full Year Forecast Position

Pay expenditure is currently forecast to end the year £35.9m adverse to pre-COVID plan. Key items include:

- COVID-19 response costs of £35.3m (the forecast for which has now been extended to cover phase 2 response requirements over the remainder of the financial year) primarily in relation to additional resourcing across Ambulance Services, IUC Services, 999 Operations and Critical Care Transfer Services.
- Forecast overspends in Med, Nursing & Clin Adv Staff (£1.6m) and Non Emergency Service staff (net £0.4m) excluding COVID due to staffing over budget levels (36 WTE and 11 WTE respectively) to support frontline vacancies.
- Corporate and frontline operations and control staff underspend excluding COVID in relation to vacancies forecast to be held (£17.8m net positive variance forecast) offset by overtime and incentives spend (£13.6m negative variance – a forecast improvement to run rate), agency, bank and secondee spend (£2.8m negative variance) and non-pay spend on professional fees and managed services.

Non Pay and Financial Charges

Non Pay by Type	Month 3 2020-21 £000			YTD Month 3 2020-21 £000			Full Year 2020-21 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Non Pay Expenditure									
Establishment Expenses	(725)	(1,001)	(277)	(2,187)	(2,819)	(632)	(8,750)	(10,524)	(1,774)
General Supplies & Services	(2,162)	(1,592)	569	(6,663)	(5,365)	1,297	(26,132)	(25,374)	758
Technology & Communications	(1,022)	(1,858)	(836)	(3,064)	(5,038)	(1,974)	(12,259)	(16,386)	(4,127)
Operations Supplies & Services	(2,437)	(2,656)	(219)	(7,357)	(17,596)	(10,239)	(28,396)	(52,171)	(23,775)
Premises & Fixed Plant	(1,119)	(1,227)	(107)	(3,373)	(4,154)	(781)	(13,157)	(16,614)	(3,457)
Transport	(1,750)	(2,046)	(296)	(5,246)	(7,438)	(2,192)	(20,852)	(28,653)	(7,801)
Total Non Pay Expenditure	**(9,215)**	**(10,380)**	**(1,165)**	**(27,891)**	**(42,411)**	**(14,521)**	**(109,546)**	**(149,722)**	**(40,176)**
Financial Charges									
Depreciation & Amortisation	(1,310)	(955)	354	(3,932)	(2,853)	1,079	(16,356)	(15,770)	586
Other Financial Charges	(395)	(391)	4	(1,185)	(1,183)	2	(4,738)	(5,378)	(639)
Total Financial Charges	**(1,705)**	**(1,346)**	**359**	**(5,117)**	**(4,036)**	**1,081**	**(21,095)**	**(21,148)**	**(53)**
Total Non Pay & Financial Charges	**(10,920)**	**(11,726)**	**(807)**	**(33,008)**	**(46,448)**	**(13,440)**	**(130,641)**	**(170,870)**	**(40,230)**

Non Pay by Directorate	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	(2,636)	(2,126)	510	(7,971)	(5,939)	2,032	(31,993)	(28,896)	3,097
Chief Executive	(49)	(36)	14	(148)	(91)	57	(530)	(408)	121
Chairman & Non-Executives	(13)	12	25	(39)	(9)	30	(157)	(114)	43
People & Culture	(462)	(247)	215	(1,475)	(488)	986	(5,674)	(5,332)	342
Communication & Engagement	(35)	(24)	11	(113)	(74)	39	(435)	(302)	133
Ambulance Services	(1,068)	(1,577)	(509)	(3,212)	(5,037)	(1,825)	(12,870)	(16,151)	(3,281)
999 Operations	(72)	(70)	2	(215)	(359)	(144)	(867)	(1,258)	(391)
IUC Services	(1,328)	(2,899)	(1,571)	(4,077)	(8,283)	(4,206)	(15,868)	(25,859)	(9,991)
Projects & Programmes	(74)	(301)	(227)	(223)	(388)	(165)	(941)	(2,665)	(1,724)
COO Management	0	(53)	(53)	0	(62)	(62)	(31)	(257)	(226)
Central Income	(3)	0	3	(22)	0	22	(32)	0	32
Corporate Governance	(35)	(48)	(13)	(106)	(91)	15	(424)	(385)	38
Finance	(86)	(54)	32	(259)	(221)	38	(1,035)	(859)	176
Performance	(3)	(39)	(36)	(8)	(114)	(106)	(38)	(456)	(419)
Strategy, Tech & Development	(38)	29	68	(115)	(53)	62	(459)	(432)	28
IM&T	(726)	(1,096)	(370)	(2,179)	(4,814)	(2,635)	(8,742)	(14,070)	(5,328)
Medical	(235)	(197)	39	(722)	(720)	3	(3,175)	(2,806)	369
Quality & Assurance	(483)	(507)	(24)	(1,450)	(1,409)	41	(5,779)	(5,755)	24
Strategic A&P Management	(0)	(0)	(0)	(1)	(12)	(12)	(3)	(17)	(13)
Property	(834)	(1,091)	(257)	(2,521)	(3,209)	(688)	(9,797)	(12,560)	(2,763)
Fleet & logistics	(2,739)	(1,404)	1,335	(8,152)	(15,075)	(6,923)	(31,791)	(52,287)	(20,496)
Total Non Pay & Financial Charges	**(10,920)**	**(11,726)**	**(807)**	**(33,008)**	**(46,448)**	**(13,440)**	**(130,641)**	**(170,870)**	**(40,230)**

YTD Position

Non pay expenditure is £13.4m adverse to pre-COVID plan. Key items include:

- COVID-19 response costs of £20.1m in relation to increased 111 IUC resourcing through external providers, increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning, personal protective equipment, medical equipment and operational consumables, and in relation to IT equipment and IT services to enable home working and expand the capacity and capability of systems and telephony.
- Offset by:
  - Depreciation underspend against pre-COVID plan (£1.1m) due to the impact of asset life reassessment not incorporated in business plan and depreciation plan phasing differences; and
  - Net non pay underspends against pre-COVID plan due to focus on COVID response requirements and plan phasing (£5.6m).

Full Year Forecast Position

Non pay expenditure is forecast to end the year £40.2m adverse to pre-COVID plan. Key items include:

- COVID-19 response costs of £45.1m (the forecast for which has been extended to cover phase 2 response costs to the end of the financial year) in relation to increased 111 IUC resourcing through external providers, increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning, personal protective equipment, medical equipment and operational consumables, IT equipment and IT services to enable home working and expand the capacity of systems and telephony, and depreciation impacts in respect of assets purchased in relation to the above.
- Offset by:
  - Depreciation underspend against pre-COVID plan (£1.4m) due to the impact of asset life reassessment not incorporated in business plan and depreciation plan phasing differences; and
  - Reducing net non pay underspends against pre-COVID plan (£4.1m) due to forecast increased technology & communications, premises and operations supplies and services spend.

IUC / 111 Services

	111 IUC Total YTD M3 2020-21 £000			111 IUC Total FY Forecast M3 2020-21 £000		
	Budget	YTD	Variance fav/(adv)	Budget	Full Year Forecast	Variance fav/(adv)
Income						
Income from Activities	7,095	0	(7,095)	28,481	0	(28,481)
Other Income	0	0	0	0	0	0
Total Income	**7,095**	**0**	**(7,095)**	**28,481**	**0**	**(28,481)**
Pay						
Substantive Staff	(2,918)	(3,826)	(908)	(12,164)	(16,036)	(3,873)
Agency	0	(774)	(774)	0	(815)	(815)
Bank	0	(309)	(309)	0	(443)	(443)
Total Pay Expenditure	**(2,918)**	**(4,908)**	**(1,991)**	**(12,164)**	**(17,295)**	**(5,132)**
Non Pay						
Establishment Expenses	(7)	(12)	(5)	(29)	(35)	(6)
General Supplies & Services	(118)	(255)	(137)	(470)	(890)	(420)
Technology & Communications	(321)	(420)	(100)	(1,285)	(1,631)	(347)
Operations Supplies & Services	(3,317)	(7,255)	(3,938)	(12,823)	(21,577)	(8,753)
Premises & Fixed Plant	(228)	(277)	(50)	(910)	(1,435)	(524)
Transport	0	(2)	(2)	0	(11)	(11)
Depreciation & Amortisation	(88)	(62)	25	(350)	(281)	69
Total Non Pay	**(4,077)**	**(8,283)**	**(4,206)**	**(15,868)**	**(25,859)**	**(9,991)**
Net Surplus/(Deficit)	**100**	**(13,192)**	**(13,292)**	**450**	**(43,154)**	**(43,604)**

Key points to note:

- The current interim finance arrangements mean that no specific IUC funding is received – these services are however covered by the block contract arrangements in place.
- YTD activity is around 50% higher than the pre-COVID plan due to COVID related demand changes.
- Significant quantities of additional resource have been engaged to help manage this position - COVID-19 response costs in relation to IUC have been around £6m YTD.
- The YTD position includes £7.2m of managed services and GP costs (FY Forecast £21.3m) to deliver stable clinical services and respond to current COVID-19 demand levels.

Capital Investment

	Actual (£m) Apr-20	Actual (£m) May-20	Actual (£m) Jun-20	Forecast (£m) Jul-20	Forecast (£m) Aug-20	Forecast (£m) Sep-20	Forecast (£m) Oct-20	Forecast (£m) Nov-20	Forecast (£m) Dec-20	Forecast (£m) Jan-21	Forecast (£m) Feb-21	Forecast (£m) Mar-21	Total
Monthly capital spend	3.554	1.842	1.770										7.166
Original plan	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	1.818	21.814
Adjusted CRL Plan	4.226	1.080	2.197	1.145	1.145	6.038	6.038	6.038	6.038	3.428	3.428	3.410	44.211
Revised forecast	3.554	1.842	1.770	4.657	4.317	4.142	3.741	3.753	3.735	3.435	3.369	5.896	44.211
Cumulative actual	3.554	5.396	7.166										
Cumulative original plan	1.818	3.636	5.454	7.271	9.089	10.907	12.725	14.543	16.361	18.178	19.996	21.814	
Cumulative revised forecast	3.554	5.396	7.166	11.823	16.140	20.282	24.023	27.776	31.511	34.946	38.315	44.211	
Cumulative adjusted CRL plan	4.226	5.306	7.503	8.648	9.793	15.831	21.869	27.907	33.945	37.373	40.801	44.211	

Programme	(£m) YTD	(£m) Forecast	YTD as % of forecast
CAD Essentials	0.019	0.366	5%
Digital 999	0.458	6.970	7%
COVID-19 Response - Phase 1	5.036	6.358	79%
COVID-19 Response - Phase 2	0.130	14.588	1%
ESR Transformation	0.000	0.000	0%
Fleet	0.126	2.519	5%
IM&T Essentials	0.054	3.212	2%
IM&T Cyber	0.000	0.360	0%
OneLondon	0.000	0.850	0%
Ready Set Go	0.555	4.483	12%
Spatial Development	0.755	4.473	17%
Other	0.033	0.033	100%
Total	7.166	44.211	16%

The Trust's capital plan was revised again in mid-late June 2020 (following review in late May) to reflect additional capital investment required in relation to its ongoing COVID-19 response. This resulted in an increase from the initial plan of £21.8m to a revised plan of £44.2m. This is likely to be funded from:
- Internally generated capital (£20.4m);
- HSLI (£1.67m);
- Grants (£0.3m);
- LHCRE PDC (£0.85m);
- COVID Phase 1 PDC (£6.4m); and
- COVID Phase 2 CRL Transfers and PDC (£14.6m).

YTD and Full Year Position
- YTD capital expenditure is £7.2m YTD compared to planned capital expenditure of £7.5m (£0.3m behind plan)
- Full year forecast capital expenditure is £44.2m in line with the Trust's latest capital plan submitted to NHSI.
- The majority of the Trust's YTD capital spend relates to its phase 1 response to the COVID-19 pandemic with £5m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment.

Cash Flow Statement

	Apr-20 Actual £000	May-20 Actual £000	Jun-20 Actual £000	Jun-20 YTD Move £000	Jun-20 YTD Plan £000	Jun-20 Var £000
Opening Balance	**25,964**	**57,387**	**58,796**	**25,964**	**25,964**	**0**
Operating Surplus	1,360	1,319	1,465	4,144	4,144	0
(Increase)/decrease in current assets	(8,741)	(2,906)	2,709	(8,938)	(8,938)	0
Increase/(decrease) in current liabilities	46,479	4,778	(3,104)	48,153	48,153	0
Increase/(decrease) in provisions	93	88	213	394	394	0
Net cash inflow/(outflow) from operating activities	39,191	3,279	1,283	43,753	43,753	0
Cashflow inflow/(outflow) from operating activities	**39,191**	**3,279**	**1,283**	**43,753**	**43,753**	**0**
Returns on investments and servicing finance	(4)	0	(8)	(12)	(12)	0
Capital Expenditure	(7,764)	(1,870)	(3,039)	(12,673)	(12,673)	0
Dividend paid	0	0	0	0	0	0
Financing obtained	0	0	0	0	0	0
Financing repaid	0	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(7,768)**	**(1,870)**	**(3,047)**	**(12,685)**	**(12,685)**	**0**
Movement	31,423	1,409	(1,764)	31,068	31,068	0
Closing Cash Balance	**57,387**	**58,796**	**57,032**	**57,032**	**57,032**	**0**

Due to COVID-19, NHSE and NHSI suspended the financial planning process for 2020/21. So the outturn statement of financial position is equivalent to the plan.

There has been a net inflow of cash to the Trust of £31.1m, this is due to NHSI paying two months block income in April and the monthly block income for July in June.

Cash funds at 30 June stand at £57.0m.

Operating Surplus
• The operating surplus is on target.

Current Assets
• The movement on current assets is (£8.9m).
• The movement is due to an increase in trade receivables (£2.5m), accrued income (£4.5m) and prepayments (£1.9m).

Current Liabilities
• The movement on current liabilities is £48.1m.
• The movements is due to an increase in deferred income £39.2m (block contract payments in advance), Accruals £12.0m and payable (£3.1m).

Provisions
• The movement on provisions was £0.4m, this relates legal and international student payments.

Capital Expenditure
• Capital cash outflow is £12.7m.

Statement of Financial Position

	Mar-20 Act £000	Apr-20 Act £000	May-20 Act £000	Jun-20 Act £000	Plan £000	Jun-20 Var £000	%
Non Current Assets							
Property, Plant & Equip	177,186	178,766	179,499	179,669	179,669	0	0.0%
Intangible Assets	8,183	9,241	9,366	10,173	10,173	0	0.0%
Trade & Other Receivables	0	0	0	0	0	0	
Total Non Current Assets	**185,369**	**188,007**	**188,865**	**189,842**	**189,842**	**0**	**0.0%**
Current Assets							
Inventories	4,508	4,770	4,688	4,575	4,575	0	0.0%
Trade & Other Receivables	22,270	30,749	33,737	31,141	31,141	0	0.0%
Cash & cash equivalents	25,964	57,387	58,796	57,032	57,032	0	0.0%
Non-Current Assets Held for Sale	0	0	0	0	0	0	
Total Current Assets	**52,742**	**92,906**	**97,221**	**92,748**	**92,748**	**0**	**0.0%**
Total Assets	238,111	280,913	286,086	282,590	282,590	0	0.00%
Current Liabilities							
Trade and Other Payables	(47,012)	(89,719)	(94,805)	(90,981)	(90,981)	0	0.0%
Provisions	(6,584)	(7,170)	(7,179)	(7,335)	(7,335)	0	0.0%
Borrowings	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	
Total Current Liabilities	**(53,596)**	**(96,889)**	**(101,984)**	**(98,316)**	**(98,316)**	**0**	**0.0%**
Total Assets Less Current Liabilities	**184,515**	**184,024**	**184,102**	**184,274**	**184,274**	**0**	**0.0%**
Non Current Liabilities							
Trade and Other Payables	0	0	0	0	0	0	
Provisions	(8,436)	(7,945)	(8,026)	(8,085)	(8,085)	0	0.0%
Borrowings	(107)	(107)	(107)	(107)	(107)	0	0.0%
Working Capital Loan - DH	0	0	0	0	0	0	
Capital Investment Loan - DH	0	0	0	0	0	0	
Total Non Current Liabilities	**(8,543)**	**(8,052)**	**(8,133)**	**(8,192)**	**(8,192)**	**0**	**0.0%**
Total Assets Employed	**175,972**	**175,972**	**175,969**	**176,082**	**176,082**	**0**	**0.0%**
Financed by Taxpayers Equity							
Public Dividend Capital	66,178	66,178	66,178	66,178	66,178	0	0.0%
Retained Earnings	54,593	54,593	54,590	54,703	54,703	0	0.0%
Revaluation Reserve	55,620	55,620	55,620	55,620	55,620	0	0.0%
Other Reserves	(419)	(419)	(419)	(419)	(419)	0	0.0%
Total Taxpayers Equity	**175,972**	**175,972**	**175,969**	**176,082**	**176,082**	**0**	**0.0%**

Due to COVID-19, NHSE and NHSI suspended the financial planning process for 2020/21. So the outturn statement of financial position is equivalent to the plan.

Non Current Assets
- Non current assets stand at £189.8m, £4.5m movement in year.

Current Assets
- Current assets stand at £97.7m, £40.0m movement in year.
- Cash position as at 30 June is £57.0m, £31.1m above plan.
- Within Trade & Other Receivables, Receivables (debtors) at £5.3m, (£1.4m) movement in year, accrued income at £20.1m is a £8.4m movement in year and prepayments at £6.7m is a £1.9m movement in year.

Current Liabilities
- Current liabilities stand at £98.3m, £44.7m movement in year.
- Within Trade and Other Payables, Payables and accruals at £32.1m, £14.7m in year movement. The increase in movement is due to trade payables £4.7m.
- Deferred Income at £39.4m, £39.2m in year movement. This is due to the Trust receiving one month block income in advance.
- Current provisions at £7.3m, £0.8m movement in year.

Non Current Liabilities
- Non current provisions at £8.1m, £0.4m movement in year.
- Borrowings at £0.1m, no movement in year.

Taxpayers Equity
- Public Dividend Capital stands at £66.2m, no movement in year.
- Revaluation Reserve stands at £55.6m, no movement in year.
- Retained Earnings stands at £54.7m, £0.1m movement in year.
- Taxpayers Equity stands at £176.1m, £0.1m movement in year.

Better Payment Practice Code (BPPC)

BPPC PERFORMANCE BY VOLUME
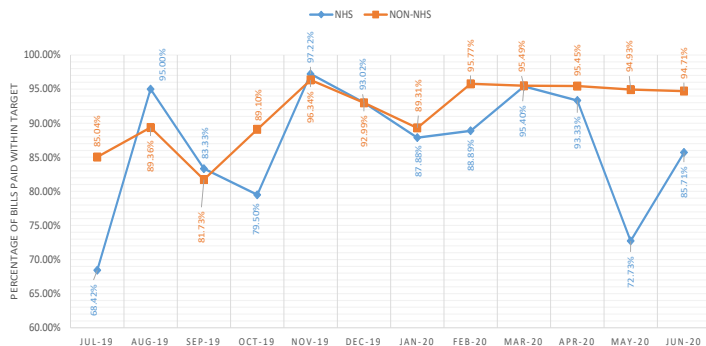
CREDITOR DAYS 2020/21
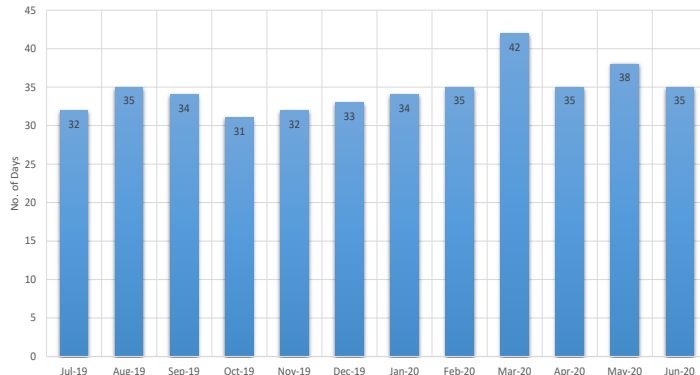
BPPC

- The government has set a target that organisations should aim to pay 95% their supplier invoices within 30 days.
- The Trust has a high volume of overdue invoices waiting to be approved. ELFS and finance team are chasing managers and staff to approve their invoices.
- ELFS and finance are working to fine tune the process of invoice approval to reduce the delays.
- The volume of invoices processed for the 3 months to the end of June 2020 is 13,558 and 132 for Non-NHS and NHS respectively.
- During the COVID period there has been a focus on paying invoices within 7 days and performance against this will be reported going forward.

Creditor Days

- The increase in creditor days in August (M5), September (M6) and March (M12) was due to an increase in capital creditors and Corvid spend.
- There has been a steady increase in creditor days over the winter months. The Trust is looking into the cause of the increase.

Debtors Analysis

Aged Debtors Summary 30th June 2020

	Note	Total	Days Overdue			
			0 - 30	31 - 60	61 - 90	Over 91 days
		£'000	£'000	£'000	£'000	£'000
NHS Debtors						
NHS North Central London CCG	1	520	-	-	419	101
NHS South East London CCG	1	515	-	-	514	1
NHS South West London CCG	1	389	-	-	387	3
NHS Havering CCG	1	227	-	-	227	-
NHS Brent CCG	1	132	-	-	97	35
NHS Newham CCG	1	109	-	-	96	12
<£101,000	1	1,126	23	13	965	124
NHS Debtors		**3,017**	**23**	**13**	**2,705**	**276**
Non-NHS Debtors						
Heathrow Airport Ltd	2	99	99	-	-	-
Kings College London	3	48	-	-	25	23
Dragonfly Film & TV Productions Ltd	4	27	-	-	-	27
University Of West London	5	21	-	-	21	-
Twickenham RFU	6	16	-	-	-	16
<£16,000	7	237	0	2	4	231
Total Non NHS Debtors		**448**	**99**	**2**	**50**	**297**
TOTAL DEBTORS 30th June 2020		**3,465**	**122**	**16**	**2,755**	**573**

Debtors Analysis (bar chart, Jul-19 to Jun-20, NON-NHS / NHS)

Debtors Position: 30th June 2020

Total outstanding NHS and Non-NHS debtors as at 30th June 2020 amounted to £3.47m, a reduction of £355k since 31st May 2020. Of this, £2.5m relates to the Flowers Legal Case contribution fees.

The total NHS debtors balance has decreased from £3.36m to £3.02m during June 2020. The NHS over 60 day's debt currently stands at £2.98m.

1. NHS Debtors over 60 days.
   - 32 x Flowers Legal Case CCG invoices (£2.5m). All invoices are all approved for credit in July.
   - 6 x CCG Invoices (£187k). 1 invoice for £148k relating to CTT K466 19/20, 1 invoice for £35k relating to Cohorting and 4 invoices for £4k, were all paid 1st July 2020.
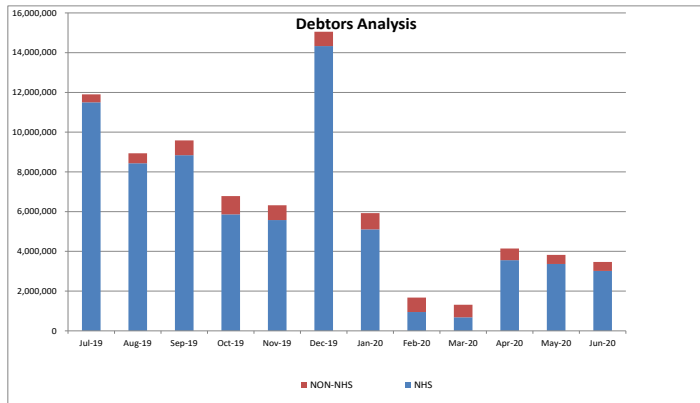   - 158 x CCG Invoices (£170k). 1 Cohorting invoice for £13k, 1 part paid CQUIN invoice for £4k and 156 small balance Extra Contractual Journey (ECJ) fees, all of which the Trust is actively pursuing.
   - 2 x West Midlands Ambulance Service Univ. NHS FT Invoices (£41k). Rachael Henderson of WMAS advised on 30th June 2020 that she will ensure the invoice are processed for payment in the in July 2020.
   - The remaining other smaller value invoices relate to salary recharges and ECJ / NCA fees which the Trust is actively pursuing.

2. Heathrow Airport Ltd - £99k (1 invoice) – The invoice does not fall due for payment until 18th July 2020. Full payment is expected during July 2020.
3. Kings College London - £48k (2 invoices) - 1 invoice for £23k was queried by Neil Adcock at KCL as further backing information was required. A breakdown was provided and the invoice is now agreed. The other invoice has not been queried and we expect full payment in July 2020.
4. Dragonfly Film & TV Productions Ltd - £27k (2 invoices) – The Trust have received confirmation that both of these invoices will be on the next payment run on 17th July 2020.
5. University Of West London - £21k (1 invoice) – The Trust have been actively pursuing but have not able to obtain a response from the payables team and are now in the process of seeking the budget holder contact information for resolution.
6. Twickenham RFU - £16k (2 invoices) - Both of these invoices were paid on 14th July 2020.
7. Non-NHS Debtors <£16k - £237k consists of; £175k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £23k of stadia events, the stadiums are being chased for payment on a regular basis. The remaining £39k is due from local Government bodies and other miscellaneous organisations.

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

London Ambulance Service
NHS Trust

Assurance report:	**Audit Committee**	**Date:**	**18/06/2020**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/07/2020**
Presented by:	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**	**Prepared by:**	**Rommel Pereira, Non-Executive Director, Chair of Audit Committee**

Matters for escalation:	**111/IUC** Following receipt of a long-awaited internal audit advisory report and findings on the 111/IUC service, members acknowledged management responses noting the evolution of learning across implementation and mobilisation. Given the significance of this to our future strategy, AC requested that QAC and FIC consider particular areas in more detail followed by a discussion at the Board. **SFI breaches** AC noted SFI breaches and hiring managers not always following legacy processes for non-permanent staff (unrelated to the new Covid rapid on-boarding procedures). AC asked that "No Purchase Order, No Pay" be mandated and that other supporting controls be put into place.
Other matters considered:	**Statutory & Mandatory Training** Internal Audit's assessment is a Partial Assurance with improvement required. Recommendations will be followed up by PCC and QAC.
Key decisions made / actions identified:	**Internal audit opinion for 19/20** The Head of Internal Audit opinion for 19/20 was confirmed as "Significant assurance with some improvement required", but noting the high priority recommendations on cyber security and that subsequent follow up had concluded they were satisfied with the actions being taken. AC approved the opinion for inclusion in the Annual Report & Accounts. **Going concern** AC considered various going concern scenarios, building upon the original Board approved financial plan and concluded that LAS remains a going concern even under the worst-case scenario, with mitigations in place. FIC would go on to consider the scenario modelling further.

Annual Report & Accounts

Following receipt of the external auditor's unqualified audit opinion (and an unqualified value for money conclusion), AC approved the Annual Report & Accounts for submission, subject to further minor amendments. The Committee thanked the Finance team for their hard work in challenging and unique circumstances.

NHS Provider Licence

AC approved the self-certification of the NHS Provider Licence, following confirmation of the Head of Internal Audit opinion and Going Concern statement.

Committee effectiveness

The Committee commended the pre-meeting summary document, which enabled good quality discussion albeit in a condensed format and would like to retain some of these apparent efficiencies. However, it was noted that these do not form part of our governance records unless the Corporate Governance function is privy to and undertakes to record this information exchange. On balance, members agreed that substantive discussion take place in Committee, with minutes providing an important corporate record of our governance, so that external audit and others may reference these for their work.

Risks:

Covid expenditure
Noting the scope of the NHSE/I Deloitte Covid expenditure review and work undertaken by Ernst and Young through their external audit, AC agreed that Grant Thornton Counter Fraud continue with planned work on Procurement and that an internal audit from Grant Thornton may also be required in the autumn.

Assurance:

Patient & Public Engagement

The audit next year could be pointed towards assessing how effectively the Public & Patients Council as an advisory body to the Board is working.

Equality & Diversity

The scope and timing of an audit this year would be dependent on the Board development session on culture, racism and inclusivity.

London Ambulance Service NHS — NHS Trust

Assurance report:	Logistics and Infrastructure Committee	Date:	14/07/2020
Summary report to:	Trust Board	Date of meeting:	28/07/2020
Presented by:	Sheila Doyle, Logistics and Infrastructure Committee Chair	Prepared by:	Sheila Doyle, Logistics and Infrastructure Committee Chair

Matters for escalation:

Members expressed concern regarding the level of foundational work that is required in order to bring the IM&T technology estate in line with other Ambulance Trusts. The committee considered the factors contributing to what now appears to be under investment in IM&T and recommended that the CIO is invited to present the Technology Improvement Plan at the next board meeting.

The CIO provided an update on the cyber remediation program. Similar to the Technology estate, cyber remediation is not in line with expectations. A series of remediation activity is underway, which will improve the Trusts cyber position.

Other matters considered:

The committee welcomed the report on the new project and programs (P&P) function. The directorate is creating a set of project roadmaps for board review. The roadmaps will outline how the projects align with the FY21 plan and the strategic priorities of the Trust. The directorate will ensure that project costs are managed appropriately and that benefits realisation plans are in place and owned by the sponsor of the project. It will provide oversight and governance of all projects that are delivered by the Trust.

More work is required to finalise the list of projects and to ensure that business cases are presented in a timely manner. The COO and CFO will provide a timeline and key milestones for business case sign off. This will follow the July board meeting where sign off of the capital plan is expected.

The committee received a report from the CIO. The report highlighted a number of issues relating to the age of the Trusts technology estate. A roadmap of improvement projects was presented. Some of these projects have already started (such as CAD technical upgrade, telephony remediation), others require further scoping. The CIO has established a project oversight group to provide assurance on delivery of the improvement program.

The committee was made aware of challenges in delivering the level of compliance across Estates. The availability of suppliers and access to

| | buildings has been challenging due to COVID 19. The COO confirmed that he expects substantial progress to be made before the Sept LIC.

Members asked for clarity on the overarching fleet strategy so that they have visibility of optimum fleet requirements including make and model, compliance with low emissions strategy for London and compliance with the Carter recommendations. Members would welcome a clearer outline of the linkage to project Zerro. Members agreed that the DCA refit business case needs to align with the overarching Fleet strategy. |
|---|---|
| **Key decisions made / actions identified:** | The committee requested additional financial and procurement information to support the DCA refit business case. The case will be reviewed by the Finance & Investment committee on July 21st.

The committee requested that the board receives regular updates on the cyber remediation program.

Recommendation that the Board receives a monthly report on the status of all material projects including risks and mitigations.

The committee requested a summary report on how outstanding Estates issues, including any requests and complaints received from staff are being addressed and resolved.

The revised terms of reference for LIC is recommended for board approval. |
| **Risks:** | The committee approved the rewording of BAF risk 58. Members asked that the risk score is revisited to reflect the risk issues highlighted by the CI)). |
| **Assurance:** | Members would like further assurance on how the new Project & Program structure will be embedded within the Trust. This may involve culture changes, adjustments to ways of working, investment in skills development and new roles. Members recommended closer alignment between the P&P and procurement functions so as to ensure that the use of single tender waivers is avoided and sufficient lead time is available for competitive tendering. Additional assurance will enable the committee to assess the effectiveness of embedding this change into the DNA of the Trust.

The committee received an update on the UPS work taking place at Bow and Waterloo. The project reported that it is tracking to Green status and expects to complete the work by March 2021. |

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Terms of Reference
Agenda item:	8.4
Report Author(s):	Syma Dawson, Director of Corporate Governance
Presented by:	Sheila Doyle, Chair of Logistics and Infrastructure Committee
History:	These are presented to the Trust Board when proposed changes required ratification. Logistics and Infrastructure Committee 14 July 2020

Purpose:	☐	Assurance	☒	Approval
	☐	Discussion	☐	Noting

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

Following discussion with the Chair of the Quality Assurance Committee, Logistics and Infrastructure Committee and Audit Committee, it was proposed that the reporting of data quality to Board Assurance Committees is amended.

It has been collectively agreed by the Chairs that data quality should be reported to the Quality Assurance Committee as it has direct impact on the quality of care and monitoring.

The Committee terms of reference have been updated accordingly and proposed changes marked in red. These changes were presented 14 July Logistics and Infrastructure who endorsed the recommendation.

Recommendation(s) / Decisions for the Board / Committee:

The Trust Board is asked to review and approve the proposed changes.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed			Relevant reviewer [name]
Quality	Yes	x	No		Chair of the Quality Assurance Committee
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		

Medical	Yes		No	
Communications & Engagement	Yes		No	
Strategy	Yes	x	No	Chair of the Logistics and Infrastructure Committee
People & Culture	Yes		No	
Corporate Governance	Yes	x	No	Chair of the Audit Committee Director of Corporate Governance

Logistics and Infrastructure Committee
Terms of Reference (effective April 2020-March 2021)

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 and the Chief Operating Officer) 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 should normally attend all Logistics and Infrastructure Committee meetings.

7.2   Other Executive 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, with Non-Executive Directors being in the majority;

   8.1.1 The Chair or nominated Chair of the Committee; and
   8.1.2 At least one of the two Executive Committee members, one of whom must be the ~~Director of Finance~~Chief Finance Officer ~~and Performance~~ or the Chief Operating Officer.

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 seek assurance (through the receipt of key performance indicators and other appropriate performance information) on the executive oversight of the following of the Trust's functions, in support of its operational delivery:

12.1.1 Fleet and Logistics;
12.1.2 Estates;
12.1.3 IM&T; and
12.1.4 Cyber Security.

12.2   To seek assurance with regard to the Trust's Data Quality and information management/governance activities.

12.312.2   To seek assurance that effective supporting strategies relating to the above functions are in place that enable the achievement of the overall Trust strategy.

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

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

12.612.5   To consider the capital and investment plans for each of the above functions, within the overall Trust financial plan and to inform/advise the Trust Board as appropriate.

12.712.6   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.

12.812.7   To receive assurance that all policies relating to each of the above functions are up to date and remain relevant and complied with.

12.912.8   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.

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Digital 999 Programme Assurance Committee ED Report
Agenda item:	8.4.
Report Author(s):	Giles Clayden, D999 Programme Director
Presented by:	Khadir Meer, Chief Operating Officer
History:	Content and recommendations consistent with D999 Programme Board on 29th June, and D999 Programme Assurance Committee on 10th July.
Purpose:	☒ Assurance ☐ Approval ☐ Discussion ☐ Noting

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

The document is intended to provide assurance on LAS Trust Board on progress across the D999 Programme, including recent developments and status of ePCR and CAD projects.

D999 status update

- The D999 Programme covers electronic Patient Care Records (ePCR) and the new Computer Aided Dispatch (CAD) systems.
- The status for both projects is green, and they are on track for their respective go-live dates (ePCR to launch in September 2020 and new CAD in May 2021).

Scope and benefits

- The document recaps the scope and proposed benefits of both projects which are broadly:
  - o Improved patient experience through new models of care to deliver greater coordination of patient pathways.
  - o Spine integration (within both ePCR and CAD) to improve data collection, accuracy, and structured data at the point of care.
  - o Improving the quality and timeliness of information derived from system to support business and clinical decision making and population health management.
  - o Improving efficiency and productivity of the workforce through more efficient processes, technology and systems.

Programme finance update

- There is a recap of the budget envelopes which were approved at the FBC stage by the Trust Board (28th Jan for ePCR and 31st March for CAD).

- Since budgets were approved, there have been further refinements to the delivery approach and underlying assumptions which have had a positive impact on budget forecasts.

- Figures are shown for Programme spend in May and June. Both projects are tracking well within the FBC Capital envelopes and associated budgets.

- The revenue budget for CAD needs to be agreed in line with the FBC as part of the current planning round in July post COVID-19.

ePCR Project Status

- ePCR development is nearing completion, having incurred a 4-6 week delay due to disruption caused by Covid-19 and the escalation to REAP Level 4 which limited the availability of frontline staff to support design workshops.

- It is confirmed that staff training will be delivered through the CSR Programme, to run for 9 weeks from 21st September. This will leave a small number of users to be trained in Q4 (<20% user group). The decision to train through CSR, has meant that the overall and project completion date has completely mitigated the impact of the COVID delay.

- The project is currently entering the technical testing phases, prior to pre-live testing starting in mid-Aug when the first live data in a real patient setting will be entered on the system.

- Engagement is ongoing with Hospital EDs to ensure the new handover arrangements are understood.

CAD Project Status

- CAD Project mobilisation is effectively complete with the contract passing through final stages of sign-off on LAS side. The CAD approach will mirror for ePCR in the early stages to foster end user buy-in by deploying a demonstration (test) system to work through the configurations needed to meet LAS needs.

- LAS have appointed an external test partner, Mason Advisory, to support CAD Testing. They will advise LAS on load and performance testing to ensure CAD resilience on the new system is sufficiently robust to handle peak demands.

Programme Governance

- Programme Governance structure has been updated and reviewed by the Programme SRO, Director of Corporate Governance and the PAC Chair.

- The new structure is intended to streamline the overall decision making-process, by bringing together Clinical, Medical Quality and Technical representation at the Programme Board.

- In a further enhancement to D999 Programme assurance, PwC have been appointed as an independent programme auditor. There are three audits planned for this FY with the first scheduled for August to review D999 Governance.

Recommendation(s) / Decisions for the Board / Committee:

The LAS Trust Board are asked to:

- Acknowledge the progress made across the D999 programme in anticipation of ePCR pre-live testing starting in mid-Aug, followed by full ePCR rollout across LAS from late Sept.

- Recognise COVID-19 second wave presents a key risk to the D999 programme timescales, noting a key Gateway Review scheduled for November D999 to review the robustness of the May 21 target Go-Live for the new CAD system.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed				Relevant reviewer [name]
D999 Programme Board (PB)	Yes	X	No		Content as per 29 June 20 PB
D999 Programme Assurance Board (PAC)	Yes	X	No		Content as per 10 July 20 PAC
Quality	Yes	X	No		Stuart Crichton, CCIO *
Finance	Yes	X	No		Lorraine Bowes, CFO ** James Corrigan, Finance Controller *
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer, COO *
Medical	Yes	X	No		Stuart Crichton, CCIO *
Communications & Engagement	Yes		No	X	
Strategy	Yes	X	No		Ross Fullerton, Director of Strategy & Transformation *
People & Culture	Yes		No	X	
Corporate Governance	Yes	X	No		Syma Dawson, Director of Corporate Governance (Governance Content Only)

* Attendance at Programme Board and Programme Assurance Committee
** Attendance at Programme Assurance Committee

DIGITAL 999 PROGRAMME

PROGRAMME STATUS UPDATE TO LAS TRUST BOARD

28 JULY 20

Current Status (RAG)	
Programme	Digital 999
Sponsor	Khadir Meer
Programme Director	Giles Clayden
Project Manager(s)	Phil Smith (CAD) / Carl Schiess (ePCR)

Author: Giles Clayden
Reviewed By: Khadir Meer
Version: 1.0
Date: 14 July 2020

D999 PROGRAMME STATUS UPDATE – 20 JULY 20

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1. PROGRAMME SCOPE

1.1. The D999 programme comprises of two projects:

- **Electronic Patient Care Records (ePCR).** This project will replace the current paper record with an electronic care record. The project will deliver a standalone ePCR system initially before subsequent integration with key systems such as CAD and OneLondon.

- **Computer Aided Dispatch (CAD).** This project will replace the current existing CAD system provided by Northrup Grumman which is nearing end of life. The new system provided by Cleric Software Solutions is a proven system in a number of other Trusts, and will enable integration with ePCR and support a move to alternative triage processes.

2. EPCR BENEFITS

2.1. The main benefits of the ePCR are:

- Improving patient experience through new models of care to deliver greater coordination of patient pathways.
- Enabling improved data collection, accuracy, and structured data at the point of care.
- Improving the quality and timeliness of information derived from system to support business and clinical decision making and population health management.
- Improving connectivity to enable sharing of information across all stakeholders.
- Improving efficiency and productivity of the workforce through more efficient processes, technology and systems.

3. CAD BENEFITS

3.1. The new CAD system builds on the benefits of ePCR and provides additional functionality enabling the following:

- Improved patient prioritisation functionality within the CAD as opposed to a 'bolt-on'.
- Spine integration with easier information sharing means frequent callers are identified more quickly saving time and effort.
- A foundation to Pathways, potentially allowing 111 to move to the same platform, creating a single unified point of access for all 999 and 111 patients and further opportunities around "hear and treat", video conferencing, telemetry etc.
- Access to better real-time information, increasing the understanding of hospital delays and enabling better utilisation of vehicles and modelling of the peak vehicle requirement (PVR).
- Better traffic information, including road closures and diversion routes, making for more effective dispatch algorithms helping improve patient care further.
- Improved identification of patient needs and access to care plans, mitigating unnecessary conveyance to hospital and acting as an enabler for "Hear and Treat" through the Clinical Hub.

4. PROGRAMME FINANCES & BUDGET

4.1. The ePCR FBC was approved by the Trust Board on 28th January and the CAD FBC on 31st March 2020. The approved envelopes for both projects are outlined in Table 1 below:

		Year 1 (FY20/21)	Year 2 (FY 21/22)
ePCR	Capital Expenditure	£1,669,355	£66,298
	Revenue Expenditure	£1,037,492	£194,332
	Total	**£2,706,847**	**£260,630**
CAD	Capital Expenditure	£5,429,976	£857,846
	Revenue Expenditure	£1,237,082	£560,998
	Total	**£6,667,057**	**£1,418,844**

Table 1: D999 annual budget envelopes approved in FBCs

4.2. Since the FBC approvals, there have been further refinements to the delivery approach and underlying assumptions which have had a positive impact on budget forecasts. Both projects are tracking well within the FBC Capital envelopes and associated budgets. Figure 1 shows the recent financial update to the Programme Board (29 June) and Programme Assurance Committee (PAC) (10 July).

ePCR	April				May			
	Capital		Revenue	-	Capital		Revenue	
Forecast	£	104,269.17	£	-	£	109,118.83	£	4,041.50
Actuals	£	63,934.33	£	5,959.50	£	69,443.16	£	5,959.50
Variance	£	40,334.84	-£	5,959.50	£	39,675.67	-£	1,918.00

CAD	April				May			
	Capital		Revenue		Capital		Revenue	
Forecast	£	72,799.58	£	-	£	137,599.58	£	-
Actuals	£	62,141.49	£	-	£	115,616.14	£	916.00
Variance	£	10,658.09	£	-	£	21,983.44	-£	916.00
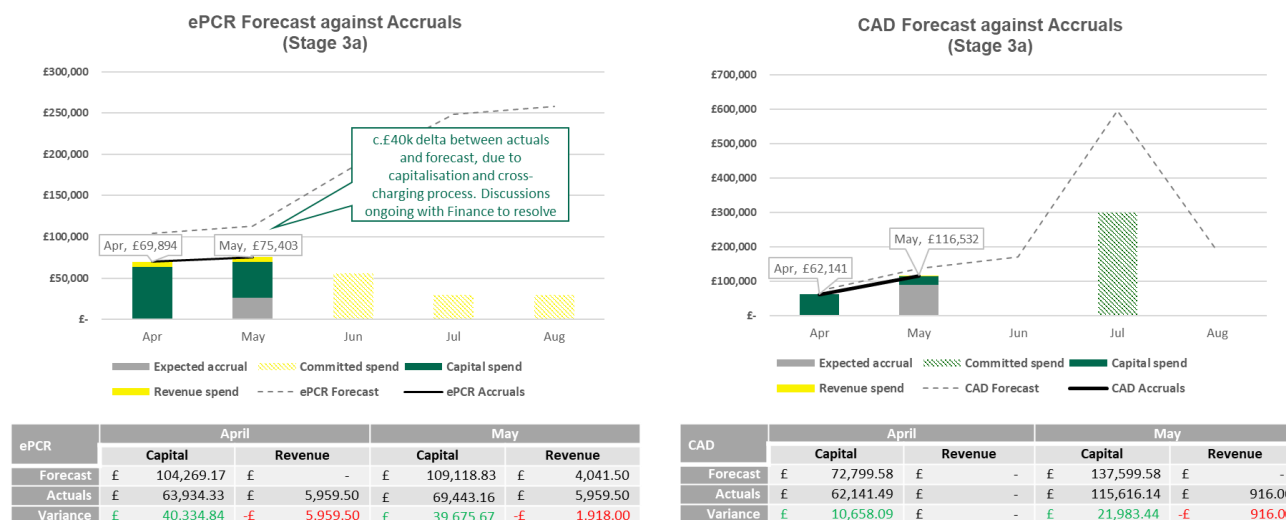
Figure 1: D999 Actuals versus Forecast for Apr & May to Stage Gate 3a

4.3. Further work is needed across the Trust to refine the capital apportionment of substantive staff to the programme. These anomalies count for the minor revenue variances shown in Fig 1 against revenue forecasts for both project.

4.4. Delivery of ePCR training through CSR will present a significant revenue saving. This will avoid c. £300k backfill costs into D999, as ePCR training through CSR will be drawn from the annual Individual Learning Allocation (ILA) for frontline staff.

4.5. The CAD revenue budget is currently being finalised as part of a Trust-wide review of revenue budgets. The FBC was approved close to transition to the new FY, and therefore CAD revenue was not factored in. To date, CAD revenue expenditure has been handled as *service development costs*, pending formal budget allocation which is expected this month.

4.6. LAS have commercial flexibility to procure £2.78m of Cleric CAD software licences across either FY20/21 or FY 21/22. The current budget assumption is that the Trust will defer the timing of this payment to next FY, concurrent with CAD Go-Live. However a further review of this is suggested later on in the FY as the Trust may wish to bring procurement of licences forward as per ePCR licences were in FY 20/21.

4.7. Strict financial control is being applied across the D999 programme, with funds being cascaded by stage gate in accordance with the LAS Project Management Lifecycle. Both projects are working towards Stage Gate 3a at the end of August in line with the forecasts shown in figure 1 above. In addition, following the PAC on 10 July, the CFO has directed that the finance team will own and sign-off on all financial reports going forwards.

5. EPCR PROJECT STATUS – GREEN

5.1. The RAG status of ePCR is currently GREEN. Confirmation that CAD will be delivered in mid-2021[1], means the programme can focus on rollout of ePCR across the majority of the Trust prior to the seasonal peak, leaving a clear path during the first half of 2021 to focus on CAD roll-out.[2]

5.2. ePCR development was impacted during April by the escalation to REAP level 4 during the COVID-19 crisis. This limited the availability of front-line staff to support a series of configuration workshops and requirements sign-off, resulting in the plan slipping by 4-6 weeks. During this period the focus turned to the implementation of technical infrastructure to flush out technical issues early and therefore minimise delivery risk later in the cycle.

5.3. The decision to deliver ePCR training through CSR not only provides savings in backfill costs, it reduces challenges around training logistics and means the majority of the paramedic staff can be trained on ePCR before December. This will leave a small number of users to be trained in Q4 (< 20% user group). Delivering training through CSR means that the overall plan has been fully received against FBC timelines with project close being marginally accelerated from 31 June (as per FBC) to 30 April.

5.4. The project is currently entering the technical testing phases, prior to pre-live testing starting in mid-Aug. Pre-live testing, which is essentially a 'field trial', will be the first time real patient data in a live setting is entered into the system.

5.5. Hospital Emergency Department engagement started on 14 July 2020 to ensuring the new handover arrangements are understood. Early feedback around ED engagement suggest this is being very well received within EDs.   Formal comms have been issued to Hospital Trust COO

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[1] The mid-2021 position was endorsed by the PAC on 8 May 2020 and further underpinned by the detailed delivery plan from Cleric, post contract award.

[2] An update to the CAD Gateway Review Decision originally expected in July was presented to PAC on 10 July and LIC on 14 July. This paper explained how CAD resilience will be enhanced by the rollout of hardware only in order to address some of the immediate hardware issues impacting the current system resilience.

5.6.   The current ePCR milestones are set out in Table 2 below:

Table 2: ePCR Current Milestone status

Milestone	Target Date	Status
Mobilisation Complete	1 March 2020	Complete
Hardware and software built	15 January 2020	Complete
Product configuration (system readiness)	22 June 2020	Complete
SAT, SIT, UAT Testing Complete	10 August 2020	On-going
ED Hospital Engagement Completes	7 August 2020	On-going
Training material dev (inc. eLearning) Complete	31 August 2020	On-going
Pre-Live Testing Go/No-Go	10 August 2020	Programme Board Checkpoint
Roll-Out Go/No Go (End of Pre-Live Testing)	25 September 2020	Programme Board Checkpoint
CSR Training Starts	21 September 2020	Planned
CSR Training Ends	27 November 2020	Planned
Transition to BAU starts	2 January 2021	Planned
ePCR Training Complete	31 March 2021	Planned
Project Close	31 April 2021	Planned

6.   CAD STATUS & TIMELINE – GREEN

6.1.   The RAG status of CAD is currently GREEN. CAD project mobilisation is now effectively complete. The contract has been signed by Cleric and is pending signature from the Trust.

6.2.   The initial phases of the CAD project will mirror the ePCR approach. A test system has been successfully installed at LAS datacentres and this will form a demonstration platform to support the configuration workshops with end users. This approach has proved highly successful in building buy-in amongst ePCR end users and staff.

6.3.   Immersion visits to SECAMB are planned in late July for EoC staff to witness first-hand the new ways of working underpinning the Cleric product, albeit in another Trust. The learnings from this stage will be key in shaping the Cleric system to LAS needs and inform new processes and procedures.

6.4.   Mason Advisory have recently been appointed as test partner, bringing extensive experience working across all forms of emergency service organisations and will manage the CAD testing. They will also advise on the optimum approach towards load and performance testing which is a key knowledge gap internally for LAS, as flagged by the PAC. An important aspect of load and performance testing will be proving the new system is sufficiently resilient for seasonal peak demand which has been an area of focus by the PAC.

6.5.   The CAD training strategy is currently being developed. The training will be scheduled as near to Go-live as possible to minimise refresher training needs. The aim is to contain this to a 9 week window without exposing LAS to any significant service degradation or drop in performance. A blended approach based on acceptable EoC abstraction rates, timing of recruitment and use of overtime are all being considered to ensure training can be contained to this window.

6.6. A second COVID-19 wave is a key risk to the programme (see section 8), particularly those activities reliant on EoC staff input e.g. configuration workshops, show & tells and training. The current CAD target Go-Live is May 21 which is entirely consistent with the FBC (timed midway between optimistic and most likely Go-Live FBC scenarios). The current milestones are as per table 3 below:

Table 3: CAD Current Milestone status

Milestone	Target Date	Status
Project initiation & planning complete	28 June 2020	Complete
Test Platform ready	4 August 2020	On-going
Server Builds complete	25 August 2020	On-going
CAD Configuration req'ts shared with Cleric	15 September 2020	Planned
SAT Testing complete	1 October 2020	Planned
SIT Testing 1&2 complete	14 December 2020	Planned
CAD System Ready for UAT	31 December 2020	Planned
SIT Testing Cycle 3 complete	31 January 2021	Planned
BI Reporting ready	1 March 2021	Planned
Trust-wide technical roll-out/system ready	26 March 2020	Planned
Staff training complete [1]	21 April 2021	Planned
Go-Live	1 May 2021	Planned
Project Close	30 June 2021	Planned (aligned to FBC)

7. PROGRAMME GOVERNANCE

7.1. At the start of July the SRO, Director of Corporate Governance, and PAC Chair reviewed the current programme governance structure to streamline the overall decision-making. The latest governance is shown in Figure 2 below, highlighting the different areas of representation:

Figure 2: Clinical, Medical, Quality and Paramedic D999 representation

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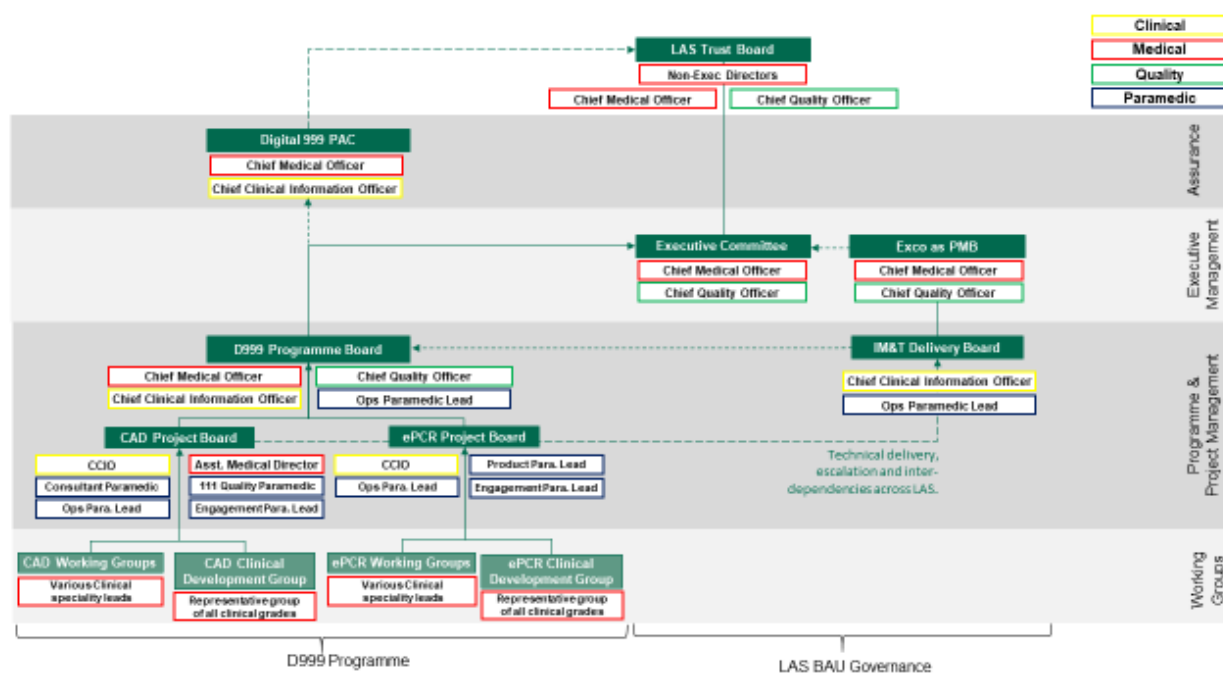
[1] 26 March 2021 – 1 May 2021 represents technical delivery contingency. Training will be occurring in April with CAD training starting on 17 Feb 2020

7.2. The new structure brings together clinical, medical, quality and technical representation at the Programme Board. This means all key decisions, approvals and items requiring escalation can pass through one board only, allowing the programme to proceed at pace without being held back by multiple reporting cycles.

7.3. The following changes have been made by comparison to the original D999 structure:

- **Chief Medical and Chief Quality Officers** will attend the programme board, providing executive management for decisions that would otherwise have been passed through the QOG, HIOG and patient safety groups as separate boards.

- The **Architecture Review Board** has been subsumed into the IM&T delivery board chaired by the CIO who attends the D999 programme board.

- The **Chair of the Quality Assurance Committee** represents the assurance interests that would previously have been addressed at the QAC through the Programme Assurance Committee.

7.4. In a further enhancement to D999 programme assurance, PwC has recently been appointed as an independent programme auditor for D999. In the first of three audits planned for this FY, PwC will be reviewing the D999 governance during early August. Subsequent audits are planned to align with core delivery milestones.

8. PROGRAMME ISSUES AND RISKS

8.1. The following key risks and issues have been identified:

Risk / Issue	Description	Mitigation / Resolution
Risk	**Covid-19 Second Wave.** There is a risk of a second wave of COVID which may impacts the availability of EOC and front-line staff to support various activities including training on both ePCR and CAD projects.	• Both ePCR and CAD project have proceeded with stable plans since mid-May once the COVID crisis started to ease. The D999 team have adapted well to working remotely. • The CSR class sizes have been reduced to no more than 25 attendees to mitigate the risk of cross infection. • Contingency has been factored into CAD technical delivery plan although the actual Go-Live will be principally dependent on training rollout if testing proceeds to plan. • The situation will be monitored closely during the autumn against current planning assumptions. A Gateway Review is planned for Nov (with PAC oversight) to assess the CAD plans and on-going feasibility of May 21 Go-Live.

Risk / Issue	Description	Mitigation / Resolution
Risk	**Change Fatigue.** There is a risk that organisational change fatigue will set in due to changes to ePCR in 2020, followed by 999/111 integration, EOC Control Room solutions and NHS Pathways, Telephony upgrades in 2021.	• The timing of ePCR roll-out prior to the seasonal peak is a deliberate programme strategy to maintain focus on ePCR first before this shifts to CAD in 2021. • The volume of change is being carefully monitored going forwards via P&P and through the IM&T delivery boards. This will provide greater management visibility and early identification of any potential risk areas.
Issue	**CAD Revenue Budget.** There is currently no CAD revenue budget apportioned to D999 due to the timing of FBC approval at the end of last FY.	• This is being reviewed during the current round of revenue budget setting over July, given COVID-19 is easing. • ePCR project has 'subsidised' revenue expenditure for shared items e.g. CAD Quicksilva licences to access NHS Spine. Although the CAD revenue budget should be resolved in July, the lack of CAD funding cannot continue indefinitely without potentially impacting one or both projects.

London Ambulance Service NHS Trust

Assurance report:	**Digital 999 Programme Assurance Board**	**Date:**	**10/07/2020**

Summary report to:	**Trust Board**	**Date of meeting:**	**28/07/2020**
Presented by:	**Sheila Doyle, Non-Executive Director, Chair of Digital 999 Programme Assurance Board**	**Prepared by:**	**Sheila Doyle**

| **Matters for escalation:** | Project finance remain within budget however the project needs additional support from the Finance team to ensure that financial controls are in place as the project ramps up.

The Trust has appointed PWC to provide a series of independent audits of project governance, quality of change, testing management and operational readiness. PWC provide a similar service for Royal Marsden (RM) Digital Transformation program. |
|---|---|
| **Other matters considered:** | The CAD replacement summary plan was presented. Members discussed the proposed approach of 3 different code drops, followed by full integration testing and user acceptance testing. Members requested a paper outlining the key milestones to CAD go live and a more detailed outline of the interplay between the code drops and end to end testing of the solution.

Members were informed that the key decision point regarding CAD go-live as set out in the CAD FBC is no longer necessary as it had been overtaken by the decision to re-platform the existing CAD on 15 September. D999 SRO and programme board recommendation are that the CAD expected Go-Live date is scheduled for May 2021.

The Chief Clinical Information Officer presented the revised ePCR governance model and an outline of the approach for delivering new features and functions post go live. Initial go-live will represent the 'minimum viable product'. A series of additional releases are planned and will include CARU, Safeguarding ROLE, GP notifications and London Air Ambulance scope. This approach is in line with experience at Secam and other Ambulance Trusts.

The ePCR roll out approach was presented; this detailed the three phases of deployment and the high level roll out and communications plan. Members considered the plan and whether there was staff side support. It was confirmed that staff side were engaged and supportive of the approach and that plans had been socialised early to enable this.

The ePCR Education strategy has been developed on the assumption that education and training for clinical staff will be delivered through the |

	Core Skills Refresher programme, which would be led by the Clinical Education & Standards team.
	Members discussed integration with hospitals and what work had been done to ensure that this is this is successful. It was stated that ePCR does not replace handovers it changes the way hospitals access the information, via a portal. Hospitals are being physically engaged and communicated with early and nominated points of contact are being sought.
Key decisions made / actions identified:	A named individual from the Finance team will provide a report on project finances at every PAC. A further update on ePCR release 2 will be provided at the next PAC. 2-3 front line staff to be invited to September PAC to provide feedback on their experience of the ePCR solution.
Risks:	There is a risk that organisation change fatigue will set in due to the magnitude of change impacting staff over the next 12 months. For example, ePCR in 2020 followed by 999/111 integration, EOC control, room solutions, NHS pathways. Members queried if the risk should be expanded to reflect other non-technical related changes that are planned or underway. An holistic view of all change programs and potential impact on staff will help the team to identify mitigations and controls.
Assurance:	The programme RAG status remains green with ePCR functional sign-off achieved on 26th June, CAD mobilisation almost complete with draft Cleric contract finalised for signature, and Mason Advisory engaged to progress testing. Members welcomed the addition of the CMO and CQO at the project board governance level. The terms of reference for PAC is being reviewed to ensure it aligns with the Trust's governance model and best practice for Digital Programs. The PWC audit will provide further assurance.

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Financial Plan update 2020/21
Agenda item:	9
Report Author(s):	James Corrigan, Financial Controller
Presented by:	Lorraine Bewes, Chief Finance Officer
History:	N/A
Purpose:	☒ Assurance	☒ Approval
	☒ Discussion	☐ Noting

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

The Trust is operating under a financial framework that reimburses COVID-related expenditure and ensures a breakeven which has recently been continued into August and is likely to last until the end of September.

In March, the Board approved a budget to the end of July, based on a business plan that assumed the year's income would be £452m.

The purpose of this paper is to set out the Financial Plan to the end of September and to seek Board approval for the issuing of revenue budgets to the end of September and the Capital plan for 20/21.

The Finance and Investment Committee has considered and recommends adoption by the Board of this proposal to extend approval to the end of September. Arrangements for the full year have yet to be finalised and it is expected that final budget proposals will be discussed in September.

Recommendation(s) / Decisions for the Board / Committee:

The Board is asked to:
- Approve the issuing of budgets to budget holders for the two months to the end of September
- Approve the capital plan of £44.2m subject to confirmation of the COVID 19 public dividend capital from the national team
- Note the Forecast Outturn as at month 3

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes		No		
Finance	Yes	X	No		Lorraine Bewes
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

1. Background and update on the national arrangements

The Trust Board received an update on the interim financial arrangements during COVID 19 on 31 March 2020. In summary, existing contracts were suspended across the NHS and a central financing arrangement was established. The current financial arrangements comprise:

- Nationally set block contracts between NHS Trusts and Commissioners

- Prospective and retrospective top up funding issued by NHS England to NHS organisations to support delivery of breakeven positions against reasonable expenditure

This framework was initially put in place for the period from 1 April 2020 until 31 July 2020, however recent guidance from NHS England has now extended these arrangements to the end of August and likely to remain in place until the end of September to allow sufficient time for the national team to continue work with government to establish a framework for the remainder of the financial year.

The impact of this extension to current block allocations and retrospective top ups is that the Trust will continue to breakeven through until the end of August with a high likelihood of breakeven in September. The proposal for the remainder of the year is yet to be finalised, however current thinking shared by the national team is as follows:

- Advance funding envelopes/allocations issued calculated to maintain BAU/core capacity
- Funding will be set at a level such that systems can continue with their (Winter 2019/20 run rates and achieve breakeven (local feedback on blocks and top ups will be reflected in the revised figures)
- Envelopes/allocations will be set on basis of achieving breakeven, however organisations will be permitted to deliver surplus/deficit positions
- There will be no retrospective top ups, however COVID 19 funding will be allocated to organisations in advance.
- Block contract arrangements may have a 'cap and collar' type element to incentivise recovery
- There will be a break glass mechanism activated by the National Incident Response Team, to deal with any exceptional circumstances including future waves.

Based on the above the risk to not breaking even in September is considered low, as there will be additional COVID 19 funding allocated to the Trust acknowledging that it will not offer the absolute certainty that the retrospective top up process allows.

In anticipation of the increased financial risk beyond month 6 the Trust is now reviewing all areas of forecast COVID 19 expenditure at the Daily Senior Leadership Teams including agreeing reasonable levels of frontline resourcing required to maintain performance at a C2 mean of 15 minutes. A separate paper is also included on the agenda that describes how the Trust will begin to reinstate its internal efficiency programme for the remainder of this financial year and beyond.

2. Budget Approval

The Trust Board approved the release of interim budgets to budget holders for 4 months at its meeting on 31 March 2020. These were based on the pre-COVID 19 plan that had been developed as part of business planning for 2020/21 and represented the 'business as usual' budget for the organisation. This allowed the organisation to separate expenditure on

'normal operations' from COVID 19 expenditure and has enabled the organisation to track the underlying run rate of the organisation.

It is proposed that release of interim budgets to budget holders is extended for a further two months to align with the extended national financial arrangements and to allow the Trust to fully understand the operational and financial impact of COVID 19 for the remainder of 2020/21 and beyond.

The table below sets out the budgets in issue for each of the first six months of the financial year and the balance to the pre-COVID 19 annual financial plan (£451.7m).

Table 1 – Statement of Comprehensive Income

	Apr	May	Jun	Jul	Aug	Sep	Annual Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Patient Care Income	37,156	37,129	36,863	37,188	36,860	36,909	445,785
Other Operating Income	239	261	1,133	172	157	1,127	5,933
Total Income	**37,395**	**37,390**	**37,996**	**37,360**	**37,017**	**38,035**	**451,717**
Employee Expenses	(26,843)	(26,618)	(26,637)	(26,809)	(27,681)	(26,778)	(320,747)
Other Operating Expenses	(9,285)	(9,391)	(9,215)	(9,159)	(9,105)	(9,177)	(109,546)
Total Operating Expenses	**(36,128)**	**(36,008)**	**(35,852)**	**(35,968)**	**(36,787)**	**(35,954)**	**(430,293)**
Total Non-Operating Expenses	**(1,706)**	**(1,706)**	**(1,705)**	**(1,683)**	**(1,685)**	**(1,685)**	**(21,095)**
Total Expenses	**(37,834)**	**(37,715)**	**(37,557)**	**(37,651)**	**(38,471)**	**(37,640)**	**(451,388)**
(Surplus)/Deficit	**(439)**	**(325)**	**440**	**(291)**	**(1,454)**	**395**	**329**

Table 2 – Divisional Analysis

Division (£'000)	Apr	May	Jun	Jul	Aug	Sep	Total Budget
Central Corporate	(3,206)	(3,269)	(2,759)	(2,882)	(2,879)	(2,913)	(34,088)
Central Income	34,273	34,265	35,007	34,341	34,108	35,112	415,459
Chairman & Non-Executives	(13)	(13)	(13)	(13)	(13)	(13)	(157)
Chief Executive	(236)	(234)	(236)	(235)	(237)	(212)	(2,718)
Ambulance Services	(17,974)	(17,896)	(18,075)	(18,166)	(18,874)	(18,174)	(218,029)
COO Management	(89)	(88)	(89)	(89)	(89)	(92)	(1,118)
Integrated Patient Care	(2,859)	(2,831)	(3,000)	(2,891)	(3,038)	(2,967)	(35,124)
Performance	(135)	(134)	(138)	(136)	(137)	(131)	(1,593)
Programmes & Projects	(221)	(220)	(222)	(221)	(246)	(226)	(2,685)
Strategic Assets & Property	(4,246)	(4,272)	(4,314)	(4,242)	(4,219)	(4,283)	(50,275)
Communications	(254)	(252)	(256)	(264)	(258)	(250)	(3,175)
Corporate Governance	(71)	(71)	(71)	(72)	(73)	(72)	(860)
Finance	(375)	(353)	(363)	(363)	(363)	(363)	(4,319)
Im&T	(1,234)	(1,221)	(1,239)	(1,227)	(1,239)	(1,229)	(14,761)
Clinical Education & Standards	(1,155)	(1,141)	(1,145)	(1,155)	(1,151)	(1,144)	(13,981)
Medical	(897)	(883)	(906)	(899)	(918)	(901)	(11,005)
People & Culture	(713)	(687)	(714)	(749)	(791)	(725)	(8,937)
Quality & Assurance	(941)	(935)	(939)	(940)	(952)	(942)	(11,301)
Strategy	(92)	(90)	(90)	(91)	(84)	(82)	(1,004)
(Surplus)/Deficit	**(439)**	**(325)**	**440**	**(291)**	**(1,454)**	**395**	**329**

3. Forecast Outturn (month 3) and COVID 19 expenditure

The Trust forecast outturn to the end of 2020/21 is summarised in appendix 2. The table compares the total underlying expenditure run rate excluding COVID 19 expenditure with the plan as detailed in section 2 above. The forecast outturn suggests that excluding the COVID 19 expenditure, the underlying expenditure outturn of the Trust is £4.6m lower than the initial

plan agreed before COVID 19. This will be due to planned contingency reserves not being utilised through COVID 19.

The current forecast is that the Trust will spend £80.7m for the full year on the response to COVID 19 and improvement of performance above that assumed on the pre-COVID 19 business plan. The financial forecast assumes an additional £5.4m for a further surge in demand in October. The actual and forecast COVID 19 expenditure is also analysed in appendix 1.

Table 3 below sets out expected changes in demand, capacity and performance for 2020/21 for the first six months of the year (H1) and the second six months (H2). This includes actual data for quarter 1 2020/21. It is expected that with funding of additional capacity in IUC, EOC and frontline ops that all performance targets would be met or exceeded across the year. The numbers below assume another Covid surge during winter. These assumptions have been used to develop the expenditure forecast outturn.

Table 3 – Demand and Performance

		H1 19/20	H2 19/20	19/20	H1 20/21	H2 20/21	20/21	H1 change	H2 change	% change
Demand	EOC Calls	999,329	1,085,079	2,084,408	855,240	1,129,710	1,984,949	-14%	4%	-5%
	F2F Incidents	583,731	597,406	1,181,137	528,841	635,311	1,164,153	-9%	6%	-1%
	111 Calls	294,524	400,606	695,130	468,218	535,770	1,003,988	59%	34%	44%
Capacity (Hours)	DCA	1,077,052	1,136,029	2,213,081	1,264,064	1,302,615	2,566,679	17%	15%	16%
	Solo	336,818	332,513	669,331	236,309	236,600	472,909	-30%	-29%	-29%
	CH/Disp	310,244	319,230	629,475	335,392	367,970	703,362	8%	15%	12%
	CHUB	44,054	44,669	88,723	46,697	47,349	94,046	6%	6%	6%
	IUC CH	81,477	83,154	164,630	148,288	151,340	299,627	82%	82%	82%
	IUC CAS	51,174	49,617	100,792	100,301	97,250	197,551	96%	96%	96%
WTE Establishment	Frontline	3,380	3,380	3,380	3,583	3,583	3,583	6%	6%	6%
	CH/Disp/CHUB	548	548	548	608	608	608	11%	11%	11%
	IUC establishment	375	375	375	938	938	938	150%	150%	150%
Perfomance	C1 Mean	00:06:27	00:07:18	00:06:52	00:06:30	00:06:30	00:06:30			
	C2 Mean	00:18:59	00:27:53	00:23:26	00:14:31	00:17:12	00:15:52			
	EOC (call answering mean)	00:14:30	00:43:28	00:28:59	00:07:11	00:02:30	00:04:51			
	IUC calls abandoned in 30s	2.5%	14.0%	8.2%	1.5%	1.0%	1.3%			
	IUC calls answered in 60s	84.2%	57.4%	70.8%	96.0%	98.0%	97.0%			

4. Capital budget for approval

The Trust submitted a capital plan to NHS Improvement for £44.2m. Table 4 below sets out the source and application of capital funding for 2020/21. Nationally the COVID 19 capital allocations are still to be confirmed; however, the Trust has worked with North West London STP to identify £6.1m of capital resource limit that is available through slippage in other organisations to support the Trust, should this be required when capital allocations are confirmed. The PDC for COVID 19 was confirmed as interest free when initially announced.

Appendix 1 sets out the detailed capital plan by project.

The additional revenue costs of capital identified to date have been included in the forecast outturn detailed in appendix 2.

Table 4 – Source and Application of Capital

Source of Capital	£'000	Memo	Type
Internally Generated Capital	20,429		CRL
HSLI	1,670		PDC
Grant (Low Floor Ambulance Project)	316		Grant
LHCRE	850		PDC
2019/20 COVID 19	6,358		PDC
2020/21 COVID 19 - of which:	14,588		
NWL transfers		6,100	CRL
Balance awaiting confirmation		8,488	PDC
Total Source	**44,211**	**14,588**	
	Projects Totals		
Application of Capital by Programme	**£'000**		
Fleet	7,760		
Estates	10,365		
Spatial Development	4,738		
Digital 999	6,740		
IM&T	4,942		
Medicines Modernisation	2,510		
Other	7,156		
Total Application	**44,211**		

5. Risks

The financial risk to the end of quarter 2 is low with the extension of the interim financing arrangements ensuring that the Trust will breakeven in August and likely to breakeven in September. The Trust forecast COVID 19 expenditure in September is currently forecast to be £5.4m so this would be the unmitigated risk to the Trust; however, the current thinking nationally is that there would be a further adjustment to baseline allocations for COVID 19 so this would ameliorate the £5.4m either partially or fully.

The current baseline allocation for the Trust is £440m for the full year based on the winter run rate adjusted for inflation. The Trust has secured an additional £27.3m in quarter 1 for COVID 19 and with existing arrangements continuing to the end of quarter 2, the Trust will have secured £47.1m in addition to the £440m. The Trust will therefore have secured £487.1m of the required £527.5m forecast.

The Trust continues to ensure that all COVID 19 expenditure is agreed as reasonable and required before it is committed through its COVID 19 expenditure approval process.

The Trust is currently working to ensure resource levels are matched more closely to demand and delivery of national performance standards whilst maintaining resilience, this should reduce the current forecast level of expenditure on frontline resource.

6. Next steps

The Trust is restarting the work undertaken pre-COVID to develop and an efficiency plan (see separate paper)

Once the guidance for the reminder of the year and allocations are confirmed then the Trust can establish the business and financial plan for the second half of 2020/21 for Trust Board approval.

7. Recommendations

The Committee is asked to:

- Approve the issuing of budgets to budget holders for the two months to the end of September
- Approve the capital plan of £44.2m subject to confirmation of the COVID 19 public dividend capital from the national team
- Note the Forecast Outturn as at month 3.

Appendix 1 – Capital Plan (and revenue requirement) by Programme/Project

Programme	Project	Capital Source and Application Summary Category	Capital Plan £'000	Revenue Plan £'000
Fleet	Super Low Floor DCA including Hydrogen range extender	Fleet	316	0
	Purchase of 37 Chassis	Fleet	1,663	0
	37 DCA conversions	COVID-19 Response - Phase 2	4,500	0
	EPRR Vehicle Replacement	Fleet	388	0
	Bunkered Fuel (phase 1)	Fleet	148	54
	Bunkered Fuel (phase 2)	COVID-19 Response - Phase 2	745	30
Fleet Programme Total			**7,761**	**84**
Estates	Training Consolidation (N&S)	COVID-19 Response - Phase 2	2,550	700
	Front of house DDA	Spatial Development	300	7
	Control Room (999/111 Expansion, SEL & Bow Expansion)	COVID-19 Response - Phase 2	2,665	320
	Ambulance Consolidation	COVID-19 Response - Phase 2	3,450	0
	BAU - Estates Backlog Maintenance (outside of Estates programme)	Spatial Development	1,400	0
Estates Programme Total			**10,365**	**1,027**
Spatial	19/20 Secure Drug Rooms	Ready Set Go	1,967	83
	UPS - Generators	Spatial Development	1,500	8
	19/20 EOC Training relocation(closing)	Spatial Development	830	0
	19/20 Bow VRV (closing)	Spatial Development	181	0
	19/20 HQ refurbishment (closing)	Spatial Development	260	5
Spatial Programme Total			**4,738**	**96**
Digital 999	CAD	Digital 999	5,288	1,270
	e-PCR	Digital 999	1,452	1,085
Digital 999 Programme Total			**6,740**	**2,355**
IM&T	Telephony (Avaya) upgrade to CM7	IM&T Essentials	155	35
	Resilience CAD (RFC)	CAD Essentials	408	0
	Data Security & Protection	IM&T Cyber	360	150
	EOC upgrade to windows 10	IM&T Essentials	350	50
	LAN refresh	IM&T Essentials	200	25
	Body-worn cameras - (Pilot only for 20/21)	COVID-19 Response - Phase 2	944	20
	Avaya & Telephony improvements	IM&T Essentials	800	100
	Telephony 999/111 integration enablers (soft phone & Adastra)	IM&T Essentials	300	50
	WiFi Phase 2	IM&T Essentials	150	0
	Infrastructure Refresh (switches, servers, Routers (EOL)	IM&T Essentials	1,000	100
	Develop data Warehouse	IM&T Essentials	100	0
	PC and laptop devices (ongoing refresh only)	IM&T Essentials	125	0
	Station IPAD remounting	IM&T Essentials	50	0
IM&T Programme Total			**4,942**	**530**
Medicines Modernisation	Medicines Packing Facility	Ready Set Go	1,500	0
	Multi-Dose Meds Packs	Ready Set Go	528	160
	Medicines Track and Trace	Ready Set Go	188	19
	Automated Remote Temperature Monitoring/Control	Ready Set Go	100	67
	19/20 Kit Prep 2	Ready Set Go	113	25
	19/20 Advanced life support (ALS) bags (Closed)	Ready Set Go	71	0
	19/20 Primary response bags (Closed)	Ready Set Go	10	0
Medicines Modernisation Programme Total			**2,510**	**271**
Other	One London LHCR	OneLondon	850	
	iPads	COVID-19 Response - Phase 1	253	
	Desktops and Associated Accessories	COVID-19 Response - Phase 1	878	
	Laptops and Associated Accessories	COVID-19 Response - Phase 1	1,167	
	Telephony and Recording system expansions	COVID-19 Response - Phase 1	1,327	
	Lifepak 15 Defibrillators	COVID-19 Response - Phase 1	584	
	Stock Management System	COVID-19 Response - Phase 1	345	
	Tempus Pro Monitor / Defibrillators	COVID-19 Response - Phase 1	380	
	Critical Care Transfer Service Equipment	COVID-19 Response - Phase 1	398	
	Under £250k items	COVID-19 Response - Phase 1	976	
Other Total			**7,156**	**0**
Grand Total			**44,211**	**4,363**
Memorandum:				
COVID Phase 1 Total			**6,306**	**0**
COVID Phase 2 Total			**14,854**	**1,070**

	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast Outturn
	£	£	£	£	£	£	£	£	£	£	£	£	£
Total Expenditure	£48,338	£45,732	£42,672	£46,582	£44,084	£42,823	£47,720	£41,485	£42,747	£42,108	£41,534	£41,650	£527,475
Covid-19 Expenditure	(£12,915)	(£7,346)	(£7,108)	(£7,968)	(£6,394)	(£5,425)	(£10,682)	(£4,476)	(£4,719)	(£4,686)	(£4,508)	(£4,484)	(£80,711)
Underlying Expenditure	£35,422	£38,387	£35,565	£38,614	£37,690	£37,398	£37,038	£37,009	£38,028	£37,422	£37,026	£37,165	£446,764
Expenditure Plan	£38,429	£37,957	£37,808	£37,752	£37,874	£37,568	£37,186	£37,228	£37,393	£37,537	£37,488	£37,168	£451,388

COVID 19 Actual/Forecast	Actual	Actual	Actual	YTD	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast Outturn
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Additional Staff Costs (EOC and Ambulance Services)	1,677	801	1,894	**4,371**	2,017	2,019	2,016	8,249	2,015	2,015	2,015	2,015	2,015	**28,746**
NHS 111 Additional Capacity - Staff	297	527	890	**1,714**	692	278	253	313	372	467	442	412	387	**5,330**
NHS 111 Additional Capacity - External Contracts	979	1,849	1,330	**4,158**	805	620	580	404	403	551	550	403	404	**8,880**
Decontamination Services - Premises	116	206	(16)	**305**	166	166	130	109	109	109	109	109	109	**1,422**
Defibrillators, Medical and Ambulance Equipment	1,229	191	(681)	**739**	343	243	120	120	120	120	120	120	120	**2,165**
Medical Consumables	0	0	0	**0**	0	0	0	0	0	0	0	0	0	**0**
IT Support	370	496	43	**909**	385	254	115	0	0	0	0	0	0	**1,663**
Private Ambulance Services	558	638	593	**1,789**	598	598	598	0	0	0	0	0	0	**3,584**
Vehicle Leasing	26	29	38	**93**	31	31	31	31	0	0	0	0	0	**216**
Telephony, Radio and IT Systems Expansion	906	112	848	**1,867**	634	362	112	62	62	62	62	62	62	**3,345**
Accommodation	400	344	241	**985**	250	245	0	0	0	0	0	0	0	**1,481**
Personal Protective Equipment	3,639	905	(1,165)	**3,380**	550	550	550	550	550	550	550	550	550	**8,330**
Fleet Maintenance and Preparation	1,531	621	1,535	**3,687**	798	679	679	679	679	679	679	679	679	**9,915**
Critical Care Transfer Service	524	242	167	**933**	194	0	0	0	0	0	0	0	0	**1,127**
Property Adjustments and Expansions	148	48	123	**320**	96	66	39	39	39	39	39	39	39	**757**
COVID Asset Depreciation	0	0	0	**0**	89	89	89	89	89	89	89	89	89	**804**
Other	516	336	965	**1,817**	321	195	112	138	138	138	30	30	30	**2,949**
Total COVID-19 Expenditure	**12,915**	**7,346**	**6,807**	**27,068**	**7,968**	**6,394**	**5,425**	**10,782**	**4,576**	**4,819**	**4,686**	**4,508**	**4,484**	**80,712**

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Stakeholder engagement update
Agenda item:	10
Report Author(s):	Antony Tiernan, Director of Communications and Engagement Pauline O'Brien, Head of External Communications Ross Fullerton, Director of Strategy & Transformation
Presented by:	Heather Lawrence, Chair Dame Christine Beasley, Chair, London Ambulance Service Public and Patients Council Antony Tiernan, Director of Communications and Engagement
History:	In late 2019 and early 2020, the Board received papers proposing the creation of a Public and Patients Council and a Staff and Volunteer Advisory Group. This paper has been reviewed by ExCo.
Purpose:	☐ Assurance ☐ Approval ☐ Discussion ☒ Noting

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

The way we deliver care is changing and the services we provide to the people of London is expanding. To this end, we have been exploring new ways to increase the level of engagement we undertake with patients, the public and other stakeholders and to build on and improve the quality of all of our engagement activity.

This paper updates on progress to date including information about the new LAS Public and Patients Council, as well as plans to host a series of significant 'town hall' events with our NHS, health and care partners.

Recommendation(s) / Decisions for the Board:

Members are asked to:
- Note the content of the report and provide feedback
- Review and agree the findings of the independent review of public and patient engagement (appendix 1)
- Review and agree the updated LASPPC Terms of Reference (appendix 5), following amendments made by LASPPC members
- Note the minutes of the first meeting of the LASPPC (appendix 4).

Routing of Paper – Impacts of recommendation considered and reviewed by:				
Directorate	**Agreed**			**Relevant reviewer [name]**
Quality	Yes		No	
Finance	Yes		No	
Chief Operating Officer Directorates	Yes		No	
Medical	Yes		No	
Communications & Engagement	Yes	x	No		Director of Communications and Engagement
Strategy	Yes	x	No		Director of Strategy and Transformation
People & Culture	Yes		No	
Corporate Governance	Yes		No	

Routing of Paper – Impacts of recommendation considered and reviewed by:

Executive Summary

1. The London Ambulance Service handles over 1.9 million emergency 999 calls each year and we attend more than 1.2 million incidents. We also deliver a 24 hour NHS111 integrated urgent care service in south east and north east London handling circa 1.4 million urgent care calls a year.

2. To help ensure we deliver the best possible care for our patients and their families, we work with a wide number of patient groups and charities to seek their advice and input into the decisions we make. A summary of current activity is included in appendix 9.

3. London's population is diverse and has a wide range of health needs that we need to plan for and meet in the appropriate way. The London health economy is also changing in line with national direction to implement Integrated Care Systems (ICSs). We operate across five ICSs in London which are becoming increasingly established in the planning and coordination of care delivery for their populations.

4. As a Trust we work with a wide range of stakeholders, including:

    a. Patients and members of the public
    b. London's five ICSs, including the Primary Care Networks, acute, mental health and community provider trusts
    c. Regional and national NHS bodies
    d. Emergency services partners including the Metropolitan Police Service and the London Fire Brigade
    e. The Mayor of London, Greater London Authority and London's
    f. Members of Parliament
    g. Governmental bodies.

5. In 2019, we commissioned a report from Judy Hague which outlined the changing stakeholder landscape across London's health and care system. The report identified a need to develop a wider approach to engaging stakeholders beyond those we historically involve and laid the foundations for the increasingly strong links we have as an organisation with the five ICSs.

6. The way we deliver care is changing and the services we provide to the people of London are expanding. To this end, we have been exploring new ways to build on and increase the level of engagement we undertake and to improve the quality of all of our engagement activity. A summary of key London stakeholders is attached, appendix 8.

7. In January 2020, the Board agreed to launch a London Ambulance Service Public and Patients Council (LASPPC). The aim of the LASPPC is to bring together a wide range of patients and the public representatives from across London at regular intervals to provide feedback on the services we provide and to help shape the way care is delivered. It will also advise the Trust on ways to gain broader engagement, as necessary.

8. We asked Mike Cooke, Independent Chair, North Central London ICS, to undertake a review of previous public engagement so that we could learn lessons for the future,

including what had gone well. The final report is attached, appendix 1. We welcome his findings and recommend them to the Board.

9. The Board has additionally agreed to establish a Staff and Volunteer Advisory Group (SVAG) as part of our commitment to improve the way we engage with staff and volunteers.

10. These actions are all form part of an overall approach that includes 'board-to-floor' engagement with our people, builds even stronger relationships with the communities we serve and provides a meaningful way of working with our many partners.

11. The next steps are to finalise a wider stakeholder engagement strategy that sets out how we intend to involve and listen to patients as well as our other partners and stakeholders. This includes how we work with each of London's ICSs who are developing their own patient engagement approaches.

12. This report provides further information regarding the Engagement Report, our newly established LASPPC, our new SVAG, the independent review by Mike Cooke and a proposed Strategic Stakeholder Group.

13. A detailed stakeholder and public engagement strategy will be presented for approval at the September Trust Board.

Engagement Report

14. In March 2019, the Chair and Chief Executive Officer commissioned a report with the following objective:

Developing and enhancing the engagement framework to support delivery of the LAS Service Strategy 2018-2023 by:

   a. Undertaking a targeted stakeholder mapping exercise identifying key organisations and influencers in the health and care sector in London and nationally to support delivery of LAS strategic priorities;
   b. Identifying opportunities for developing influence and fostering relationships, networks and collaboration to deliver the LAS's strategic objectives including 'mental health' as a priority area and enhancing engagement with Sustainability and Transformation Plans (STPs) implementation;
   c. Identifying approaches to strategic engagement by the Board and senior managers which could be included in the future LAS engagement framework, strategy and action plan.

15. The report identified a wide range of stakeholder groups with which LAS could be engaged and set out a series of recommendations including the development of action plans for strategic engagement, partnerships and public engagement. This is particularly important given the overlapping remit of some of the groups as outlined in Figure 1.

16. 2019/20 was a 'transitional year' for health service strategy and planning. STPs were setting up additional engagement opportunities as they refreshed and updated their local plans in the light of the NHS Long Term Plan and starting to transition to ICSs.
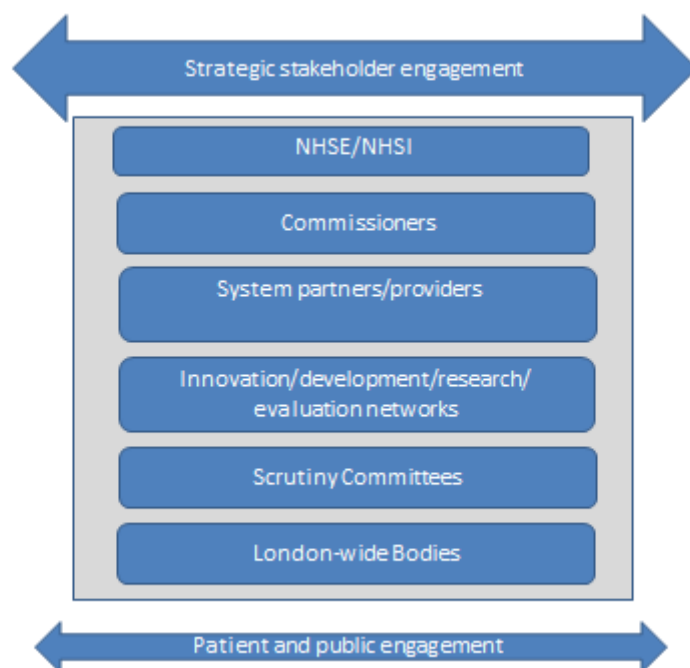
Figure 1 Stakeholder groups

17. This transitional period has allowed us to build on existing strong relationships and to develop a closer working relationship with areas that were not well led. This work needs to continue, for example as the Primary Care Networks begin to have an impact, and as London's health and care system reforms following the COVID-19 pandemic.

18. The outline findings of the report were discussed at a Board development session in April 2019 and shaped the formation of the LASPPC.

London Ambulance Service Public and Patients Council

19. In January 2020, the Board finalised plans to launch a LASPPC. The aim of the LASPPC is to bring together a wide range of patients and the public representatives from across London at regular intervals to provide feedback on the services we provide and to help shape the way care is delivered. It will also advise the Trust on ways to gain broader engagement, as necessary.

20. The LASPPC remit covers a broad areas of activity, from individual care/treatment, research and service design/delivery through to transformation, strategy and forward planning.

21. The LASPPC has 20 members and two co-chairs. The minutes of all meetings will be formally recorded and submitted to the Trust Board. In addition, the LASPPC will report annually to the Trust Board in respect of the fulfilment of its functions in connection with its agreed Terms of Reference.

22. An interim Chair – Dame Christine Beasley – has been appointed to lead the establishment of the LASPPC. Dame Christine was previously the Chief Nurse for England. The LASPPC will meet circa four times a year, with members having been appointed based on their individual skills, experience and networks.

23. In early 2020, we wrote to over 100 patient, voluntary and community groups, as well as charities, inviting them to express an interest in joining the LASPPC. The list of the organisations we approached, which is created in partnership with NHS North West London Collaboration of Clinical Commissioning Groups, is attached (appendix 2).

24. To date, we have confirmed 17 members of the LASPCC, including:

- Laura Bennett, Carers Trust
- Audrey Lucas, Healthwatch Enfield
- David Law, Healthwatch Haringey
- Mary Leung, Healthwatch Harrow
- Ian Buckmaster, Healthwatch Havering
- Angela Cross-Durrant, Healthwatch Kingston
- Patrick Burns, Healthwatch Merton
- David Elliman, Healthwatch Sutton
- Lynne Strother, Independent
- Michael Bryan, Independent
- Dr Kathy French, London Clinical Senate
- Oonagh Heron, London Clinical Senate
- Arif Hoque, Mayor's Fund for London – Youth board member
- Jacqui Morrissey, Samaritans
- Dora Dixon-Fyle MBE, Southwark Health and Wellbeing Board
- Peter Hollely, St John Ambulance
- Glenda Bonde, Terence Higgins Trust.

25. The Terms of Reference for the LASPPC are attached, as well as the minutes of the first meeting which took place in June (appendices 4 and 5). A number of small amendments, highlighted in yellow, have been made to the Terms of Reference by the LASPPC (at its first meeting) and Board is asked to note and approve them. The agenda of the June meeting is attached, appendix 3.

Independent Review

26. LAS has a longstanding track record of working with various public representative bodies including the 'Patients Forum for the LAS'. In order to learn from these experiences, the Trust Chair commissioned a review by Mike Cooke, Independent Chair of North West London ICS, to establish what went well and what could be improved.

27. We wish to thank Mike for his efforts in producing this report during a challenging period while the NHS was responding to COVID-19.

28. The report is included as appendix 1 to this document. The summary findings of his report are:

    a. There appears to be a shared and deep commitment to patient and public involvement within the Trust.
    b. It is recognised within the Trust that the Patients' Forum has contributed much over the years.

c. The Trust has appropriately identified that it needed to expand and broaden its approach to public patient involvement.

d. There have been some specific concerns in respect of the Trust's and Patients' Forum relationship and there are lessons from these.

e. The decision-making associated with the Trust's adoption of its new approach to patient and public engagement appears appropriate and effective.

f. I support the approach to the new LAS Public and Patient Council

g. It is important to conclude the development of a wider public engagement strategy.

29. The Board is requested to accept the summary findings of the report including the development of a wider public engagement strategy.

Staff and Volunteer Advisory Group

30. The SVAG has 70 members from across the Trust, including our staff survey champions, representatives from our staff networks (Lesbian, Gay, Bisexual and Transgender (LGBT+), Black, Asian and Minority Ethnic (BAME) and ENABLE, our disability forum), a representative from our international group, a representative from the retirement association and volunteers.

31. The SVAG is chaired by the Trust Chair and aims to meet four times a year. A Co-Chair, appointed from the membership, is due to be appointed.

32. Two meetings have taken place so far, focusing on staff and volunteer welfare and wellbeing. The agenda are attached (appendices 6 and 7).

Strategic Stakeholder Group and Sector Stakeholder Group

33. Given the complex nature of the organisations LAS interacts with it is proposed that we establish a Strategic Stakeholder Group who would meet regularly to exchange intelligence and share best practice and experiences. LAS is a unique organisation – no other organisation has our pan-London remit, our national media profile and our critical role in protecting the nation. We are also unique as an ambulance service: we serve a small but densely populated city which is on a world stage. The demands and expectations on us are high.

34. As a result of these challenges we need to carefully analyse and manage the relationships with our strategic stakeholders to ensure they understand the role we play, the challenges we face and the opportunities we are uniquely placed to deliver.

35. Chaired by the Trust Chair, members of this group would include the Chief Executive, Chief Operations Officer, Director of Communications and Engagement, other directors, the Chief of Staff, Head of External Communications and Chair of the LASPPC.

36. This group would focus on international, national and regional stakeholders, for instance ICSs and sustainability and transformation partnerships (STPs), Association of Ambulance Chief Executives, central Government including the Department for Health and Social Care, The Mayor's Office, Greater Local Authority, NHS England,

NHS London, Care Quality Commission, other arms-length bodies, Healthwatch England, Patients Association and national charities.

37. A Sector Stakeholder Group, which includes the Assistant Directors of Operations, Chief Operating Officer, Director of Communications and Engagement and Head of External Communications, would focus on sub-regional stakeholders and will report to the Strategic Stakeholder Group. This group would focus on local healthcare systems (Trusts and Primary Care Networks), London boroughs and local MP's constituency issues.

Annual General Meeting 2020

38. Our Annual General Meeting (AGM) is a good way to engage with patients, local people and other partners. Our AGM in 2019 was attended by circa 180 people with many more watching a live broadcast via Facebook and YouTube.

39. We are in the process of agreeing the format and content for this year's meeting. As a result of COVID-19 and the ongoing need for people to socially distance, it is likely that we will need to take a different approach to the event. We will confirm further details for the event shortly.

APPENDIX 1

The Patient Involvement Review by Mike Cooke is included as a separate document.

APPENDIX 2

Organisations contacted to express an interest in joining the London Ambulance Service Public and Patients Council:

- Abbey Community Centre
- Age UK
- Alcohol Concern
- Barking & Dagenham
- Black Thrive
- BME Health Forum
- British Heart Forum
- Carers Trust
- Citizens' Advice Bureau
- Crisis
- Epilepsy Research UK
- Hands International
- Healthwatch Barnet
- Healthwatch Bexley
- Healthwatch Brent
- Healthwatch Bromley
- Healthwatch Camden
- Healthwatch Croydon
- Healthwatch Ealing
- Healthwatch Enfield
- Healthwatch Greenwich
- Healthwatch Hackney
- Healthwatch Hammersmith & Fulham
- Healthwatch Haringey
- Healthwatch Harrow
- Healthwatch Havering
- Healthwatch Hillingdon
- Healthwatch Hounslow
- Healthwatch Islington
- Healthwatch Kingston upon Thames
- Healthwatch Lambeth
- Healthwatch Lewisham
- Healthwatch Merton
- Healthwatch Newham
- Healthwatch Redbridge
- Healthwatch Richmond upon Thames
- Healthwatch Southwark
- Healthwatch Sutton
- Healthwatch Tower Hamlets
- Healthwatch Waltham Forest
- Healthwatch Wandsworth
- London Clinical Senate Patient and Public Voice
- Marie Curie
- Mencap
- Mind – all London branches
- National Autistic Society – all London branches
- National Deaf Children's Society
- National Union of Students
- National Voices
- Patients' Association
- Patients Forum
- Refuge
- RNIB
- RNID
- Samaritans
- Shelter
- Social action for health
- St John Ambulance
- St Mungos
- Stonewall
- Terence Higgins Trust
- The Passage
- Third Age Trust
- UK Youth
- Women and Girls network
- Women's Institute
- YMCA

ENDS

Meeting of the London Ambulance Service Public and Patients Council on Tuesday 16 June 2020, at 10:00am – 12.00pm, via Zoom Video Conference

Agenda

Item		Owner		Time
1.	**Welcome**	Dame Christine Beasley, Chair	Verbal	10.00
2.	**Introductions**	All	Verbal	10.05
3.	**Background to the LASPPC, its creation, role, appointment of co-chair and induction for members**	Antony Tiernan, Director of Communications and Engagement	Verbal	10.20
4.	**Indicative terms of reference**	Antony Tiernan/All	Paper	10.30
5.	**COVID-19** 5.1 How the London Ambulance Service has responded to the COVID-19 pandemic so far and plans for the future 5.2 Feedback from members about the NHS/LAS response	Pauline Cranmer QAM, Director of Ambulance Services All	Paper Verbal	10.40
6.	**Electronic Patient Care Record (EPCR)** 5.1. What is EPCR and what does it mean for our patients and the public? 5.2. Discussion: how do we involve patients and the public?	Stuart Crichton, Chief Clinical Information Officer and Peter Rhodes, Assistant Director of Operations All	Verbal	11.10
7.	**Future agenda**	Antony Tiernan		11.40
8.	**AOB**	Dame Christine Beasley		11.50
9.	**Upcoming Board meeting 28 July 2020**	Antony Tiernan		11.55

APPENDIX 4

Meeting of the London Ambulance Service Public and Patients Council on Tuesday 16 June 2020, at 10:00am – 12.00pm, via Teams Video Conference

Summary

Attendees

Council
Dame Christine Beasley, Co-Chair; Peter Hollely, St John Ambulance; Dora Dixon-Fyle MBE, Southwark Health and Wellbeing Board; Audrey Lucas, Healthwatch Enfield; Lynne Strother, Independent; Glenda Bonde, Terence Higgins Trust; Jacqui Morrissey, Samaritans; Dr Kathy French, London Clinical Senate; Patrick Burns, Healthwatch Merton; Ian Buckmaster, Healthwatch Havering.

LAS
Antony Tiernan, Director of Communications and Engagement; Pauline Cranmer, Director of Ambulance Services; Eilidh Ramsden, PA – Director of Communications and Engagement; Peter Rhodes, Assistant Director of Operations; Stuart Crichton, Chief Clinical Information Officer; Belinda Glasgow, Communications Lead – EPCR; Pauline O'Brien, Head of External Communications.

Observers
Daniel Plummer, LAS Commissioning Team – Lead, North West London Collaboration of Clinical Commissioning Groups; Alvin Kinch, Volunteering and Regional Network (London) Manager, Healthwatch England.

Welcome

Dame Christine Beasley [CB], Co-Chair of the Council welcomed all to the meeting. Although the current situation (in relation to COVID-19) is unprecedented, it was felt that it was important for this forum to commence at this time.

Introductions

CB invited all present to introduce themselves. A separate document containing a 'mini biography' of members as per these introductions will be compiled. All were looking forward to contributing to the Council.

> ➢ **Action:** Eilidh Ramsden (ER), PA to Antony Tiernan (AT), Director of Communications and Engagement to draft 'mini biographies'.

CB thanked all for making time to be part of the Council.

Background to the LASPPC, its creation, role, appointment of co-chair and induction for members

AT thanked CB for opening the meeting and agreeing to be Chair.

The London Ambulance Service (LAS) Trust Board had agreed to form the London Ambulance Service Public and Patients Council (LASPPC). The Council will bring together a

wide range of patients and the public representatives from across London at regular intervals to provide feedback on the care LAS provides and to help shape the way care is delivered.

The Council will cover a broad areas of activity, from individual care and treatment and research through to service delivery, design and transformation.

The purpose of the Council is to: provide a voice for patients, the public and carers in the design, development and delivery of Trust services; advise the Trust on ways to gain broader engagement, as necessary.

Members are appointed based on their individual knowledge, skills and experience, not to represent a specific organisation. To ensure a variety of experience we will look to appoint a balanced and diverse membership drawing from across different stakeholder groups including: patient, carer and public voice networks; and, voluntary and community sector.

Final membership will be circa 20 – we have 11 now. Currently membership is of a one year tenure. Declarations of Interest are required.

> **Action:** AT/ER to facilitate to declarations.

Feedback from LASPPC meetings will be reported to the LAS Trust Board. With regards to the appointment of a Co-Chair, it was agreed that this would be addressed at the next meeting (recognising we are short of circa nine members).

AT advised that three induction sessions for members will be set up (via Zoom or Microsoft Teams) covering:

1. The NHS, health and care – in a nutshell
2. London Ambulance Service – structure and services
3. London Ambulance Service – future strategy.

> **Action:** AT/ER to facilitate. Members would receive invites directly.

A list of organisations approached to express an interest in joining the LASPPC would be shared. Members are asked to give feedback on any missing groups/organisations.

During discussion there were suggestions for possible engagement with schools of nursing and that input of younger person(s) would be very useful. Members let AT know of any useful contacts such as former colleagues etc whose input they felt might be useful.

> **Action:** Expressions of interest – AT/ER to provide list.

> **Action:** Members to advise AT of any useful contacts.

Indicative terms of reference

AT informed the meeting that the LAS Trust Board wished for LASPCC membership to be happy with and in agreement of the terms of reference (ToRs).

Discussion took place regarding looking at how to link in with similar bodies/forums, research councils etc on both local and national level.

> ➢ **Action:** Members to advise AT of any comments/suggested amendments they have on the TORs by **3 July**.

COVID-19 update

This item was led by Pauline Cranmer QAM, Director of Ambulance Services (PC).

Key points from the CEO Board summary paper on how LAS planned/responded and current situation going forward were highlighted and discussed. Business continuity plans have been "beefed up" in terms of worst case scenario planning. Planning to keep staff, volunteers and patients safe began in February and implemented fully during March and April. This built on regular major incident and business continuity planning.

999 calls grew from circa 5,000 a day, to a peak of over 11,000 calls by the end of March, putting extreme pressure on control room (999) operations. This was effected by absence over the period due to sickness and need for staff and volunteers to self-isolate. Call handling times became significantly extended.

Vehicles had to be taken fully out of service for deep cleaning after each attendance.

The huge and fantastic support from volunteers was noted for example assisting with logistics functions in issuing personal protective equipment (PPE).

Staff and volunteers are being supported in coping with increased impacts such as dealing with for patients' reluctance to go to hospital, relatives not being able to accompany them etc. Support for staff and volunteers unable to go home (to protect their families etc) has also been a focus. With necessary consolidation of stations during the crisis, this learning will be taken forward.

The focus now is to pause and reflect on what has gone well and lessons to be learnt. There is work to be done in signing best points of contact for patients, support of the 111/IUC service/level of response pathway.

The excellent response of staff and volunteers was noted.

CB thanked PC and others who contributed and invited questions.

Points raised and discussed by members were:

- Were any staff put onto the furlough scheme? It was confirmed that no staff had been furloughed
- Looking at ways to adapt and innovative ways of keeping staff and volunteers engaged and looking at use of clinical skills
- Virtual rest rooms
- Peer support and engagement to utilise staff and volunteer skills.

Discussion took place around the issue of the impact of a possible second wave of COVID-19 and what steps have been taken to re-model to assure of ability to cope with if necessary. PC confirmed that a second wave has been anticipated and strengthening of the interface between 111/IUC and 999 is in place. It was noted that volunteers, re-joiners, London Fire Brigade, St John Ambulance, military and other ambulance services were a huge support during the peak.

Challenges on public engagement going forward including reluctance to go to hospital and how to address support for non COVID-19 "normal" calls to be addressed with new care pathways emerging.

With regards to what to take out of recent events, PC noted that currently it is a case of lessons "identified" rather than "learnt" in order to shape things going forward. It has been identified that some patients do not have digital services, for example older persons and also there are those for whom English is not a first language.

Electronic Patient Care Record (EPCR)

Stuart Crichton, LAS Chief Clinical Information Officer (SC) and Peter Rhodes, Assistant Director of Operations (PR) led on this item and reported that currently records are paper based relying on scanning and copying. LAS are moving to a digital platform as part of the One London Programme: www.onelondon.online.

This represents a huge change in working practices and currently assurance processes are being thoroughly addressed with a view of that review in August/September 2020 with potential roll out by end of 2020.

Members were asked to express any feedback/questions they had regarding the initiative. Points raised were the need to re-assure patients and staff regarding the use of iPads etc. PR informed that 20 staff will be trialling week one of the assurance process. SC reported that the product has been tried and tested very successfully within three other ambulance trusts.

With regards to ownership of the data, this belongs to LAS. Issues regarding access by social services are subject to strict statutory requirements regarding safeguarding. Carers/interested parties currently in paper format in care plans etc will follow the patient electronically.

SC confirmed that there will be workshops taking place as part of the One London Programme and views/guidelines from these will be fed back to the Council.

> ➤ **Action:** Members to advise AT/SC/PR of any comments/concerns and suggestions on general engagement issues and any help they feel they are able to offer to facilitate the programme.

Future agenda

AT informed the meeting of his suggestions for future agenda items:

- Trust strategy/transformation including estates vision
- Public and patient engagement strategy
- Shaping of new/revised patient pathways.

AT asked members to let him know of any items they would like to include in future agendas.

- ➢ **Action:** Members to advise AT/CB of any items they wish to include in future Council meetings.

Any Other Business

With regards to consideration of frequency of LASPPC meetings i.e every 2 or 3 months, matter to be considered by AT/CB.

- ➢ **Action:** AT/CB to discuss frequency of meetings and report their suggestion to members.

APPENDIX 5

London Ambulance Service Public and Patients Council – indicative Terms of Reference

1. Purpose

1.1   The London Ambulance Service Public and Patients Council (the Council) will bring together a range of patients and the public representatives from across London at regular intervals to provide feedback to the Service on the care it provides.

1.2   The Council's membership will bring broad public and patient insight and experience to discussions, helping to shape the way care is delivered ==across the Trust's full range of services, including on scene, online and on the phone (999/111)==. They will cover a number of broad areas of activity including:

1.2.1   Individual care and treatment;
This could include the way in which our staff interact with individual patients (i.e. how they greet them), through to how we treat cohorts of patients with certain conditions (i.e. sickle cell patients).

1.2.2   Research
This would address how we involve patients in our in-house ==clinical audit== and research activity, which would include providing a PPI link for individual projects as required, and also providing representation on the Trust's Clinical Audit and Research Steering Group ==programmes – co-producing projects we run in line with national guidance==.

Research
This would address how we involve patients in our in-house clinical audit and research activity, which would include providing a PPI link for individual projects as required, and also providing representation on the Trust's Clinical Audit & Research Steering Group.

1.2.3   Service delivery, design and transformation
This moves away from the individual to all our patients and the public, for example the manner in which we identified the need for, the provision and impact of the mental health care service.

1.2.4   Strategy and forward planning
This provides us with a formal mechanism for engaging more widely in the development of our Trust strategy and the enabling strategies.

1.3   The purpose of the Council is to:

1.3.1   Provide a voice for patients, the public and carers in the design, development and delivery of Trust services
1.3.2   Advise the Trust on ways to gain broader engagement, as necessary.

1.4   The Council will have an agreed programme of work to allow for additional engagement activity to be conducted in advance of meetings to help bring wider insight to the membership as appropriate. The Council is not itself responsible for implementation and nor does it cut across the current statutory accountabilities of the London Ambulance Service NHS Trust.

2. Constitution

2.1   The Council is an advisory committee of the Trust's Board of Directors. These terms of reference are subject to amendment at future meetings of the Trust Board.

3. Accountability

3.1   The Council will report directly to the Trust Board.

4. Membership

4.1   The Council will have a membership of around 20 people and should ensure a diversity of age, gender, background and experience of health services.

4.2   Members are appointed on an individual (not ex-officio) basis but will be drawn from a range of public and patient groups to ensure a plurality of experience. Terms of membership will be reviewed on an annual basis.

5. Chair

5.1   The Council will be led by two independent Co-Chairs. The Co-Chairs will be appointed through a formal process and will ~~not~~ be drawn from the Council membership.

5.2   The Co-Chairs will help build and safeguard the cohesion, reputation and effectiveness of the Council.

5.3   The Co-Chairs will have a role both at and between meetings in setting the Council's agenda and ensuring that the Council is influential and impactful.

6. Attendance

6.1   Officers from the London Ambulance Service NHS Trust and other health and social care system partners will participate in all sessions of the Council in attendance (in limited number).

6.2   Experts may be invited to meetings or sessions of meetings on an ad-hoc basis to provide opinion, information and evidence on specific matters.

7. Quorum

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

        7.1.1   One of the Co-Chairs of the Council; and
        7.1.2   At least one-third of the total membership of the Council.

8. Meeting administration

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

8.2   The draft minutes and action points will be available to the Council within ten working days of the meeting.

9. Notice of meetings

9.1 Meetings of the Council shall be called by the secretary of the Council at the request of the Co-Chairs.

9.2 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 Council, any other person required to attend, no later than seven calendar days before the date of the meeting. Supporting papers shall be sent to Council members and to other attendees as appropriate, at the same time.

9.3 Late and additional papers will be tabled at the discretion of the Co-Chairs of the Council.

10. Frequency of meetings

10.1 Meetings of the full Council will be typically held four times per annum.

11. Duties

11.1 Key duties of the Council will include:

      11.1.1 Reviewing and commenting on new and emerging strategies
      11.1.2 Considering proposals for new research projects
      11.1.3 Commenting on the Trust Business Plan and Annual Quality Strategy and Account
      11.1.4 Commenting on proposed new models of care/service provision.

12. Review and reporting responsibilities

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

12.2 The Council 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.

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

13. Equality and diversity

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

ANNEX

Principles of membership

Members must at all times:

- Observe the values and respective behaviours of the London Ambulance Service – respectful, professional, innovative and collaborative
- Observe the highest standards of impartiality, integrity and objectivity in relation to the advice they provide
- Be accountable for their activities and, as appropriate, not share or disclose information which is confidential

- Not misuse information gained in the course of their membership of the Council for personal gain or for political purpose, nor seek to use the opportunity of public service to promote their private interests or those of connected persons, firms, businesses or other organisations
- Challenge information provided if they are unclear of the meaning or if they feel the evidence for a decision/action is weak
- Not hold any paid or high-profile posts in a political party, and not engage in specific political activities on matters directly affecting the work of the Council. When engaging in other political activities, members should be conscious of their public role and exercise proper discretion.

Declarations of interest

Upon appointment all members of the Council will be formally required to complete a Declaration of Interest Form and a Register of Members Interests will be established and updated on an annual basis. It is the responsibility of members to declare any new interests as and when they arise and to ensure that the Register of Members Interests is kept up to date.

The Chairs will be responsible for managing declarations of interest and any conflicts of interest within the meeting and determine on what basis a member declaring a relevant interest can participate in discussion.

ENDS

APPENDIX 6

MEETING OF THE STAFF ADVISORY PANEL ON TUESDAY 03 MARCH 2020 AT 10:00-11:30 IN THE OXFORD SUITE, H10 LONDON WATERLOO, 284-302 WATERLOO ROAD, SE1 8RQ

Agenda

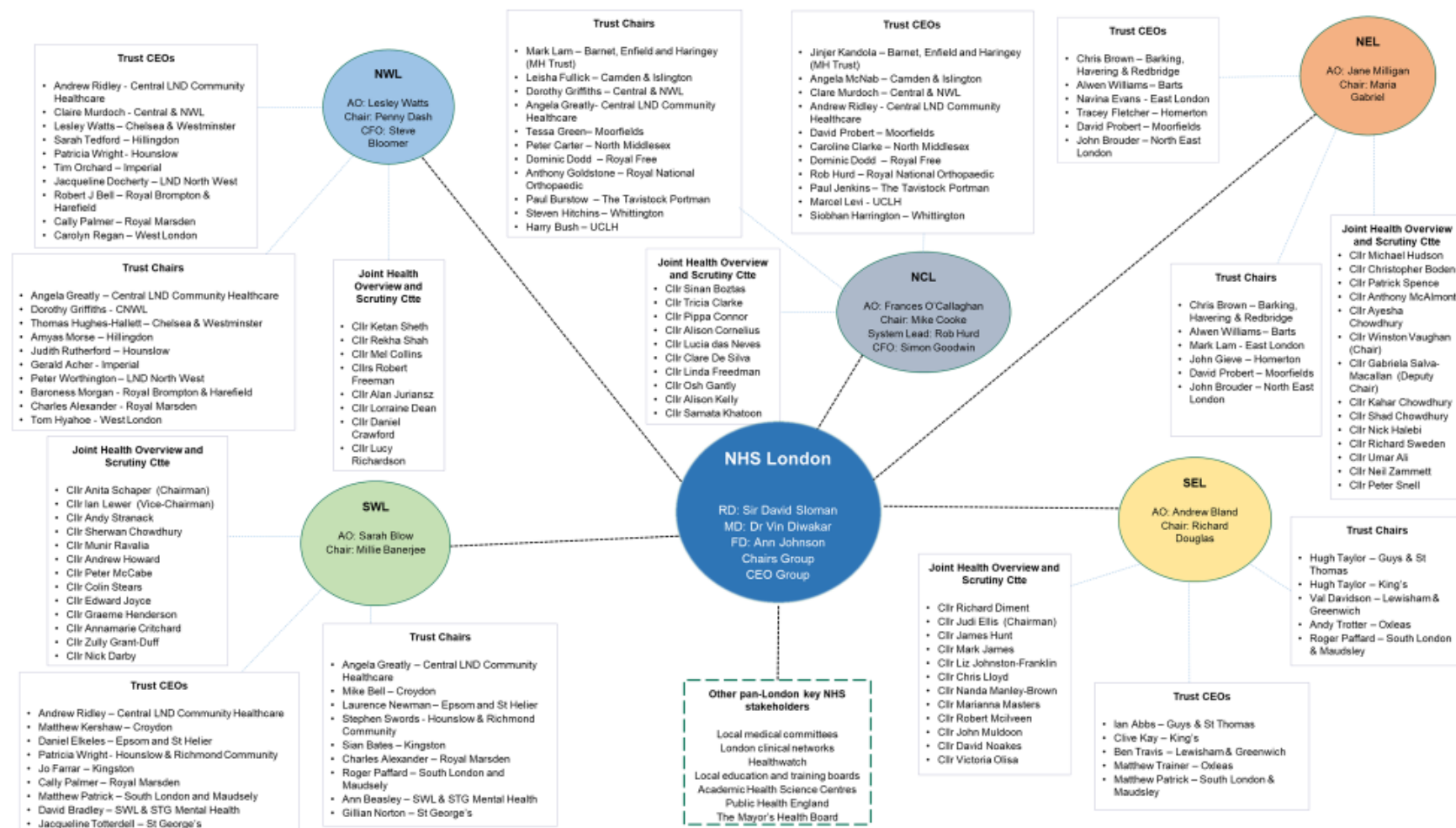| Timing	Item	Ref.		Owner	Status Assurance Decision Discussion Information
10.00	1.	SAP/19/01 Oral	Welcome and apologies To welcome attendees, introductions and outline the purpose of the meeting	HL	Information
10.10	2.	SAP/19/02 Oral	Declarations of Interest To request and record any notifications of declarations of interest in relation to today's agenda.	All	Assurance
10.15	3.	SAP/19/03 Attached	Terms of Reference To note the Terms of Reference of the Staff Advisory Panel	AT	Information
10.20	4.	SAP/19/04 Oral	Joint Chair discussion To invite expressions of interest from the attendees to attend as Joint Chair of the Panel	AT	Information
10.25	5.	SAP/19/05 Oral	Knowing what you know, what can the Trust Board do to make LAS a better place to work?	HL	Discussion
10.55	6.	SAP/19/06 Oral	What can the Trust Board do to ensure great patient care?	HL	Discussion
11.20	7.	SAP/19/07 Oral	What are your key items you would like to bring to this discussion for the future?	HL	Discussion
11.30	8.	SAP/19/08 Oral	Meeting close	HL	
	Date of next meeting: To be confirmed				

Meeting of the Staff and Volunteer Advisory Panel on Thursday 21 May 2020, at 10:30am – 12pm, via Zoom Video Conference

Agenda

Item		Owner		Time
10.	**Welcome and meeting etiquette**	Heather Lawrence	Verbal	10.30
11.	**Notes and feedback from meeting 3 March 2020**	Heather Lawrence	Enclosed	10.35
12.	**Opening from the Chair: Board update**	Heather Lawrence	Verbal	10.40
13.	**Digital 999 Programme Assurance Committee (Board sub-Committee)** 4.1. Update from the Chief Operating Officer Khadir Meer	Khadir Meer	Verbal	10.50
	4.2. Discussion: would you like to be involved in the digital programmes and if so, how?	All		11.05
14.	**People and Culture** 5.1. Your Wellbeing	All	Verbal	11.20
	5.2. Lessons learned			11.30
15.	**Open discussion**	All		11.45
16.	**Upcoming Board meeting 26 May 2020**	Heather Lawrence		11.55
	Meeting close			

APPENDIX 8

London Healthcare System – key stakeholder map

Trust CEOs
- Andrew Ridley - Central LND Community Healthcare
- Claire Murdoch - Central & NWL
- Lesley Watts – Chelsea & Westminster
- Sarah Tedford – Hillingdon
- Patricia Wright - Hounslow
- Tim Orchard – Imperial
- Jacqueline Docherty – LND North West
- Robert J Bell – Royal Brompton & Harefield
- Cally Palmer – Royal Marsden
- Carolyn Regan – West London

Trust Chairs
- Angela Greatly – Central LND Community Healthcare
- Dorothy Griffiths - CNWL
- Thomas Hughes-Hallett – Chelsea & Westminster
- Amyas Morse – Hillingdon
- Judith Rutherford – Hounslow
- Gerald Acher - Imperial
- Peter Worthington – LND North West
- Baroness Morgan - Royal Brompton & Harefield
- Charles Alexander - Royal Marsden
- Tom Hyahoe - West London

Joint Health Overview and Scrutiny Ctte
- Cllr Anita Schaper (Chairman)
- Cllr Ian Lewer (Vice-Chairman)
- Cllr Andy Stranack
- Cllr Sherwan Chowdhorn
- Cllr Munir Ravalia
- Cllr Andrew Howard
- Cllr Peter McCabe
- Cllr Colin Stears
- Cllr Edward Joyce
- Cllr Graeme Henderson
- Cllr Annamarie Critchard
- Cllr Zully Grant-Duff
- Cllr Nick Darby

Trust CEOs
- Andrew Ridley – Central LND Community Healthcare
- Matthew Kershaw – Croydon
- Daniel Elkeles – Epsom and St Helier
- Patricia Wright - Hounslow & Richmond Community
- Jo Farrar – Kingston
- Cally Palmer – Royal Marsden
- Matthew Patrick – South London and Maudsley
- David Bradley – SWL & STG Mental Health
- Jacqueline Totterdell – St George's

NWL
AO: Lesley Watts
Chair: Penny Dash
CFO: Steve Bloomer

Joint Health Overview and Scrutiny Ctte
- Cllr Ketan Sheth
- Cllr Rekha Shah
- Cllr Mel Collins
- Cllrs Robert Freeman
- Cllr Alan Juriansz
- Cllr Lorraine Dean
- Cllr Daniel Crawford
- Cllr Lucy Richardson

SWL
AO: Sarah Blow
Chair: Millie Banerjee

Trust Chairs
- Angela Greatly – Central LND Community Healthcare
- Mike Bell – Croydon
- Laurence Newman – Epsom and St Helier
- Stephen Swords - Hounslow & Richmond Community
- Sian Bates – Kingston
- Charles Alexander – Royal Marsden
- Roger Paffard – South London and Maudsley
- Ann Beasley – SWL & STG Mental Health
- Gillian Norton – St George's

Trust Chairs
- Mark Lam – Barnet, Enfield and Haringey (MH Trust)
- Leisha Fullick – Camden & Islington
- Dorothy Griffiths – Central & NWL
- Angela Greatly- Central LND Community Healthcare
- Tessa Green– Moorfields
- Peter Carter – North Middlesex
- Dominic Dodd – Royal Free
- Anthony Goldstone – Royal National Orthopaedic
- Paul Burstow – The Tavistock Portman
- Steven Hitchins – Whittington
- Harry Bush – UCLH

Joint Health Overview and Scrutiny Ctte
- Cllr Sinan Boztas
- Cllr Tricia Clarke
- Cllr Pippa Connor
- Cllr Alison Cornelius
- Cllr Lucia das Neves
- Cllr Clare De Silva
- Cllr Linda Freedman
- Cllr Osh Gantly
- Cllr Alison Kelly
- Cllr Samata Khatoon

Trust CEOs
- Jinjer Kandola – Barnet, Enfield and Haringey (MH Trust)
- Angela McNab – Camden & Islington
- Clare Murdoch – Central & NWL
- Andrew Ridley - Central LND Community Healthcare
- David Probert – Moorfields
- Caroline Clarke – North Middlesex
- Dominic Dodd – Royal Free
- Rob Hurd – Royal National Orthopaedic
- Paul Jenkins – The Tavistock Portman
- Marcel Levi - UCLH
- Siobhan Harrington – Whittington

NCL
AO: Frances O'Callaghan
Chair: Mike Cooke
System Lead: Rob Hurd
CFO: Simon Goodwin

NHS London
RD: Sir David Sloman
MD: Dr Vin Diwakar
FD: Ann Johnson
Chairs Group
CEO Group

Other pan-London key NHS stakeholders

Local medical committees
London clinical networks
Healthwatch
Local education and training boards
Academic Health Science Centres
Public Health England
The Mayor's Health Board

Joint Health Overview and Scrutiny Ctte
- Cllr Richard Diment
- Cllr Judi Ellis (Chairman)
- Cllr James Hunt
- Cllr Mark James
- Cllr Liz Johnston-Franklin
- Cllr Chris Lloyd
- Cllr Nanda Manley-Brown
- Cllr Marianna Masters
- Cllr Robert Mcilveen
- Cllr John Muldoon
- Cllr David Noakes
- Cllr Victoria Olisa

Trust CEOs
- Chris Brown – Barking, Havering & Redbridge
- Alwen Williams – Barts
- Navina Evans - East London
- Tracey Fletcher – Homerton
- David Probert – Moorfields
- John Brouder – North East London

NEL
AO: Jane Milligan
Chair: Maria Gabriel

Joint Health Overview and Scrutiny Ctte
- Cllr Michael Hudson
- Cllr Christopher Boden
- Cllr Patrick Spence
- Cllr Anthony McAlmont
- Cllr Ayesha Chowdhury
- Cllr Winston Vaughan (Chair)
- Cllr Gabriela Salva-Macallan (Deputy Chair)
- Cllr Kahar Chowdhury
- Cllr Shad Chowdhury
- Cllr Nick Halebi
- Cllr Richard Sweden
- Cllr Umar Ali
- Cllr Neil Zammett
- Cllr Peter Snell

Trust Chairs
- Chris Brown – Barking, Havering & Redbridge
- Alwen Williams – Barts
- Mark Lam - East London
- John Gieve – Homerton
- David Probert – Moorfields
- John Brouder – North East London

SEL
AO: Andrew Bland
Chair: Richard Douglas

Trust Chairs
- Hugh Taylor – Guys & St Thomas
- Hugh Taylor – King's
- Val Davidson – Lewisham & Greenwich
- Andy Trotter – Oxleas
- Roger Paffard – South London & Maudsley

Trust CEOs
- Ian Abbs – Guys & St Thomas
- Clive Kay – King's
- Ben Travis – Lewisham & Greenwich
- Matthew Trainer – Oxleas
- Matthew Patrick – South London & Maudsley

APPENDIX 9: CURRENT ACTIVITY

40. The Trust currently engages with patients, local people and other partners in a variety of ways, including:

- Bulletins – we issue monthly updates including to London MPs, GPs and councillors
- Meetings and events – including our Annual General Meeting and Board
- Social media – via our popular Twitter, Facebook, Instagram and LinkedIn accounts
- Website – our site is viewed by up to 100,000 unique visitors each month
- Visits – we regularly host visits and observers from a wide range of partner organisations
- Education – in 2019, our staff and volunteers undertook over 900 school and community talks/visits, engaging with over 178,000 people (see below for breakdown).

Age	Number	Type of visits
All	133,680	Basic Life Support (7%), careers (57%), road safety (13%)
1-5	1,329	Nursery visits
5-11	11,778	Junior Citizen's Scheme
5-16	8,921	School visits including those with special educational needs (3%)
5-18	1,820	Brownies, cubs, etc
10+	12,305	Knife crime awareness
11-18	309	Visits to LAS
16+	30	College visits
18+	8,065	Blue Light Collaborative (99%), alcohol awareness (1%)
60+	130	Older people's groups

<u>**Report of an Independent Review:**</u>
<u>**London Ambulance Service: Public and Patient Engagement**</u>

Mike Cooke
Independent Chair
North Central London Integrated Care System

May 2020

1. Introduction

The London Ambulance Service NHS Trust is transforming its approach to involving patients and the public in its work. It took a key strategic decision in December 2019 which included a decision to update its patient and public engagement strategy and establish a new Public and Patients' Council. The Trust Chair was keen to ensure that the new approaches learnt from what has taken place in the past, including what has gone well. In order to assist with this process of learning, the Chair asked me to undertake a small scale review in order to identify the most important lessons. The Terms of Reference for this review are attached as Appendix 1 to this report.

The review was undertaken at the same time as the Trust was providing essential services during the Covid-19 national emergency. It was decided at an early stage that it was important to undertake the review during this time so that the LAS was well positioned to begin its refreshed approach to public involvement as soon as the worst of the emergency situation was over. It will be critical to undertake discussions with the public about future LAS services not least because of the its strategic London wide roles and contributions at a time when, across London, NHS services are needing to be organised around Covid-19 infection control measures.

I am extremely grateful to everyone who agreed to and made time to be interviewed as part of the review during this very challenging and demanding period. I am also grateful to the colleagues that assisted with the practical and other support that enabled the review to be completed in a timely way.

In this report I have used the term Patients' Forum to refer to what I understand is the organisation which has the formal title of "The Patients 'Forum for the LAS and Patients 'Forum Ambulance Services (London)".

2. Public and Patient Participation and Involvement

It is worth beginning this review by stepping back and reflecting briefly on some aspects of public and patient participation including its purpose. It is very frequently cited as an essential part of service planing and delivery. A recent LAS board paper said clearly: "patients should be partners in the design, development and delivery of services. The voice of patients should be ever-present in all parts of our organisation." This is likely to be a widely understood view and one that it is very hard to disagree with.

However, public and patient involvement is more complex than it might first seem. The Kings Fund publication "People in Control of their Own Health and Care: the state of involvement"

(Foot et al 2014) summarised this when it stated: "…we lack clarity about the business of involving people in health. What is it? Why do it? What does the evidence say? What are the benefits?". The publication serves as a reminder of the importance of being clear as to the purpose of engagement and involvement and then finding the best ways that the purpose can be achieved.

Patient involvement has different roles including:

- Citizens taking responsibility for staying healthy
- Involving patients in their own care and treatment
- Involving patients in service design
- Patient involvement in policy making

Wigan serves as a good example of the above. Wigan has become well known for establishing a 'social contract' between public service organisations and the people of Wigan. It describes the various levels of involvement in this contract as residents having "influence over their own care and treatment" through to "having a say in the way services are planned" and finally "helping to bring about improvements in the way care is provided".

To a large extent, public and patient involvement has become a social value: a belief that public services have a duty to involve people both in specific decisions that are made about them as individuals and in the design of services that exist for their benefit and that, ultimately, for which as tax payers they are the metaphorical shareholder. Of course for some types of decisions, involvement goes beyond being a value system and instead becomes a legal responsibility such as when statutory consultation is required.

There is, in addition, an important imperative that underpins public and patient involvement, namely that of ensuring that services are designed and delivered in ways that achieve their desired purpose (and, usually, do so within a given budget). Many public services have been designed by people with professional expertise but the resultant services have been less than effective because they have not taken full account of people's requirements and real life situations. By involving patients, carers and prospective patients services are more likely to be designed such that they are effective in meeting the needs of patients. There is of course a discipline to this type of involvement which includes gathering evidence and making decisions using that evidence, setting aside pre-conceived views. This is at the heart of the Quality Improvement work which many NHS Trusts have adopted.

As Davis simply states in his publication "Responsibility and Public Services" (2016): "The message is simple: understand people in context and find out what matters to them. The solutions are far easier and cheaper."

As part of my review Mr Alexander of the Patients' Forum kindly sent me an article written by Olivia Butterworth, Head of Public Participation for NHS England and NHS Improvement, that helpfully illustrates this kind of approach to service re-design. I attach it as Appendix 2 for reference. The article emphasis the criticality of involvement being genuine and authentic as well as highlighting its potential to bring about fundamental and positive shifts in services. What is particularly interesting about the example used by Butterworth is that it illustrates perfectly the way in which the LAS is at the heart of a complex London wide health and care system and that the LAS cannot act alone in bringing about changes to the relevant parts of the system of health and care: other agencies have critical roles to play in engaging with the public and in facilitating changes in services and service usage.

My final reflection on patient and public involvement in the light of all of the above, is that it needs to be seen as a continuous process that requires regular evolution and adaptation to changing situations and expectations.

3. Summary of Findings

My findings can be summarised as follows:

1. There appears to be a shared and deep commitment to patient and public involvement within the Trust.
2. It is recognised within the Trust that the Patients' Forum has contributed much over the years.
3. The Trust has appropriately identified that it needed to expand and broaden its approach to public patient involvement
4. There have been some specific concerns in respect of the Trust's and Patients' Forum relationship and there are lessons from these.
5. The decision-making associated with the Trust's adoption of its new approach to patient and public engagement appears appropriate and effective.
6. I support the approach to the new Public and Patient Council.
7. It is important to conclude the development of a wider public engagement strategy (which I understand is in progress).

4. Findings

1. There appears to be a shared and deep commitment to patient and public involvement.

As mentioned in the introduction, it is vital that public involvement is authentic and meaningful: this was strongly emphasised by a number of contributors to the review. Ultimately this stems from the belief system of the staff and the organisation's leadership. I was struck by the way in which the Trust colleagues whom I interviewed spoke genuinely about the importance of public involvement. They were able to speak as advocates illustrating the benefits of improved services that have come from working closely with patents and carers in service improvement processes. They also were able to give many examples of how they personally had contributed to these. The colleagues I spoke with were very supportive of the refreshed approach that has been put in place and in no small part this seemed to stem from wanting patient involvement to go more deeply and to ensure that it reached a wider range of people.

I was pleased to be told by the Chair of the Trust that a refreshed approach to listening to and involving staff has also been put in place. Without this, there would have been a risk that a refreshed approach to patient and public involvement might have created a lack of congruence for staff. But this had been identified already and illustrates how the organisation's leadership is setting about ensuring participation is approached holistically.

It is important not to take this apparently shared value of patient and public involvement for granted. It is a real asset that can be built upon.

2. It is recognised within the Trust that the Patients' Forum has contributed much over the years.

All the LAS colleagues I interviewed were of the view that the work with the Patients' Forum over many years had contributed much. This was also reflected by Mr. Alexander who has said that the Patient's Forum and the LAS has worked productively and successfully for many years. There were a number of examples cited including working together on:

- pre-CQC preparation
- Quality accounts
- Sickle cell patient services
- Maternity related services
- The training academy.
- Learning and making changes from complaints.

There was gratitude for the contribution of the Patients' Forum in helping these achievements to be made. The key lesson appears to be that there is already clear evidence within the Trust of the benefits of patient involvement in service redesign and improvement and this needs to continue under the new strategy.

3. The Trust has appropriately identified that it needed to expand and broaden its approach to public patient involvement

If there have been positive achievements in working with the Patients' Forum, it begs the question as to why a strategic change of direction was needed. The answer to this lies in two parts, one which is covered in this section and one in regard to finding 4 below.

The view of Trust colleagues was clearly stated as being that the Trust has changed and expanded its range of services over many years. This has been brought into sharp relief during the Covid-19 emergency when its 111 services has been a pivotal part of the London wide health system response. At the same time London and its population has continued to change and become more diverse in terms of population make up and also in terms of health and care needs. There is a strongly held view amongst Trust colleagues that it needs to reach out in new and different ways to listen to and involve wider groups of citizens in order to ensure it is involving a wider and representative set of views. In other words there is a view that the Trust is missing out by not reaching many groups or sections of the wider London communities. I was struck, for example, that the LAS does not have deep and established relationships with many of the large national charities that could represent certain patient groups and who could facilitate access to speaking with patients with certain conditions.

This view was reached by the Trust's Board in April 2019: the notes of a Board seminar states:

"The Board deliberated on the range of patient groups represented by the Patients Forum and considered that a greater diversity should be represented, in line with the diverse communities   across   London."

As I have alluded to in Section 2 of this report, public involvement can bring about significant service innovation and can shed new light both on new problems and long standing challenges. It can be a vibrant and exciting process, albeit one with challenges. However to become like this, the process of involvement does need to ensure that the people affected

by services are involved and listened to and so the "reach" must be broad as well as deep. It must regularly be refreshed too.

I therefore endorse the Trust's identification of a strategic risk which has prompted it to move to improving the scope and representation of the patients and citizens who are involved in its work. It follows that it was appropriate for it to take action to address this gap.

4. There have been some specific concerns in respect of the Trust's and Patients' Forum relationship and there are lessons from these.

In addition to the reason set out in finding 3 above, there have been another set of factors involved in the Trust's decision to re-set how it goes about patient and public involvement.

These have manifested themselves in a view amongst Trust staff that responding to the requests from the Patients' Forum had become exceptionally demanding. The position was portrayed to me as being one where multiple requests for information or sometimes access to services were being submitted with no apparent co-ordination. It was explained that this had become custom and practice over a long period of time and that the purpose of these manifold requests and what benefits they were bringing had become unclear.

This, however, seems to be only a symptom of a deeper issue, namely that at the heart of the relationship there is a fundamental disagreement about some aspects of the Patients' Forum's role. The Forum explicitly states on its website that it sees itself as "monitoring" the work of the LAS. When the Forum's representative met the Board in April 2019, the Board discussed this role conflict with the Forum. The Board notes state:

"Board members considered the current role of the Patients' Forum and observed the need for a separation of external scrutiny that it sought to undertake and the internal growth and improvement role that it could usefully pursue. Concern was expressed that the current role of the Forum conflicted with the objectives of LAS."

There are already a range of established means of monitoring the work of the Trust. The role of the Board, particularly its non executive directors is in part to undertake a monitoring and challenge role in respect of the Executive team. In addition, NHS England as the strategic service commissioners undertake performance monitoring. Finally the Care Quality Commission has a crucial and rounded monitoring and inspection role.

The Patients' Forum as an independent organisation is entitled to decide what roles it aims to fulfil and it is not for me to either criticise or endorse the choices it makes. The core point is that this monitoring function is not accepted by the LAS Trust. It has become a source of tension not least because the Forum has chosen to publish comments about the LAS which the latter believes are unfair and misrepresent what has occurred. The Trust is entitled to determine how much resource it wishes to invest in servicing this purpose and it has clearly decided it does not wish to. It has concluded that this activity goes well beyond what is generally understood to be patient involvement and is putting the Patients' Forum in an almost campaigning role. The LAS's response is a reasonable and rational response given the apparent cost of servicing the requests that were being made.

There is a lesson for the future from this in the sense that should such role conflict emerge in similar situations, it is advisable for these to be addressed and resolved at the earliest possible opportunity.

In order to attempt to co-ordinate its response, since the Autumn of 2019 and with the appointment of a new responsible Director, the Trust has instituted a 'single point of contact' approach to the Patients' Forum correspondence and requests. This was entirely sensible and appropriate and is an approach that is seen in many organisations. In itself it should have been fairly uncontroversial. I had a sense from my discussions with the Forum's representative that the adoption of this approach had exacerbated the Forum's concerns about the relationship and that it did not really understand the rationale.

Finally, mention must be made of a training event in September of 2019 when three Trust colleagues were presenting to members of the Forum in a training setting. It was reported to me that some comments were made by some Forum members which were interpreted and received by the LAS colleagues as being highly offensive. The staff involved were upset by the incident and that such behaviour could be exhibited unchecked. It is not within the scope of this review to look into this incident; instead I refer to it to draw out a key lesson that under the new arrangements with a new Public and Patient's Council, and indeed for any public engagement, I think it is important to set out in advance a statement of expected behaviours and working protocols under which the new arrangements will operate and participants will abide by.

5. **The decision-making associated with the Trust's adoption of its new approach to patient and public engagement appears appropriate and effective.**

I was provided with relevant Board papers and minutes of meetings and it is clear that the Board has spent time over many months considering the way forward on patient and public involvement. It appraised the relationship with the Patients' Forum from a strategic point of view, identified the Trust's strategic requirement and agreed an approach.

As part of its decision making it was considering the relationship with the Patient's Forum in April of 2019 and received a paper with proposals in November; the Board asked for some clarification before deciding and sought assurance on the robustness of the proposed new council of patients and public, deciding that:

"It was also important that the [*new*] Council had an appropriately diverse membership, which did not necessarily view the LAS favourably, as challenge would be valuable…"

The Board approved the new Public and Patient Council in December 2019. It appears to have taken a balanced and considered approach over a period of at least nine months and has expressed the view that it is seeking challenge from a diverse representation.

6. **I support the approach to the new Public and Patient Council.**

At the heart of the refreshed approach to involvement is the establishment of a new Public and Patient Council, with Dame Christine Beasley as its first Chair. The purpose of the Council has been set out to be:

• 　To provide a voice for patients, the public and carers in the design, development and delivery of Trust services

• 　To advise the Trust on ways to gain broader engagement, as necessary.

I interviewed Dame Christine as part of this review and she set out how she saw the new Council as having a strategic focus. It will aim to be a check and a challenge and it will advise and assist in achieving representative involvement in service improvements and in

listening to patients. It will do this through its members' connections rather than being individual advocates or by seeking that detailed involvement in service improvements from the members of the council themselves.

I support this approach. There would have been a risk if the new Council had aimed to be all things to all people or thad sought to undertake all aspects of patent involvement: specifically the risk is that it would become too stretched or unfocussed in its efforts.

It is important to note that when the Council commences it will need some time to establish itself and it will need to learn and develop as it progresses. There will need to be a regular dialogue between the. Council and the Trust, not least to ensure that its development is on a pathway that is mutually agreed rather than one that results in inadvertent 'scope creep'.

As mentioned above, it would also be helpful to establish a statement of behaviours and working protocols under which the Council and the LAS colleagues will operate and adhere to. This could be as simple as adopting the same or similar codes of practice or values statements that currently exist for staff.

7. It would be beneficial to conclude the development of a wider public engagement strategy (which I understand is in progress).

As I outline in Section 2 of this report, patient involvement can take place at different levels and in different ways within any organisation. It would be advisable to continue the development of a documented, comprehensive patient involvement and engagement strategy for the Trust. I understand that the national emergency has meant that it has not been possible to develop this strategy further before now.

The new Council will not be the only means of involving the public and indeed there is a risk of overburdening it with expectations rather than seeing engagement and involvement in a wider framework of action and activity across the Trust. I see no reason why the Council cannot begin its work before that wider strategy is concluded: indeed it could be a very helpful contributor to it.

Amongst other things it would be helpful if the strategy could set out :

- The purpose of different levels and types of involvement: what does the LAS want them to achieve? How will success be measured?
- How patient involvement in service design and quality improvement will continue;
- The role, if any, the LAS sees for deliberative enquiry / participation;
- Roles and responsibilities for working with patients within the organisation;
- Engagement with partner organisations;
- How the LAS can best link into the five emerging Integrated Care Systems across London on a consistent basis (these are likely to put in place strong patient and citizen involvement methods so there is the opportunity for synergies of approach and effort).
- How the Board intends to listen to patients on a regular basis;
- The level of practical support for involvement and engagement activities;

Needless to say, perhaps, but the strategy will need to be kept under review so that the approaches and methods are kept fresh, innovative and to ensure it is meeting its objectives.

5. Conclusion

I have no doubt that the LAS Trust leadership is deeply committed to public and patient involvement.

After many years of working with the Patients' Forum, the Trust has decided that it needs to adopt a new and broader approach. In doing so there is a recognition that the Forum has supported the Trust in some significant learning and service improvements that have stemmed from patient involvement.

However, the LAS's services have expanded, it has a wider role and London's population has become more diverse and more complex. Therefore the Trust has appropriately and effectively decided that it needs to modernise and refresh its approach and has set out the first steps in that regard, namely the establishment of a new Patient and Public Council. I support this strategic decision and the emerging new approach. The Trust now needs to also consider and agree a new comprehensive engagement and involvement strategy which can help set out, direct and enable the wider engagement and involvement work of the Trust.

Mike Cooke
20 May 2020

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APPENDIX 1

Stakeholder Governance Review
Terms of Reference

Overview

1. The London Ambulance Service NHS Trust (LAS) is transforming the way in which it ensures that the voice of the patient is heard clearly in everything that it does. In the past the Trust has worked exclusively with the organisation known as the Patients' Forum (PF). The LAS is now in the process of establishing an updated patient and public engagement strategy and, as part of this, a Public and Patients Council. In order to inform the successful delivery of both of these, the Trust Chair has decided to commission an independent review of its experiences of public and patient engagement to date and the actions that it has taken to establish its new approach.

Scope of work

2. The work should cover the following key areas:

   A. **The history and nature of the Trust's recent relationship with the PF; and**
   B. **The decision-making associated with the Trust's adoption of its new approach to patient and public engagement.**

3. This is with a view to enabling the best possible understanding of how best to achieve excellence in the Trust's future patient and public engagement activities.

4. It is anticipated that the following approach would be adopted in addressing these key areas:

A. The history and nature of the Trust's recent relationship with the PF

5. It is anticipated that this will require a combination of documentation review and a small number of interviews with key individuals.

6. With regard to document review, it is anticipated that this should focus on the documents produced by the PF and LAS responses to these. This will enable an understanding of the manner in which the PF has conducted its formal interactions with the LAS and how the LAS has engaged with these.

7. With regard to the interviews, it is proposed that the following individuals are interviewed:

   a. Trisha Bain, LAS Chief Quality Officer
   b. Antony Tiernan, LAS Director of Communications and Engagement;
   c. Heather Lawrence, LAS Chair;
   d. Garrett Emmerson, LAS Chief Executive;
   e. Jules Lockett, Practice Learning Manager, 999 Operations Management;
   f. Christine Beasley, LAS Public and Patients Council Chair designate;
   g. Lizzie Bovil, LAS Commissioner representative;
   h. A representative of the PF Executive; and

      i. Malcolm Alexander, PF Chair.

      j. Stella Franklin, CQC

8. It is proposed that these individuals are interviewed in order to gain a more nuanced understanding of the interactions between the PF and the LAS, from a variety of perspectives. It is proposed that a representative of the PF Executive is included in this group in light of the recent changes in the leadership of the PF.

9. This combined approach is expected to address the manner in which the PF has carried out and governed its engagements with the LAS and the manner in which these have been responded to by the LAS and its commissioners. This will ensure that any learning from this relationship is carried into the new arrangements being established by the LAS

B. The decision-making associated with the Trust's adoption of its new approach to patient and public engagement

10. This is expected to be a desk-based review of the documentation associated with the decision-making process. It should include the supporting documents and notes of the relevant informal Trust Board Development session where a new approach to patient and public engagement was first discussed, the documents associated with the actions arising from that session and the papers and minutes of the Board meeting where the decision to establish a Public and Patients Council was made.

11. This will enable a clear articulation of the issues considered in the Trust's adoption of its new approach.

Anticipated milestones and timeframes

12. It is anticipated that the review will be completed by the end of May 2020.

13. Initial findings from the review are to be discussed with the LAS Chair and LAS Public and Patients Council Chair designate in the week commencing 11 May 2020. This should enable a draft report to be shared in the week commencing 18 May 2020.

24 April 2020

Appendix 2

We need to create a future NHS that is driven by people
Olivia Butterworth *is Head of Public Participation for NHS England and NHS Improvement. This article first featured in the Jan/Feb issue of NHE.*

"The NHS has long had a duty to involve 'the public'. The discharge of this duty is often played out through set piece engagement and formal consultation processes. It's not always clear how it influences, changes or improves things. We have defaulted to referring to 'PPI 'or 'PPE 'as a shorthand which also stand for entirely different things outside the NHS bubble.

To transform our NHS and care services we need to engage with **people and communities in ways that really do hear their experiences and ambitions and then take action, together, that leads to real change**. The involvement of people and communities is essential and needs to be at the heart of how our organisations and systems work, bringing people's experience and ideas into the decision-making spaces in inclusive and transparent ways.
It's often an engagement lead who is despatched 'to do 'the engagement and then feed back, usually through written reports to those who make the decisions. We need to change this.
We will continue to miss the opportunities for real change unless those who have the power to make change happen, work with and alongside people to understand what the issues are and what some of the solutions might be.
I'll give you a simple example – it's based on a real story.

A GP practice notices that it has very high A&E use by people from a particular community. This same group also experience higher than average diabetes. It's always been like that, say the partners.
A new partner steps out of the practice and in to the community, connects with people in the community and asks questions about how people are using services, why they go to A&E and what their lives are like. They build relationships with community groups and start to develop a deeper understanding of the people who live there and the lives they live.
Working in partnership with this community they understand why people go to A&E and work with the community newspaper and radio station to talk about the other services available, in ways that people understand. Working with a community café they talk about the foods people are eating and start to understand how this could be linked to their diabetes. The café changes the ways it's cooking some foods and shares their learning with the rest of the community.
Guess what? A&E use goes down and diabetes starts to reduce.

Connecting with the people and groups in communities offers us vast insight and opportunities to work together to make change, rather than continuing to do things to people that don't resonate with their lives. 2020 and beyond offer great opportunity to make this change – whether it's the emergence of Primary Care Networks, CCGs transforming their commissioning practice, providers developing integrated and person-centred services, the strategic leadership of STPs and ICS', the relationship with social care and the potential reforms on the horizon – the involvement of people and communities is critical to shifting the culture and achieving change.
Stop doing to people and start working with them"

_____

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Board Assurance Framework
Agenda item:	11.1.
Report Author(s):	Frances Field, Risk and Audit Manager
Presented by:	Syma Dawson, Director of Corporate Governance
History:	N/A
Purpose:	☒ Assurance ☒ Approval
	☒ Discussion ☐ Noting

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

This Board Assurance Framework is presented to the Trust Board for review and approval.

Recommendation(s) / Decisions for the Board / Committee:

The Board is asked to note that changes to the BAF are highlighted in red for ease of reference and to discuss / approve the following:

- Amended entry: BAF risk 45 A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. This risk has been completely reviewed and updated by the CIO to reflect that teams are now working to remediate gaps and issues directly linked to documented risks, no change to the risk rating.

- Amended entry: BAF risk 58 relating to the catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients. This risk has been completely reviewed and updated by the CIO with a change to the risk scoring to 16, to reflect the increased risk of IT failure.

- Amended entry: BAF risk 61, COVID-19 Impact – changes to sub-strategic risk assessments relating to quality, clinical and operational in light of reduced demand and increased capacity, no change to People and Culture or Finance ratings. The Finance risk has been reviewed to reflect the announcement that the interim financial framework is extended to August and likely September, which may impact the delivery of business plan objectives in 20/21 due to the lack of an agreed funding envelope on which to approve a budget for the full year.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes	X	No		Trisha Bain, Chief Quality Officer
Finance	Yes	X	No		Lorraine Bewes, Chief Finance Officer
Chief Operating Officer Directorates	Yes	X	No		Khadir Meer, Chief Operating Officer
Medical	Yes	X	No		Fenella Wrigley, Chief Medical Officer
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes	X	No		Ali Layne-Smith, Director of People and Culture
Corporate Governance	Yes	X	No		Syma Dawson, Director of Corporate Governance

IMPACT (vertical axis)

	Rare	Unlikely	Possible	Likely	Almost Certain
Catastrophi			45		
Major			54 56 58	61	
Moderate					
Minor					
Negligible					

LIKELIHOOD

In order of severity:

BAF Risk 61
COVID-19 Impact

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

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 trained specialist trained resource requirements and performance which may result in the Trust not fully delivering its strategy.

BAF Risk 56
The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets.

BAF Risk 58 (awaiting approval by Trust Board)
Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients

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) recognizes 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 Framework – July 2020

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, 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.	• Development of productivity measures to add to the performance score card to ensure oversight of productivity. This action requires scoping of a new automated productivity system that can extract information from the telephony, in line with what we have in CISO for ambulance services. **(These actions are paused and scoping/procurement to be resumed as part of trust Covid recovery, as well as agreement of the metrics.)** • Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing. This is ongoing and the model constantly reviewed – currently affected by Covid-19. **(The accuracy of this model and our ability to check its longer term impact are currently affected by Covid-19, however work is undertaken to develop this further)**. There is short term modelling put in place for the time of the pandemic
1-8	61 COVID-19 Impact	• COVID-19 decision making review underway. • To review and assess the Trust's Strategy and strategic risks following COVID • The organisation has been asked to set out its position including funding to deliver health care at system level.

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GOAL 2   Be a first class employer, valuing and developing the skills, diversity and quality of life or our people

</td>
<td>**DELIVERABLE**</td>
<td>

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.

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Links to Deliverables	BAF Risk	Further mitigation required
9	**56** The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets	**Due to Covid-19, the roll out of these activities is delayed and there are now a number of unknowns in regards to the longer term planning.** • Determine skill mix to support patient requirements and operational delivery within the financial budget available. • Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers. • Develop and agree Design and Operating Model for Ambulance Services. • Develop Trust plan for 999 and 111 integration across call handling and telephony based clinical services.
9-15	61 COVID-19 Impact	• COVID-19 decision making review underway. • To review and assess the Trust's Strategy and strategic risks following COVID • The organisation has been asked to set out its position including funding to deliver health care at system level.

| | 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
17	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.	• Development of productivity measures to add to the performance score card to ensure oversight of productivity. This action requires scoping of a new automated productivity system that can extract information from the telephony, in line with what we have in CISO for ambulance services. **(These actions are paused and scoping/procurement to be resumed as part of trust Covid recovery, as well as agreement of the metrics.)** • Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing. This is ongoing and the model constantly reviewed – currently affected by Covid-19. **(The accuracy of this model and our ability to check its longer term impact are currently affected by Covid-19, however work is undertaken to develop this further)**. There is short term modelling put in place for the time of the pandemic.
16-19	61 COVID-19 Impact	• COVID-19 decision making review underway. • To review and assess the Trust's Strategy and strategic risks following COVID • The organisation has been asked to set out its position including funding to deliver health care at system level.

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

22	45 There is a risk that a cyber- attack could materially disrupt the Trust's ability to operate for a prolonged period.	1. Deliver technical control/assurance projects:
		  a. Network segregation and access control (Cisco ISE and TrustSec)
		  b. Hardening of internet-facing systems (configuration and improved access control)
		  c. N365 – IG Compliance monitoring and data loss prevention (potential requirement for license upgrade)
		  d. SolarWinds Logging solution and Security Information & Event Management (SIEM)
		2. Leverage NHSD funded opportunities:
		  a. Cyber Risk Framework workshops to enable enterpise integrated cyber risk management
		  b. CORS Support – Supplier cyber management process, training needs analysis, baseline secuirty architecture patterns, cyber cultural vision statement
		  c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised quals.

20-24	61 COVID-19 Impact	• COVID-19 decision making review underway. • To review and assess the Trust's Strategy and strategic risks following COVID • The organisation has been asked to set out its position including funding to deliver health care at system level.
22	58 Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients	**See pages 16-17 of the BAF for detailed actions**

BAF Risk no. 61	COVID-19 Impact				
Risk Classification: All	**Risk Owner:** Garrett Emmerson			**Scrutinising Committee:** Board	
Date risk opened:	**Date risk expected to be removed from the BAF: TBC**				
Change since last review:					
Area	**Strategic Risk(s) Description**	**Gross Rating**	**Current/Net Rating**	**Target Rating**	
People	Risk of insufficient resources to meet increased demand; impact on staff welfare and wellbeing; safety and reputational from rapid recruitment process; impact on BAU and recruitment of paramedics due to COVID-19 as well as significant cultural impact.	16	12	8	
Operational	As a result of the Covid-19 pandemic, all operational areas in LAS will suffer from reduced ability to deliver timely responses to meet demand. There is a risk of reduced infrastructure and staffing capacity to support demand and recover performance levels following the pandemic	20	(16) 12	8	
Clinical	Due to unprecedented demand from COVID-19, patients may have a delayed response which has necessitated LAS having to respond using different internal and external pathways.	16	(12) 8	8	
Quality	Due to unprecedented demand from COVID-19, patients may have a delayed response which has necessitated LAS having to respond using different internal and external pathways. There is an increased risk of breaching constitutional standards due to additional pressures on our Governance systems in the delivery and monitoring of quality and safety.	16	(12) 9	(8) 6	
Financial	COVID-19 has changed the national and local delivery of care at system level, if the organisation isn't reset and funded at the cost needed it will not be able to deliver a strategic response. Non-delivery of the agreed 2020/21 financial trajectory of the Trust due to the impact of Covid-19 pressures.	20	16	8	
Existing Controls		**Positive Assurance of Controls**			

Board Assurance Framework – July 2020

1. Strategic Recovery Group to work with each directorate to develop action plans for future resilience and sustainability.
2. Pandemic business continuity plans being developed, incorporating lessons learned and preparing for any potential peaks in future.
3. Post COVID considerations led by the CFO, COO and Director of Strategy and Transformation to agree the optimal operating model including resources and estates requirements, identify and retain efficiencies and operating opportunities across all areas of operations.
4. Utilise Joint Decision Making (JDM) / Decision Log protocols to capture decisions made / authorisation levels etc. during the COVID period Regular contact with EPRR teams to seek advice on the above
5. Membership of regional and national network bodies (e.g. Ambulance HRD forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working
6. Australian recruitment programme regularly reviewed and approach updated as necessary.
7. Appointment of dedicated COVID Wellbeing lead with remit for creating the Trust's COVID staff wellbeing delivery plan and working with internal and external partners to deliver the plan
8. The Trust has set up a strategic Incident Room (COVID 19 cell) to plan and monitor impacts of COVID 19 on the Trust in alignment with the Pan London Strategic Coordination Group and planning assumptions for London.
9. Working with CQC and NHSI to agree SI process meet whilst recognising the scale of investigations required to meet LfD regulatory requirements.
10. The Trust has established a COVID 19 Resource Tracking template to be completed for all COVID 19 related resource requests, these are all approved by Trust Gold and reported to Exco and FIC on a regular basis.
11. In year monthly financial reporting and forecasting continues to provide assurance on underlying financial position of the Trust and to ensure all material COVID 19 expenditure has been captured
12. The Trust continues to fully document all COVID 19 related expenditure to ensure it will with stand the scrutiny of both internal audit and parliament.
13. The Trust is completing a 2020/21 top up submission to NHS London Region to ensure that cash flow is maintained throughout the COVID 19 for known omissions from the COVID Baseline allocation i.e. Agenda for Change
14. The Trust is planning for Post COVID 19 led by the CFO, COO and Director of Strategy and Transformation to agree the optimal operating model including resources and estates requirements, identify and retain efficiencies and operating opportunities across all areas of operations. A case has been submitted to London Region for discussion at National level to secure resources required to support the Trust's changes to its operating model post COVID.

1. Reports are provided to the Board Assurance Committees on COVID-19 related activities.
2. Reports provided to Executive Committee who sign off strategic risks and actions.
3. Status reports provided to the Trust Board via weekly NED calls and monthly Trust Board meetings.

15. We are now working in partnership with the NW partnership to agree income for 20/21 income.
16. Antony Marsh, National Strategic Advisor for Ambulance Services has been commissioned to undertake a benchmarking review to provide independent assurance to the system to support funding settlement for 20/21 and beyond.
17. Secured capital of £44M to support the capital programme for transformation requirements in 20/21.
18. There has been an agreement in principle from the London wide system to make a business case for a 5 year self-funding transformation.

Gaps in controls
19. Risk that the Trust does not implement mandated guidance or policy in relation to COVID19.
20. Risk of difficulty in recovering performance following pandemic.
21. Increased demand on IT infrastructure resulting in temporary loss of access or interruptions to digital services.

Further Actions	Responsible Person/s	Due Date
1. COVID-19 decision making review underway. 2. To review and assess the Trust's Strategy and strategic risks following COVID 3. The organisation has been asked to set out its position including funding to deliver health care at system level.	1. External governance consultant, Philippa Harding. 2. Ross Fullerton and Syma Dawson 3. Executive Committee Members	

Signed:

Board Assurance Framework – July 2020

BAF Risk no. 45 - There is a risk that a cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period

Risk Classification: IM&T	Risk Owner: Syma Dawson/Barry Thurston	Scrutinising Committee: Logistics & Infrastructure Committee
Date risk opened: 01/06/2017	Date risk expected to be removed from the BAF: Ongoing	

Change since last review:
- Barry Thurston and Syma Dawson now taken over responsibility for this risk.
- Teams are now working to remediate gaps and issues directly linked to documented risks.
- Compliance with the DSPT will give some assurance against this risk but greater level of assurance will be achieved by completion of the Cyber Security Roadmap

Underlying Cause/Source of Risk: The changing sophistication and nature of cyber threats poses a risk to the Operation of all technology dependant organisations including the LAS. The Trust has established an ongoing cyber programme to identify and address gaps in technology and business cyber risk mitigation.	Gross Rating	Current/Net Rating	Target Rating
	20	15	10

Existing Controls	Positive Assurance of Controls
1. Technical cyber protection, detection and remediation solutions are deployed but require review. 2. The continuation of a professional cyber security team as a managed service to deal with incidents and cyber response e.g. Royal Surrey ransomware notification. Information Security Management support in Corporate Governance. 3. Auditable set of documents covering people, processes, procedures and technical controls; reviewed by NHSD and third parties at least twice a year 4. Broad set of real-time security reporting and alerting with ability to take immediate action 5. NHS specific intelligence feed from NHS Digital implemented in technical controls and cyber responses **Gaps in Controls** 1. Differing controls across different infrastructure lead to inconsistent application e.g. anti-virus 2. Incomplete technical vulnerability visibility across entire estate 3. Out of support operating systems, infrastructure and software (lack of application control) 4. Partially completed projects e.g. transition to new firewalls	1. Compliance-based cyber security KRIs/KPIs (reported to IM&T SMT and monthly CEO performance review) 2. Performance reporting to L&IC through IM&T 3. Internal Audit and independent audit against DSPT 4. Additional NHSD assurance support through CORS programme 5. CareCert notifications performance measured and reported as part of the IM&T's KPIs,reported to IM&T SMT & ExCo monthly **Gaps in Assurance** • Auditable evidence of procedural controls for DSPT • Cyber-specific risk management documentation • Ability to conduct own assurance of closed vulnerabilities

Further Actions	Responsible Person/s	Due Date

3. Deliver technical control/assurance projects:
   a. Network segregation and access control (Cisco ISE and TrustSec)
   b. Hardening of internet-facing systems (configuration and improved access control)
   c. N365 – IG Compliance monitoring and data loss prevention (potential requirement for license upgrade)
   d. SolarWinds Logging solution and Security Information & Event Management (SIEM)
 4. Leverage NHSD funded opportunities:
   a. Cyber Risk Framework workshops to enable enterpise integrated cyber risk management
   b. CORS Support – Supplier cyber management process, training needs analysis, basleine secuirty architecture patterns, cyber cultural vision statement
   c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised quals.
 3. Recruitment of substantive IG and Information Security resource at 2nd line of defence.
	1. Simon Brownhill
	
	 2. Barry Thurston
	
	 3. Syma Dawson
		1. August 2020
		
		 2. November 2020
		
		 3. November 2020

Signed: Syma Dawson/Barry Thurston

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: Khadir Meer	Scrutinising Committee: Quality Assurance Committee
Date risk opened: 05/03/2019	Date risk expected to be removed from the BAF: October 2020	

Change since last review:	**Due to the COVID-19 impact on 111 providers, there has been a national decision to pause the KPI requirement. We are achieving these KPIs due to increased capacity through response to COVID-19 so this may no longer be a risk as currently worded. There is an expectation of changes to the nature of the contract for 111/IUC call taking and at that point we propose to review / close this risk and open a new risk based on the new contract arrangements.**

Underlying Cause/Source of Risk: Ability to recruit and retain advanced clinical medical staff such as GPs. Call answering 96% within 60 seconds, call abandonment <2% in NEL / <5% SEL.	Gross Rating	Current/Net Rating	Target Rating
	16	12	8

Existing Controls	Positive Assurance of Controls
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. 8. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. 9. Agile approach to the mitigation of risks in place. 10. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan. 11. Phased approach to implementation of SEL based on learning identified during the NEL mobilisation. 12. Secured the support of regulators and commissioners in identifying further potential sources to recruit and retain medical staff within the CAS. 13. Additional capacity and capability engaged to assist in the delivery of the improvement plan.	• Daily performance report published to executives / commissioners. • Plan signed off by Medical Director. • IUC delivery, standard agenda item at ExCo meetings. • Evidence of completed actions stored on x drive. • Minuted meetings • NEL IUC has had additional performance management measures (put in place by NEL commissioners and HLP/NHSE) lifted in line with improved performance and is now subject to routine contractual performance management. • We are in the process of developing a plan to address current agency costs overspend while maintaining focus on KPI delivery.

Further Actions	Responsible Person/s	Due Date
1. Development of productivity measures to add to the performance score card to ensure oversight of productivity. This action requires scoping of a new automated productivity system that can extract information from the telephony, in line with what we have in CISO for ambulance services. **(These actions are paused and scoping/procurement to be resumed as part of trust Covid recovery, as well as agreement of the metrics.)**	1. Paul Cook, Head of IUC Performance 2. Chris Nightingale, Head of Forecasting and Planning	End Oct 2020 End Oct 2020

Board Assurance Framework – July 2020

2. Forecasting and Planning Team are developing an initial forecasting model to improve planning of health advisor staffing. This is ongoing and the model constantly reviewed – currently affected by Covid-19. **(The accuracy of this model and our ability to check its longer term impact are currently affected by Covid-19, however work is undertaken to develop this further)**. There is short term modelling put in place for the time of the pandemic.		

Signed: Khadir Meer, Chief Operating Officer

BAF Risk no. 56   The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets

Risk Classification: Human Resources	**Risk Owner:** Ali Layne-Smith	**Scrutinising Committee:** People and Culture
Date risk opened: 15/05/2019	**Date risk expected to be removed from the BAF: 30 September 2020**	
Change since last review:	COVID-19 and introduction of Government	

Underlying Cause/Source of Risk: The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS (NHS Long Term Plan) which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets.	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	16	12	8

Existing Controls	**Positive Assurance of Controls**
1. The Trust has built strong pipelines for paramedic recruitment overseas which will allow it to respond to an under supply in the UK market. A number of these activities are currently on hold due to Government restrictions. 2. 20/21 UK Graduate recruitment in place - a proposal to bulk recruit 96 UK Partner Paramedic students. 3. Strategic workforce planning has been developed over 2018/19 and has resulted in the establishment of a Strategic Workforce Planning Group which is chaired by the Director of People and Culture and in which the Chief Medical Officer and Chief Operating Officer will be essential participants. 4. Engagement in national workforce planning group to influence debate on challenges of English Ambulance Trusts with funded paramedic places 5. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation and has recently moved it to HQ to give greater visibility of their work and to enable more collaborative and efficient ways of working with operational colleagues 6. The Trust is developing a paramedic apprenticeship to attract and retain local employees 7. The Trust is developing accessible career pathways for non-registered clinical roles 8. We are working on a new Band 5 TEAC / Future Paramedic programme at Band 5. (currently on hold due to social distancing) 9. A tender process had been completed for a provider for an apprenticeship programme for paramedics, and the contract is still pending. The HCPC approval visit is arranged for June 2020, the LAS clinical education team is working on agreeing the curriculum with the chosen supplier. The target course start date is October 2020. 10. The Trust will hold primary authority for the supply of Paramedics to the 220 London Primary Care Networks. This has been built into the recruitment plans for 2020/21. 11. Ambulance services have developed (signed off at ExCo), an 18 month recruitment plan for paramedics and TEACs, which takes into account the expected requirement over the year, as well as the PCN requirement from April 2021. A number of these activities are currently on hold due to Government restrictions. 12. 20/21 UK Graduate recruitment in place - a proposal to bulk recruit 96 UK Partner Paramedic students into NQP posts sooner (July) is currently being worked through. 96 UK partner graduates will be starting on the 10 August.	1. The International recruitment campaign is ongoing via skype interviews for 2020/21. 2. ExCo led Strategic Workforce Planning Group is in place to develop and agree a three year strategic workforce plan which takes into account internal and external priorities 3. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo.

BAF Risk no. 56 The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets

Risk Classification: Human Resources	**Risk Owner:** Ali Layne-Smith	**Scrutinising Committee:** People and Culture
Date risk opened: 15/05/2019	**Date risk expected to be removed from the BAF: 30 September 2020**	
Change since last review:	COVID-19 and introduction of Government	

13. One to one retention interviews with international paramedics approaching their three year anniversary with the LAS have continued and we have agreed to fund any international paramedics who wish to apply for indefinite leave to remain. We are supporting staff to utilise the Government's automatic one year visa extension.

14. Covid bank to LAS Bank - procedure now in place to help support front-line resourcing.

15. Work is currently underway to develop an Ambulance Ops Sustainability Plan.

16. Introduced new Band 4 role (Assistant Ambulance Practitioner) New cohort will be operational in October 2020.

17. There are a number of working groups have been developed including LFB working group, non-patient facing clinicians working group and a recruitment working group, all of which are part of the clinical personnel recovery group.

Gaps in controls

International recruitment trips are currently on hold due to Government restrictions

Further Actions	Responsible Person/s	Due Date
Due to Covid-19, the roll out of these activities is delayed and there are now a number of unknowns in regards to the longer term planning. 1. Determine skill mix to support patient requirements and operational delivery within the financial budget available. 2. Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers. 3. Develop and agree Design and Operating Model for Ambulance Services. 4. Develop Trust plan for 999 and 111 integration across call handling and telephony based clinical services.	1&2 Directors - Medical, Operations, and People and Culture 3&4 Directors - Medical, Operations, and People and Culture	Ongoing March 2021
Signed: Ali Layne-Smith, Director of People and Culture		

BAF Risk no. 58 *Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients*

Risk Classification: Strategic Assets and Property	**Risk Owner:** Khadir Meer	**Scrutinising Committee:** Logistics and Infrastructure Committee
Date risk opened: 30/01/20	**Date risk expected to be removed from the BAF:** October 2020	
Change since last review:	Current risk rating increased to 16 following discussions at the Logistics and Infrastructure Committee on 14 July 2020.	

Underlying Cause/Source of Risk: There have been critical failures, each of which has seen a review and investigation and a determination around root causes. Datix risks have been raised and there is recognition that this needs to be defined on the BAF. Examples of which include: UPS, CAD hardware, and telephony infrastructure.	**Gross Rating**	**Current/Net Rating**	**Target Rating**
	16	16	4

Existing Controls	**Positive Assurance of Controls**
1. Completed a review of CAD infrastructure, vulnerabilities and weakness, Report provided to COLT and LIC and recommendations accepted 2. Report on telephony system in EOCs completed and submitted to COLT and LIC and recommendations accepted 3. Contract set up with Northrop Grumman to carry out daily checks on the CAD database put in place 4. Regular monitoring of CAD performance in place and ongoing 5. New generator provided at HQ prior to lockdown 6. ITK links established with all English Trusts and the Trust now receiving updates from all. 7. Contractor appointed to oversee UPS implementation – plan developed. 8. CAD system replicated across both sites – site switchover in the last 12 months 9. Significant internal knowledge of systems **Gaps in controls:** 1. Identified single points of failure across the 3 defined infrastructure systems. 2. Outdated systems are still being used until they can be replaced. 3. Project work is currently being undertaken to mitigate risks but has not yet been completed for all areas.	1. Regular reporting to committees, sub-committees and groups. 2. IT Delivery Board established with Terms of Reference 3. Draft roadmap developed and is being socialised with operations 4. Commissioned independent reports. 5. Routine planned maintenance. 6. Outline business cases. 7. Project boards established for replacement of critical systems 8. Capital allocation of funds for corrective actions. 9. D999 Programme Board established and overseeing key projects 10. Issues with systems discussed at all levels of the Trust

IT	**Responsible Person/s**	**Due Date**
1. There are two CAD replacement strategies in parallel: one is to replace the existing hardware in October 2020. The second is to replace the complete system, both hardware and software in April 2021 2. Avaya CM7 programme for EOCs to be restarted 3. Define and agree remediation plan for UPS. 4. Complete project review and lessons learnt for UPS programme.	1. CIO (Chief Information Officer) 2. CIO (Chief Information Officer) 3. Director of Strategic Assets and Property 4. Director of Strategic Assets and Property 5. CIO (Chief Information Officer)	31/10/2020 – 01/04/2021 01/08/2021 31/10/2020 31/08/2020 30/09/2020

BAF Risk no. 58 *Catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients*

Risk Classification: Strategic Assets and Property	**Risk Owner:** Khadir Meer	**Scrutinising Committee:** Logistics and Infrastructure Committee
Date risk opened: 30/01/20		**Date risk expected to be removed from the BAF:** October 2020
Change since last review:		Current risk rating increased to 16 following discussions at the Logistics and Infrastructure Committee on 14 July 2020.

5. Roll out and update of the CM7 Avaya telephony system (version 7) Due to go live end of August / September.	6. CIO (Chief Information Officer) 7. CIO (Chief Information Officer)	30/09/2020 31/08/2020
6. Review Avaya architecture fall back arrangements and resilience for current and proposed Avaya systems. Project ongoing with resources assigned complete for go live August/September.		
7. Review CISCO telephony platform and create a plan for transitioning from the current system. Delayed not yet started due to focus on Avaya, revised due date to be reported in August 2020.	8. CIO (Chief Information Officer)	30/07/2020
8. Planned replacement of the current CAD system (this action's due date is under discussion, but has been informally agreed to be brought forward to October 2020, pending further discussion and interdependent project deliverables).		
9. Re-platform the current CAD system (this action is under review due to the due date of the CAD replacement potentially being brought forward to October 2020).	9. CIO (Chief Information Officer) 10. CIO (Chief Information Officer)	31/10/2020 31/10/2020
10. CAD Essentials board to be restarted and control room risks will be an agenda item		31/10/2020
11. Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place	11. CIO (Chief Information Officer) 12. CIO (Chief Information Officer)	31/10/2020 31/10/2020
12. Audits of telephony system	13. CIO (Chief Information Officer)	31/10/2020
13. CAD dashboard to be implemented and reviewed at CAD essentials board	14. CIO (Chief Information Officer)	Completed
14. Cyber to be moved to ICT and a clear roadmap developed to resolve outstanding issues including patch management	15. CIO (Chief Information Officer)	31/08/2020
15. Completion of build of new hardware platform for existing CommandPoint to be completed at Crown Hosting Centres	16. CIO (Chief Information Officer) 17. CIO (Chief Information Officer)	Completed 31/07/2020
16. IT Priorities reassessed and focused on key areas		
17. IT Structure to be reviewed and areas of capacity and capability identified and corrected		

Signed: Khadir Meer, Chief Operating Officer

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director/s : Fenella Wrigley		Clinical Safety	
Risk assessment using NHS risk matrix	**Initial Rating**	**Current Rating**	**Target Rating**
	16	**8**	**8**

Strategic Risk Description:

Risk of reduced patient outcomes or experience from the COVID pandemic surge and response.

Due to demand from COVID-19, patients may have a delayed response resulting in worsening clinical outcomes or a poor patient experience, and which may affect Ambulance Quality Indicators. Managing the surge has required the use of novel internal and external pathways that require close governance to minimise any associated risks.

Key activities and actions to mitigate the risk:

- Expanded the CHUB and CAS to enable greater hear and treat (where appropriate) and maintain oversight of held calls including utilising advanced Paramedics in Urgent Care, Critical Care, MRU, CRU, CTMs and specialist clinical teams.
- Audits for new clinicians and call handlers in the IUC using accredited audit tools looking at compliance to NHS Pathways (for call handlers and NHS Pathways clinicians), clinical assessment, management and prescribing for clinicians and overall performance
- Increased senior clinical support in the CHUB and CAS – 2 navigators at 111 and APP / senior clinical support in the HUB
- Increased senior clinical support in EOC to provide guidance on cardiac arrest care and decision making
- 24-hour senior clinical on call led by Strategic Medical Advisor, and a new Senior Clinical Leadership on call rota, which included 12 hours on duty cover as part of the Trust Strategic Command when Gold was sitting.
- Working with pan-London, Clinical Networks to provide updated patient pathways in real time, and communicating those to changes to the Operations Directorate.
- Clinical guidance to provide support to crews in decision making taking into account the ambulance service environment.; All clinical guidance was disseminated on multi-media platforms, to ensure wide and timely distribution to frontline staff.
- Working with NHSE London and HLP to rationalise and agree patient pathways
- Direct support to crews who have been in contact with a confirmed COVID-19 patient through the welfare team, with input from the Head of Health Strategy, Policy and Operational Improvement.
- Robust and dynamic review of PHE guidance by the Head of Infection Prevention Control to ensure our staff, and in turn patients, were protected as much as possible through updated PPE guidance.
- Peer review of processes through NASMED and the NHSE Clinical Advisory Groups, both at regional and director level of all clinical decision making.
- A Critical Care Transfer service, to provide an essential service for patients requiring advanced clinical assistance whilst being transported to Nightingale Hospital, without impacting on the 999 emergency calls,
- Recontact audits to review any patients who made a second contact with the LAS 999 service within 24 hours of being discharged on scene after assessment and where, on second contact, their condition had deteriorated significantly (ie requires pre-alert to ED or had died)
- Serious incident panel met weekly throughout to review any incidents raised via internal systems, quality alerts or via the patient experiences team
- Review of patients where there was a delay to answer the 999 call or respond and where this delay may have impacted on their outcomes

COVID-19 Sub-category Strategic Risk Assessments

CAVEAT: The Board recognises that due to the overwhelming nature of the pandemic on London healthcare, suboptimal outcomes must be considered in the context of the whole response and the provision of high quality care to the largest number of patients possible.

Risk Score reviewed 29 June 2020 and reduced from a current score of 12 to 8, due to the Trust not being under the operational and therefore clinical pressure we have been and we have sustained our service delivery for a month meeting national performance targets

COVID-19 - Sub-category Strategic Risk Assessments

Responsible Director: Lorraine Bewes		Financial	
Risk assessment using NHS risk matrix	**Initial Rating**	**Current Rating**	**Target Rating**
	20	**16**	**8**

Strategic Risk Description:

In light of the announcement that the interim financial framework is extended to August and likely September due to the impact of Covid-19, there is a risk to the delivery of business plan objectives in 20/21 due to the lack of an agreed funding envelope on which to approve a budget for the full year.

Underlying Cause

The Trust had approved a financial plan for 20/21 before the Covid pandemic but had not reached agreement with commissioners for the required funding to deliver business plan objectives at the time that contracts and CIPs were suspended. The Covid response has required a significant uplift in expenditure which is currently funded to break even through a combination of a BAU allocation based on 19/20 winter run rate and retrospective top up to cover Covid claims and other exceptional items. There is a risk of a funding gap when new funding arrangements are put in place after September.

1. Fails to capture the material financial impacts of COVID 19 Cannot recover the full income required for COVID 19 from NHS England/Improvement.

   Actions taken:
   - The Trust has established a COVID 19 Resource Tracking template to be completed for all COVID 19 related resource requests, these are all approved by Trust Gold and reported to Exco and FIC on a regular basis.
   - The Trust continues to fully document all COVID 19 related expenditure to ensure it will with stand the scrutiny of both internal audit and parliament.
   - An inventory management system has been procured and implemented in Deptford for COVID 19 related stock management.
   - Budget based on approved financial plan (less CIP) has been issued to Directorates and is being monitored with focus on Covid spend to determine ongoing run rate and bear down on any unnecessary spend.

2. Is unsuccessful in securing sufficient income to cover its underlying cost base from Commissioners as it exits the COVID 19 response following suspension of contracting arrangements i.e. impact of Agenda for Change on Ambulance services, changes in operating model costs and stranded costs post COVID 19 (decommissioning Nightingale ambulance station etc) funding from month 5 onwards remains a risk.

   Actions taken
   - In year monthly financial reporting and forecasting continues to provide assurance on underlying financial position of the Trust and to ensure all material COVID 19 expenditure has been captured
   - The Trust is completing a 2020/21 top up submission to NHS London Region to ensure that cash flow is maintained throughout the COVID 19 for known omissions from the COVID Baseline allocation i.e. Agenda for Change.
   - Comprehensive resource model developed which links workforce, frontline fleet capacity, finance, and demand to forecast ability to deliver national response performance standards.
   - The Trust has started to plan for Post COVID 19 led by the CFO, COO and Director of Strategy and Transformation to agree the optimal operating model including resources and estates requirements, identify and retain efficiencies and operating opportunities across all areas of operations.

- Operational sustainability plans in place with clear resource and capacity assumptions linked to demand modelling.
- Early engagement with NWL ICS AO and CFO has led to agreed process and introduction of independent ambulance expert to support agreement of revenue funding in the short term

3. Is unable to identify and sustain cost efficiencies from opportunities post Covid-19

Actions taken
- We are now working in partnership with the NW partnership to agree income for 20/21 income.
- Sir Antony Marsh, National Strategic Advisor to be commissioned to undertake a benchmarking review to provide independent assurance to the system to support funding settlement for 20/21 and beyond.

4. Is unable to identify and sustain innovation and improvements during and post Covid-19 i.e. CAD replacement/EPCR implementation.

Actions taken
- Secured capital of £44M to support the capital programme for transformation requirements in 20/21.

5. Experiences an increase in loss of assets due to fraud and theft (tracking and receipting of goods to be enhanced)

Actions taken
- Case for urgent Covid funding includes investment in asset tracking of key equipment and kit required for ambulances to be functional across the whole organisation and deployment points to track and manage inventory and reduce the risk of fraud.
- The Trust is maintaining its existing control environment across segregation of duties, adherence to SFIs, Scheme of Delegation and procurement controls.

Additional action against mitigation of risks 1-5
- We have expanded senior Finance capacity: CFO full time with further proposal to increase senior finance establishment.
- Present revenue bridge for ICS CFO agreement
- Review of monthly Covid spend by Directorate
- Development of downside mitigation plan
- Development of a BAU and transformation efficiencies plan

Assurance of controls
- Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn.
- Bi-monthly Integrated Performance Reports to the Trust Board
- Daily Senior Leadership Team priority theme for July is Budget resilience

Risk reviewed 21 July 2020 by FIC – rating remains unchanged

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Khadir Meer		Operational	
Risk assessment using NHS risk matrix	**Initial Rating**	**Current Rating**	**Target Rating**
	20	12	8

Operational Risk Description:

As a result of the Covid-19 pandemic, all operational areas in LAS suffered from reduced ability to deliver timely responses to the 999 / 111 / IUC demand. In addition to failing to deliver service, there are risks of gaps in IM&T response to the changing situation, supply chain gaps, business continuity, and emergency preparedness. The three main strategic risk components are: risk of reduced infrastructure availability to support demand; reduced staffing capacity to respond to demand and reduced responsiveness in with a view of circumstances change. The current concern is focused on the need to potentially responde to an additional peak combined with the usual winter pressures.

The three main strategic aims that the activities listed below cover:

- Increased capacity and capabilities in terms of infrastructure

- Increased staffing across different LAS services

- Increased process responsiveness to changes in situation (both internally and through collaboration with system partners). This includes operational side focus to recover activities during times of reduced Covid-19 impact and then returning to a full capacity operation as well as a pattern of recurring peaks in demand that is forecasted.

Key activities and actions to mitigate risk:

- COLT has been set up to support information sharing, enable a resilient response to the situation and robust decision making. This is being converted into a BAU daily Exec-led group
- Priorities in development that will drive the Exec group focus over the next 9-12 months.
- Sustainability plans developed to cover operational response in the next 18 months.
- Review of the current recruitment position across the Trust to ensure we are able resiliently respond to additional peaks combined with winter pressures.
- The Trust has set up a Strategic Incident Room (COVID 19 cell) to plan and monitor impacts of COVID 19 on the Trust in alignment with the Pan London Strategic Coordination Group and planning assumptions for London.which was then stood down with the reduction of demand, however there are plans to reinstate it as required.
-
- Write a detailed plan of operational and clinical response based on different levels of expected impact on the service.
- Operational recovery planning is taking placeongoing to shape the response for decreasing pressure, in view of the forecast. Some of the actions are to be implemented at the end of the incident and some after LAS is after the peak.
- Close Rreview of performance and the impact of the various actions undertaken through a response for Covid-19 had. This will be used to inform the plans for operational response to additional peaks of Covid-19 demand.
- Ongoing review of specifically Covid-19 related risks and response to those.
- Oversight of CAD stability:
  - ✓ CAD Essentials board to be restarted and control room risks will be an agenda item
  - ✓ Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place
  - ✓ Audits of telephony system

> ✓ CAD dashboard to be implemented and reviewed at CAD essentials board

- IM&T to respond to Trust requirements where a change in practice is requiring a technological change, as part of this increasing the availability of remote working via TEAMS.
- IM&T to provide assurance that bandwidth capacity is available to enable higher numbers of staff to work remotely.
- The Trust has ~~rolling out~~rolled out a staffing plan to deploy non-standard ambulance to simplify scheduling and increase oversight of delivery levels.
- The Trust conducted its assessment of the risks faced by the Trust in the event of a <u>worst case</u> sickness levels across LAS and the wider system, in line with the framework mandated by the Department of Health and Social Care. This risk assessment has now been published, available for the public.
- Expansion of the DCA fleet to maximise the vehicle availability to respond to increasing demand.
- Incorporated a wide range of volunteers into the 999 and 111 services to support continued service delivery.
- Expansion of 999 control room capabilities and capacity to respond to calls.
- Separated out the Covid-19 calls from 999 and 111 to allow a specialised response.
- Fuel stocks confirmed which address the civil contingency act requirement to supply 24 days' supply. And a fuel monitoring system is installed and working to protect fuel stocks. This is
- The trust rolled out a plan for distribution and testing of FFP3 masks as well as plans for acquiring further supply, with systems in place to source additional PPE as required to respond to changing demand
- Engagement with CCG's NHSE&I, PHE and all system partners throughout the planning, preparedness, response and recovery to maintain confidence across the system of robust arrangements within the London Ambulance Service.
- Continue adapting the plan clinically and operationally as the situation develops.
- To seek assurance from third party suppliers to the Trust that they have a robust Business Continuity Plan to provide supplies to the Trust.
- With the focus of the organisation on COVID 19 and the potential staffing impacts of this, other business has been assessed for its viability during this period.

Risk rating reviewed 29 June 2020 and remains a major impact x possible likelihood = 12

COVID-19 Strategic Risk Assessments

Responsible Director : Ali Layne-Smith		People and Culture	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	12	8

1. **Not enough staff to meet increased service demand due to incrementally increased staff COVID related sickness and self-isolation absence.**
   Key activities and actions to mitigate risks:

   - Departmental business continuity plans created to map provision of business critical activities at 25 / 30 / 50 / 50% + sickness absence
   - Daily sickness absence monitoring and reporting of COVID / non-COVID sickness absence to allow for trend analysis once sufficient data is available. Resourcing plans then adjusted in anticipation of trend
   - Early access to national testing programme to enable staff to return sooner if self-isolating and have a negative result
   - Contact tracing arrangements in place for crew members and co-workers
   - Rapid recruitment of additional volunteers and Bank staff to provide backfill in operational frontline areas to offset workforce resourcing gaps as a result of increased sickness absence, and increased call and ambulance demand.
   - Covid bank to LAS Bank - procedure now in place to help support front-line resourcing. Work is currently underway to develop an Ambulance Ops Sustainability Plan.

2. **Limited welfare and wellbeing support to meet staff's physical, emotional and mental wellbeing requirements.**
   Key activities and actions to mitigate risks:

   - Appointment of dedicated COVID Wellbeing lead with remit for creating the Trust's COVID staff wellbeing delivery plan and working with internal and external partners to deliver the plan
   - Prioritisation of additional mental health support across the Trust – publicise and bolster existing services, identify and rapidly introduce new internal and external support routes
   - Provision of clinical advice to line managers and staff relating to self-isolation and testing
   - Provision of food for staff self-isolating, unwell or unable to access refreshments on shift
   - Provision of accommodation of staff who have vulnerable relatives at home, or need to self-isolate away from home.
   - Increase availability of staff and partners with mental health and psychology backgrounds to our staff at group stations, call centres and office locations

3. **Possible safety and reputational risk through the rapid recruitment of significant additional staff and volunteers to be deployed to frontline and support areas.**
   Key activities and actions to mitigate risks:

   - Utilise national "fast track" arrangements put in place for the NHS with agencies such as DBS, UK Visa,
   - Utilise existing services such as NHS Passport to verify employment history, statutory and mandatory training, qualifications and registration or existing and returning NHS staff members
   - Expand existing Bank arrangements to hire staff and reduced risk of co-employment exposure
   - Require departmental risk assessments that confirm supervisory requirements, limited access to restricted areas
   - Establish and accelerated Occupational Health declaration process for new staff and volunteers

- Incorporate requirements for 3rd party resource providers to verify and guarantee staff have the correct authorisation to work, qualifications, registrations, DBS etc.

4. **Impact on BAU Recruitment especially the Australian Paramedic programme**
   Key activities and actions to mitigate risks:

- Departments encouraged to review all current and planned recruitment at the beginning of the COVID period and decisions made to pause, delay or stop recruitment
- BAU recruitment resource redirected to focus on priority recruitment areas such as call handlers, blue-light drivers, C1 licence holders through the dedicated "Personnel hub".
- Australian recruitment programme regularly reviewed and approach updated as necessary. Current status – planning to continue on a Skype basis as international travel to conduct interviews is not possible. This will require training of non-operational staff to conduct interviews.
- 12 to 18 month Workforce plan created incorporating additional skills types and volunteers that will enable surge capability as required.
- One to one retention interviews with international paramedics approaching their three year anniversary with the LAS have continued and we have agreed to fund any international paramedics who wish to apply for indefinite leave to remain. We are supporting staff to utilise the Government's automatic one year visa extension.

5. **Ensure new and redeployed staff receive the training and equipment they require to fulfil new and existing roles safely**
   Key activities and actions to mitigate risks:

- Bespoke training programmes created to equip staff to carry out new roles safely e.g. EOC support call handler
- Buddying and supervisory shifts implemented before new starters work in "live" environment
- Induction days for specific role types e.g. London Fire Brigade vehicle orientation
- Home working Health & Safety guidance provided for those now working from home for the first time
- Additional IT resources provided – laptops, heads sets, MSTeams roll out

6. **Governance risk**
   Key activities and actions to mitigate risks:

- Utilise Joint Decision Making (JDM) / Decision Log protocols to capture decisions made / authorisation levels etc. during the COVID period
- Regular contact with EPRR teams to seek advice on the above
- Membership of regional and national network bodies (e.g. Ambulance HRD forum) to share knowledge and build consistency where possible in relation to temporary changes to terms and conditions, and ways of working
- Extraordinary staffside / management consultation arrangements in place
- People & Culture Committee short form process established
- Membership of COVID Operational Leadership Team (COLT), represented at GOLD meetings and calls, daily submission of metrics and reports with regards to P&C elements e.g. sickness absence, accommodation required, and staffing

7. **Future impact on our culture of actions taken and behaviours adopted through COVID period.**
   Key activities and actions to mitigate risks:

- Conduct organisational "temperature check" of impact of COVID on our cultural aspirations, values and behaviours to inform identification of a strategic partner to work with LAS to achieve our aim of becoming a "World class Ambulance Service for a World Class City".

- Continuing FTSU arrangements in place
- Regular contact between P&C HR Managers, HR BPs, line managers and staff side to ensure issues captured and addressed quickly and fairly as most hearings and investigations are paused
- Resolution framework recommended for adoption to provide swift resolution of staff issues supported by external mediation resource. Staffside agreement required
- NB: National reporting for Gender Pay Gap and WRES on hold.
- Solution required to ensure monitoring and visibility of staff issues and concerns is in place.

Risk reviewed on 22 July 2020 – risk rating remains the same

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: Trisha Bain		Quality	
Risk assessment using NHS risk matrix	**Initial Rating**	**Current Rating**	**Target Rating**
	20	**3x3= 9**	**2x3= 6**

Key activities and actions to mitigate risk: UPDATED 29TH JUNE 2020

- Populate excel (short –term) decision log with decisions made in the Strategic Incident Room and perform risks assessments. COVID19 risk register developed
- Produce weekly flash scorecards for monitoring by Extended Leadership Group that reflect any new risks that have been raised.
- Review all assurance quality and risk processes to ensure they remain at minimum value level.
- Produce weekly quality report
- Develop and implement real-time web based tool for all 'hubs' and directorates.

Updated position from 1st June
- All compliance and standards audits have been re-established. Quality assurance programme re-commenced for all sectors/services to identify any gaps in controls and immediate actions taken.
- COVID19 Review for patient harm has been completed and learning will be taken forward.
- All risks captured and be monitored via BAU e.g. RCAG and Board.
- Demand has reduced significantly, number of incidents back to expected position and continue to be monitored via daily safety hub and SIG.
- Plans for managing a potential second peak have been developed therefore an increase SI position is not expected.

Controls to mitigate risk:

- Patient Safety and Risk Hub established to collate all incidents, risks, complaints, and other quality data.
- Daily safety and risk hub report
- COVID19 risk register (inc EPPR risk register)
- Minutes of direct reports meetings
- Daily monitoring of Datix (COVID19 and non-COVID19) by corporate teams and weekly gathering of soft intelligence via QGAMs
- Daily report to all senior managers on themes and actions
- Weekly quality directorate call held to collate issues/escalations
- Daily direct reports to escalate any issues
- SIG monitoring and reporting all Serious incidents – COVID19 and non-COVID19 related – monthly end to end review of patient pathway incidents (IUC and Emergency pathways)
- Worked with CQC and NHSI and agreed SI process whilst recognising the scale of investigations required to meet LfD regulatory requirements
- Real-time web based decision tool (In-Phase) developed/staff trained from all areas to collate all decisions ensure risk/QIA assessed, identification of policies/SOPs, clinical sign off – automated link to risk register.
- All quality assurance systems assessed to maintain oversight whilst reducing pressure on operational staff – i.e. audits , serious incidents
- Working with national leads for safeguarding, coroners to maintain oversight whilst reducing operational pressures.

COVID-19 Sub-category Strategic Risk Assessments

- **Risk Score reviewed 29 June 2020 with current score reduced from a major impact and likelihood of possible (12) to a moderate impact and a possible likelihood (9) due to the measures that have been put in place**

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Corporate Risk Register
Agenda item:	11.2
Report Author(s):	Lisa Gibb, Risk Manager
Presented by:	Trisha Bain, Chief Quality Officer
History:	N/A
Purpose:	☐ Assurance ☒ Approval ☒ Discussion ☐ Noting

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

Corporate (Trust Wide) Risks rated 15 and above were considered by the Risk Compliance and Assurance Group (RCAG) on 9th July 2020.

- Risk ID 844 - There is a risk of project slippage due to an undefined technical solution (Kit prep / Wifi) for medicines packing and management at Logistics Support Unit Deptford. This may lead to the maintenance of paper based systems and poor data collection if not properly managed.
  The Group was updated that IM&T had completed the Wifi upgrade and provided iPads with Ethernet connectors to connect to the wired network.

- Risk ID 872 - There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM.
  The Group were updated that the immunisation programme was presented and approved at the People and Culture Committee.

- Risk ID 910 There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.
  This risk is due for review again in October 2020.

- Risk ID 945 - There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of

expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.

The Group were updated that there will be a new project to either implement Kitprep 2 or another solution. The group discussed the ownership of the risk and this will reviewed at the next meeting.

- Risk ID 967 - There is a risk that patient experience will be adversely impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times for category 2/3 calls.

  There was no representative at the meeting from People and Culture and no update was provided for this risk.

- Risk ID 973 - There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety patients, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.

  The Group were updated that the mystery shopper audits were in progress and all security incidents are reviewed regularly. The digital vehicle project had approval from the Programme Management Board to restart.

- Risk ID 1032 - For the last two financial years (18/19 and 19/20), no funds were made available to replace EOL hardware. It is now imperative that we immediately replace the system server hardware platforms on which essential LAS services run (Ambulance station servers, webmail, email, file shares, SQL and DMZ) etc. The existing hardware is no longer supported by dell because the hardware is now more than 7 years in production (obsolete). This is also required to provide storage requirement not only for essential services and also for CAD ancillary services such as hospital handover, CAD link, Diba etc.

  The Group were informed that capital funding had been allocated to a number of projects which will address this risk.

- Risk ID 1050 – There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the new response bags due to packing errors by VP or being diverted by staff which could lead to failure or delay in patient care. The Group were updated that a meeting would be held between all key stakeholders to devise an agile approach to resolving. The issue had been escalated to the Daily Senior Leadership Team Meeting for action.

- Risk ID 1112 There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.

  The Group were informed that when 999 upgraded to CM7 a workaround was put in place to delay the system logging an operator back in. Investigations are underway to see whether this workaround can be applied to IUC.

Recommendation(s) / Decisions for the Board / Committee:

The Board is asked to discuss and approve the Corporate (Trust Wide) Risk Register.

Routing of Paper – Impacts of recommendation considered and reviewed by:

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes	X	No		Chief Quality Officer RCAG
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

ID	Sector / Department	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)	Progress Notes:
844	Fleet and Logistics	There is a risk of project slippage due to an undefined technical solution (Kit prep / Wifi) for medicines packing and management at Logistics Support Unit Deptford. This may lead to the maintenance of paper based systems and poor data collection 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.	Justin Wand	09/07/2020	16	High	BT and two IM&T engineers provide status reports into the ongoing problem with suggested solutions.	8	Significant	09/07/20 Reviewed at RCAG. IM&T upgrade to Wifi is complete, iPads have been provided with Ethernet connectors to connect to the wired network.
872	HR / Workforce	There is a risk that the health and well-being of our staff may be compromised through the failure of our occupational health provider to ensure that all staff have appropriate immunisations due to lack of accurate staff records and lack of nursing resource from PAM to carry out immunisations which could lead to staff being exposed to infection or staff declining to attend jobs where there is risk of infection which could impact on performance.	10/12/2018	12	Significant	1. PAM monthly performance review meetings with Account Manager (LAS representatives, Nicola Bullen and Julia Crossey, Sharon Edgell, H&S) 2. KPI Dashboard provided by PAM, monthly 3. Monthly CEO Performance meetings including progress update and on Imms progress 4. Formal letter to PAM setting out concerns of performance against contract 5. Monthly immunisation report provided by PAM to track progress 6. As needed meetings with recruitment as the major user of OH service	Ali Layne-Smith	09/07/2020	16	High	1. Ongoing engagement direct with employees via various channels to get direct feedback on service (Nicola Bullen) 2. PAM survey of customer experience (PAM Account Manager). To be included in contract meeting 3. Follow up meeting with PAM Managing Director and Account Manager (December 2018) 4. PAM nurse to provide update on outstanding imms 5. Active management of OH issues escalated and future action identified to clarify and resolve	8	Significant	09/07/20 Reviewed at RCAG. Immunisation programme was approved at People and Culture Committee.
910	Finance	There is a risk that the normal business continuity arrangements followed by the Trust will need to be enhanced in the event of a no deal departure from the EU due to the unknown nature and extent of the potential disruption to business.	12/03/2019	16	High	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 31 October 2019, in line with the framework mandated by the Department of Health and Social Care. 2. The Trust's standing orders allow for urgent decisions to be taken when necessary. 3. The Trust has business continuity plans in place which are being tested in the context of hypothetical EU exit scenarios. 4. 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. 5. Fuel stocks confirmed which address the civil contingency act requirement to supply 20 days' supply. 6. A fuel monitoring system is installed and working to protect fuel stocks. 7. Fuel management plan in place- (continuity) aligned to the national arrangement for fuel distribution co-ordinated by NARU – NACC 8. Local business continuity plans reviewed and updated to ensure EU response ready. 9. Annual leave for Directors and direct reports is now available through GRS, providing visibility of senior staff availability.	Khadir Meer	22/04/2020	16	High	Exit from the EU to be a standing item on the Executive Committee agenda going forward. 2. 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. 3. 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. 4. 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. 5. 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. Internal audit review noted significant areas of assurance from the	8	Significant	22/04/20 Reviewed at Virtual RCAG. The EU Exit meeting has been stood down and will be subject to review again in October.
945	Medical Directorate	There is a risk to the integrity of the data being produced by Kitprep due to the system not working as expected which leads to inaccuracy in the Perfect Ward audit tool of expiry dates of drug packs and discrepancies when reconciling the number of drug packs with the system.	14/06/2019	15	High	Daily drug audit (Perfect Ward) Manual updates to system to rectify errors (incident reports submitted for all discrepancies and flagged to IM&T)	James Brade	09/07/2020	15	High	Discussed at medicines management group bimonthly and included in the MSO report Reported at performance review	6	Moderate	09/07/20 Reviewed at RCAG. There will be a new project to implement Kitprep 2 although LAS may go ahead with a different solution to ensure issues with Kitprep 1 are resolved by the application capability.
967	Organisational Development	There is a risk that patient experience will be adversely impacted at specific times of the week as a result of the lack of flexibility within the current Annual Leave agreement in place within operations resulting in a significant drop in the number of available staff and longer patient waiting times for category 2/3 calls.	30/07/2019	20	High	Use of supplementary roster to aim to provide additional staffing Use of overtime OPC rostering with high focus on weekend provision PAS/VAS commission	Ali Layne-Smith	09/07/2020	16	High	Performance data	8	Significant	09/07/20 Reviewed at RCAG. No further update provided.
973	Estates	There is a risk that ambulance premises, operational ambulance fleet HQ, vehicle security and other LAS assets may be accessed by unauthorised persons because of inadequate physical security arrangements, which may lead to damage and/or loss of assets which are critical for the delivery of the care and patient safety, unplanned financial costs for the repair/replacement and damage the reputation of the Trust if not properly managed.	02/09/2019	15	High	1.Security Management Policy implemented. 2.Organisational procedure on station duties in place and communicated to staff. 3.Incident reporting system in place to enable the prompt reporting, investigation and management of incidents. 4.Security surveys being carried out on vulnerable sites. 5.Support available from the Metropolitan Police where acts of theft, damage, vandalism are reported. 6.Security awareness training incorporated into H&S training delivered across the Trust. 7.Engagement of security guards at sites where delays in garage door/shutter repairs are outstanding	Justin Wand	09/07/2020	15	High	1. Incidents reported on Datix. 2. Monitoring of Incident reports by Corporate Health & Safety Committee. 3. Regular review of incidents by Trust LSMS.	4	Moderate	09/07/20 Reviewed at RCAG. Mystery shopper audits are currently underway and the report is due in a few weeks. Ops and Compliance review all security reports on Datix along with the H&S team. PMB have agreed that the digital vehicle project can restart post COVID.

ID	Area	Risk Description	Date Raised	Score	Rating	Controls	Owner	Review Date	Score	Rating	Assurance	Target Score	Target Rating	Update
1032	Information Management & Technology (IM&T)	For the last two financial years (18/19 and 19/20), no funds were made available to replace EOL hardware. It is now imperative that we immediately replace the system server hardware platforms on which essential LAS services run (Ambulance station servers, webmail, email, file shares, SQL and DMZ) etc. The existing hardware is no longer supported by dell because the hardware is now more than 7 years in production (obsolete). This is also required to provide storage requirement not only for essential services and also for CAD ancillary services such as hospital handover, CAD link, Diba etc.	27/01/2020	16	High	A replication infrastructure is in place at the secondary site however some of the hardware are EOL as well.	James Brade	09/07/2020	16	High	No assurance can be given due to no funds were made available for two consecutive finance years	8	Significant	09/07/20 Reviewed at RCAG. Capital funding has been allocated but awaiting implementation dates for a number of projects to address this risk.
1050	Fleet and Logistics	There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the new response bags due to packing errors by VP or being diverted by staff which could lead to failure or delay in patient care.	12/03/2020	16	High	Staff should check bag at start of each shift. VP are replacing all missing pieces of equipment and will place a note in the bag if any supply chain issues.	Justin Wand	09/07/2020	16	High	QA checks on completion of packing and at VP hubs on delivery by LGMs, quartermasters and project team. Staff sign the tag on each sealed bag to state who has packed bag for audit trail. Project group are receiving data regarding incidents.	4	Moderate	09/07/20 Reviewed at RCAG. Meeting to be held between all stakeholders including clinical and ops to take forward a project using Agile approach.
1112	NHS111	There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.	05/06/2020	16	High	On a daily basis all unmanned phones are checked once per shift to ensure they are logged off. Incidents are raised if an unmanned phone is left logged in and staff member notified. All patients whose calls have been missed and not noted to have recontacted the service will be called back	Jon Goldie	09/07/2020	16	High	Incidents are raised on Datix to document when phones are left unmanned but logged in. All patients whose calls have been missed and not noted to have recontacted the service will be called back	4	Moderate	09/07/20 Reviewed at RCAG. It was noted that when 999 went live with CM7 a workaround was put in place to delay the log back in whereas in IUC the system automatically logs the person back in. Investigation underway to test whether 999 workaround can be used in IUC.

Report to:	Trust Board
Date of meeting:	28 July 2020
Report title:	Annual Safeguarding Report
Agenda item:	Report for Information
Report Author(s):	Alan Taylor, Head of Safeguarding
Presented by:	Trisha Bain, Chief Quality Officer
History:	Quality Oversight Group Quality Assurance Committee 7 July 2020
Purpose:	☒ Assurance ☐ Approval ☐ Discussion ☒ Noting

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

In 2019 2020 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and "adults at risk" remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times

The Safeguarding Team has expanded this year and have worked hard to support staff, monitor and review safeguarding practice and raise the standard of safeguarding training. This in turn has enabled us to increase the profile of safeguarding and the team both internally and externally during 2019 20

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the structure and assurance measures within the Trust to ensure compliance with the Care Quality Commission Key Lines of Enquiry, the Children Act 1989/2004, the Care Act 2014 and the NHS contract requirements.

During 2019/20 the document highlights that:

- 2019-20 saw a range of Safeguarding improvement
- Safeguarding Training targets were met
- LAS was the first ambulance Trust to Introduce Contextual Safeguarding referrals
- Increased safeguarding team and delivered training via specialists
- "Twiddlemitts" provided on ambulances to improve support to dementia patients
- Introduce safeguarding star and certificate awards

Further to this the document outlines the top priorities for 2020/21.

Recommendation(s) / Decisions for the Board / Committee:

Following review and approval by the Quality Assurance Committee the Trust board are asked to note the content of the report.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes	x	No		Chief Quality Officer Quality Assurance Committee
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes	x	No		Chief Medical Officer Quality Assurance Committee
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Governance	Yes		No		

Safeguarding Annual Report 2019 – 2020

Introduction

In 2019/2020 the London Ambulance Service NHS Trust (LAS) has continued to ensure the safeguarding of children and "adults at risk" remains a focal point within the organisation and the Trust is committed to ensuring all persons within London are protected at all times.

The Safeguarding Team has expanded this year and have worked hard to support staff, monitor and review safeguarding practice and raise the standard of safeguarding training. This in turn has enabled us to increase the profile of safeguarding and the team both internally and externally during 2019/20.

With Safeguarding Leads and teams for both Children and Adults there is a much greater focus on both and we have seen improvements across safeguarding throughout the year.

The Trust serves a population of 8.78 million, covering 607 square miles and is made up of 32 boroughs. The Trust responds to over 5000, 999 calls every day and in 2019/20 we raised safeguarding concerns for an average of 2.0% of incidents received. The Trusts 111/ Integrated Urgent Care services in SE and NE London also raised safeguarding referrals and concerns via the Trusts reporting process.

This report provides evidence of the Trusts commitment to effective safeguarding processes and procedures. The report details the structure and assurance measures within the Trust to ensure compliance with the Care Quality Commission Key Lines of Enquiry, the Children Act 1989/2004, the Care Act 2014 and the NHS contract requirements.

The Trust has 64 Safeguarding Boards it engages with. Whilst it is not possible for the Trust to attend all Boards we do support local Strategy and Joint Agency Review meetings and provide information to support the work of the Boards. The Trust has Brent Children and Adult Boards as its lead safeguarding Board. Scrutiny of the Trusts practice is assured through Brent. Reports and audits provided for Brent are also available to other boards across London.

With Covid-19 happening at the end of this financial year this report may not contain the depth of information we would usually provide as we are still in the response mode and resources are actively working on the Covid-19 response.

The Trust would like to thank all staff who have played a part in protecting child and adults a risk throughout the year.

LAS Safeguarding Achievements 2019/20

Published quarterly safeguarding newsletters	Use of alternative pathways for Hoarding with LFB, DA with Women's Aid and Youth Violence	Developed Safeguarding Star badge and certificate to recognise good and outstanding safeguarding practice
All clinical staff being trained to Level 3 Safeguarding	Improved Partnership working and engagement	Introduced Twiddle Mitts onto all ambulances to support dementia patients
Split welfare/care concerns and safeguarding processes	Safeguarding Specialist for each operational area including IUC/ EOC	>90% safeguarding training compliance. Level 2 & 3 face to face
First Ambulance Trust to introduce contextual safeguarding pilot	Maintained safeguarding focus and practice during Covid - 19	Moved safeguarding training to be delivered by specialists

Senior Safeguarding Structure

Dr. Trisha Bain

The Executive Director Lead for Safeguarding

Dr. Bain ensures that safeguarding is positioned in core business in strategic and operational plans. Trisha oversees, implements and monitors the ongoing assurance of safeguarding in the trust.

This ensures the adoption, implementation and auditing of policy and strategy in relation to safeguarding.

Dr. Mark Spencer

The Non-Executive Director (NED) for Quality Inc. Safeguarding

Dr. Spencer chairs the Quality Assurance Group (QAG)

Alan Taylor

Head of Safeguarding and Prevent

Alan is responsible for ensuring that the trust is compliant with legislation and practices in relation to safeguarding and setting strategic objectives for the Trust.

Alan ensure that the Trust acts to safeguard children, young people and adults at risk.

Safeguarding Team Structure

LAS SAFEGUARDING TEAM STRUCTURE 2020

Alan Taylor — Head of Safeguarding and Prevent

Hannah Whittington — Adult Safeguarding and MCA Lead

June Freed — Child Safeguarding and Child Death Lead

Julie Carpenter — Adult Specialist — SE Sector, LeDer, IRO, NET's

Ben Wayland — Adult Specialist — NE Sector, CRU, MRU

Yvonne Wright — Adult/Child Specialist — SW Sector, IUC NEL/SEL

Gemma Taylor — Child Specialist — NC Sector, EOC

Natalia Croney — Child Specialist — NW Sector, HART, EEPR, VR

Vacant Post — Safeguarding Governance and Training Support

Dawn Mountier — Safeguarding Officer

Jason Jackman — Safeguarding Training Administrator

Elizabeth Ogundipe — Safeguarding Data Coordinator & Administrator

Safeguarding Team cont.

The Safeguarding Team are responsible for all the Trust safeguarding processes and functions, providing expert, evidence based clinical leadership on all aspects of the safeguarding agenda. The team has a responsibility for ensuring the development and implementation of systems and processes across all areas of the Trust, working with partner agencies in line with local and national standards and legislation and delivering safeguarding training and education and raising the standard of safeguarding concerns/referrals.

The team ensures the implementation of appropriate CQC core standards and other relevant external targets including standards contributing to national and local inspections and assessments of safeguarding arrangements.

The team provides information and support to partner agencies for example in undertaking safeguarding investigations, Serious Case Reviews (SCR) now known as Local Child Safeguarding Practice Reviews (LCSPR), Safeguarding Adult Reviews (SAR), Care Proceedings, Child Death Overview Panels (CDOP's), Section 42 enquiries, Domestic Homicide Reviews(DHR), Multi –Agency Safeguarding Hub enquiries (MASH) and Multi-Agency Risk Assessment Conference's (MARAC).

The team supported by local Managers, work with the Local Safeguarding Children Boards (LSCB) and Adult Safeguarding Boards (LSAB) ensuring attendance at safeguarding review meetings.

The Emergency Bed Service (EBS) managed by Alan Hay, processes all safeguarding concerns from staff and sends to the relevant local authority or partners. They have a close working relationship with the Safeguarding Team

The Trust recruited 6 more staff into the Safeguarding Team this year to strengthen the resource requirements with the introduction of the intercollegiate documents on "Roles and Responsibilities of Health Care Staff" and the requirement to train all registered professionals to level 3 and provide safeguarding supervision across the Trust.

Trust Safeguarding Responsibilities

'All staff have a responsibility to protect children and adults at risk from harm and report safeguarding concern's either in relation to the public or a member of staff'

Safeguarding requires a whole trust approach and in addition to the responsibilities of the executive team, the Head of Safeguarding and the Safeguarding Team, we are reliant on EBS, local managers and staff to implement safeguarding practice.

Emergency Bed Service (EBS)

- Manage timely referral to Social Services (LA) via MASH (Multi Agency Safeguarding Hub) or Front Door.
- Collates information on referrals
- Provide a focal point for staff safeguarding questions 24/7
- Receives feedback from the LA for referrals which is recorded on Datix and fed back to staff.

Local Managers

- Support staff with safeguarding concerns, audit compliance of Clinical Performance Indicators and feedback to staff.
- Provide attendance at Joint Agency Review meetings, and support staff with safeguarding allegations which are referred to the Head of Safeguarding and Chief Quality Officer.

Safeguarding Governance Arrangements

The Trust has a Safeguarding Assurance Group (SAG) that meets Quarterly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice.

SAG reports to the Quality Oversight Group (QOG) bi-monthly providing assurance and raising issues for escalation to the Quality Assurance Committee (QAC). This is the Trust assurance committee that feeds into the Trust Board. QAC is chaired by a non-executive director Mark Spencer.

Safeguarding reports to commissioners via the Brent CCG Designated Nurse/professionals and the Clinical Quality Review Group.

These reports contain safeguarding assurance for all areas of the Trust including Integrated Urgent Care in NE and SE.

Members of the safeguarding team attend the following committees; Serious Incident Group, Serious Incident Learning and Review Group, Patient & Clinical Effectiveness Group, Patient Safety & Effectiveness Group and Quality Oversight Group. The Safeguarding Specialists are members of their local area governance meetings.

SAG → **QOG** → **QAG** → **TRUST BOARD**
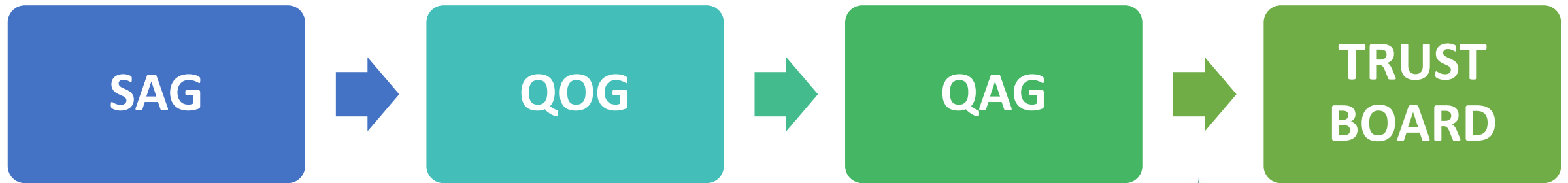
Safeguarding Governance Arrangements

POLICIES

- Safeguarding Children Policy TP018
- Review due **Oct 22**
- Safeguarding "Adults at Risk" Policy TP019
- Review due **May 20**
  - Domestic Abuse Policy TP102
- Review due **Nov 22**
  - Safeguarding
  - Supervision Policy TP119 review due **Feb 22**
- Chaperone Policy TP118 review due **Oct 22**
- Prevent Policy TP108 review due **Nov 22**
- **HR Policy**
  - Allegations Against Staff Policy HR039 review due **Jul 21**
- **Medical Directorate Policies**
  - Operational Procedure for the use of
  - Restraint of Patients OP0 -review due **under review**
- Consent to Examination or Treatment OP031review due **Dec 19**

COMMITTEES

- Safeguarding
  - Assurance Group SAG
  - (which reports to)
- Quality Oversight
  - Group (that reports to)
  - Quality Assurance Group of the Trust Board. (SAG has a sub group and two practice review groups)
- **Review groups:**
- Safeguarding Incident Review Group
  - Care Home Concerns Review Group
  - Prevent Review Group
  - Child Deaths are reviewed virtually

REPORTS

- Safeguarding Annual Report
- Section 11
- Safeguarding Adults
  - Risk Assessment Tool
  - (SARAT)
- Safeguarding Health
  - Outcomes Framework
  - (SHOFT)
  - Safeguarding Balanced Score Card
- Quality Report
- Area Safeguarding Reports
- Concerns identified by the Care Home Review Group are investigated and then if required:
  - reported to the
  - CCG/CQC
  - Information on attendance at Care Homes is also produced quarterly and provided to commissioners and CQC

RISKS

- EBS business continuity
- Safeguarding risks in relation to Covid-19 have been established and are ongoing

AUDITS

- Internal audit by Grant Thornton looking at
- Policy/Safer
  - Recruitment and
  - Referral processes
- EBS audit quality of referrals on each call taker during the year.
- NASG looking at undertaking peer reviews during 2020

SAFEGAURDING LEADS

- Executive Lead - Chief Quality Officer
- Non-Executive Director for Safeguarding
- Head of Safeguarding
  - (Named Professional)
  - Safeguarding Lead Children
  - Safeguarding lead – Adults & MCA
  - Safeguarding Specialist in each area including EOC/ IUC
- EBS manage:
  - safeguarding referrals
  - & concerns
- Additional members of
  - Safeguarding Team
  - Safeguarding Officer
  - Safeguarding
    - Governance and
    - Training Support
  - Safeguarding Data
- Coordinator and Administrator

Safeguarding Work Plan

The work plan (see appendix one) is monitored by SAG. The Trust has made progress with all elements in the work plan in 2019 -2020. Some aspects have been put on hold due to our vacant Governance and Training during this period. The role has now been recruited to and work will restart and is highlighted in the 2020-21 work plan.

The work plan focused on 6 key areas:

- Development of the Safeguarding Team

- Successful delivery of safeguarding training plan, local education and supervision

- Safeguarding innovation and review current practices to identify cost savings.

- Ensure integration of 111 & IUC

- Forge effective relationships internally and externally to safeguarding children and adults

- Excellent governance and assurance of the Trusts safeguarding processes and compliance (on hold)

Key Achievements

- All areas in the 2019/20 work plan have been achieved.
- The Trust is providing a good standard of safeguarding practice and assurance.

Top Priorities

- To deliver on the 2020/21 work plan
- Implement thorough audit and assurance process.

Safer Recruitment

The Trust has a Policy/Standard Operating Procedure for safer recruitment and includes permanent, fixed term, bank agency, students and celebrity visitors.

The Trust has a three yearly programme of checking staff and as at 31st March 2020 we have completed 99% of these rechecks.

All staff in patient facing roles can only commence if all of their employment checks have been completed, they have a completed DBS check or one in progress, and a risk assessment has been undertaken.

Our international Paramedics require a certificate of good standing from their home country which is the equivalent of a National Police Check and is DBS equivalent.

Key Achievements

- 99% of eligible workforce are compliant within the requirements of Safer Recruitment.
- In 19/20 we completed 2,000 DBS rechecks.

Top Priorities

- To start the next programme of DBS rechecks in 20/21.
- To refresh our DBS Policy.

Child Protection Information Sharing (CP-IS)

CP-IS scheme is a national project lead by NHSE to ensure agencies share information of children or unborn children who are subject to a child protection plan. Local authorities are uploading CP plan flags onto the NHS spine. There is a requirement for all NHS staff to access this information when dealing with patients, this information will add to or aid decision making.

Currently introduced into clinical Hub and looking to introduce into 111 once external Adastra issues have been fixed. Once EPCR is embedded will look to introduce for all at patients side.

Safeguarding Education and Training

An extensive amount of safeguarding training has been undertaken during 2019-20. The safeguarding team would like to thank the Clinical/EOC Education Tutors and the Safeguarding Specialists for all their work to achieve the target. Overall the Trust is compliant with Safeguarding Training for 2019-20.

Safeguarding Training End of Year

Staff feedback on training

‘'Specialists were able to happily talk around the course in a very Knowledgeable and competent way.

It was also very clear that they had a passion for safeguarding that was infectious as they were able to make what could have been a very dry day both interesting and informative".

‘'It was obvious that both members of staff had knowledge far above what was needed for the course content …it has left me regretting that I must wait three years for further safeguarding training!"

"Best Training I have had in the LAS".

Key Achievements

- Overall Trust compliance is:
- Level 1 96.16%
- Level 2 96.19%
- Level 3 116.50% (against trajectory of 800. 932 received training)
- Commissioning target for Safeguarding Training is 90%
- Trust Board was on target for 100% compliance with training booked prior to Covid-19

Top Priorities

- Continue to deliver level 3 to all clinical staff over the next year, whilst recognising meeting next year's target maybe challenging with Covid-19

We have developed a range of educational materials to support safeguarding education and training.

This included four posters which have been distributed to staff within the Trust. This includes, referral/concern raised in 2019/2020, Domestic Abuse and Mental Capacity Act and Youth violence/ knife crime.

The Trust also continues to issue the third edition off Safeguarding Pocket Books which were issued to all clinical staff (see image front page).

The Trust also introduced the Safeguarding Star Badges & certificates. These are given to staff who demonstrate outstanding or good safeguarding practice.

Posters

Booklet
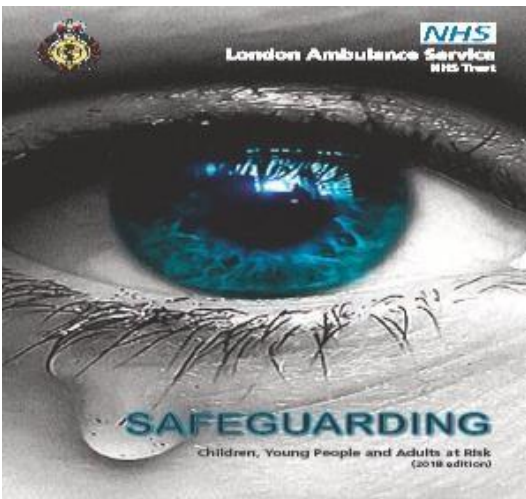
Newsletters

Star badges and certificates

This year we introduced a new staff recognition award for good and outstanding practice in safeguarding.

We award a star when the safeguarding team agree staff actions were outstanding or over and above what would be expected. We issue a certificate when a member of the safeguarding team feels that staff have done a good job in supporting a vulnerable person.

Those who have received a Star Badge for excellent/outstanding safeguarding are:

* **Alan Hay (EBS Manager)**, this was awarded for his ongoing to support the LAS safeguarding process.

* **Mark Burnell- Emergency Medical Technician**

Marks's Story

* Mark attended a patient who was taken to hospital following a fire. The patient absconded from hospital the following morning. The patient was found by LAS in the burnt out property, there was no electric or water and extensive smoke damage. The patient had extensive physical and mental health needs and Mark made every effort to ensure this patient received the required help. Mark contacted multiple services to access help for the patient and after discussing with the housing association, they were able to organise emergency accommodation, food and clothing for the patient. Mark stayed with the patient, spending a considerable amount of time with her.

Brent Complex	Deptford Complex	Hanwell Complex	HQ	North West IRO
New Malden Complex	Trauma Response Unit	Westminster Complex		

Twiddle Mitt's

This year the Trust working in partnership with Knit for Peace a not for profit organisation has placed Twiddle Mitts on all frontline ambulances.

The Safeguarding Team and Fleet & Logistics have developed a plan for ensuring every ambulance has 2 twiddle mitts per ambulance.

What are Twiddle Mitts?

Twiddle mitts are knitted mittens or hand warmers with beads, buttons and other objects sewn on to them. These are useful for patients with dementia as having something to "twiddle" helps to calm agitation and restlessness- both of which are common symptoms of dementia.

Why did we introducing them?

People living with dementia are sometimes less able to interpret process and adapt to both environmental and psychosocial stimuli. Once this happens, those living with dementia can experience an increase in levels of stress which can manifest in anxiety, agitation or aggression. This can make things difficult for our staff in trying to manage the scene and treat the patient.

Providing sensory stimulation at this stage can be hugely beneficial, improving mood and encouraging positive behaviours, achieving or maintaining a state of well-being, and bringing a kind of relaxation. When the quality of life improves for the patient, it does for our staff as well.

"I gave him a twiddle mitt and he was instantly clam and put it straight to he's face as if to comfort him''

James Laws
Used one with a lovely lady with LD

She absolutely loved it - she even said she felt safe.

Absolute winner

2 d   Like   Reply   2

"These things are amazing"

Sarah Gregory-Carr
That's a brilliant idea!

2 d   Like   Reply

Posts

Make featured photo

Like   Comment

Yvonne Wright and 154 others

Safeguarding supervision

The Trust has embedded safeguarding supervision into the Trust with a safeguarding Supervision Policy (TP119) published on the Trusts website.

The policy outlines the staff groups that should have mandatory safeguarding supervision and those that can access it as and when required.

Supervision is provided individually and via group sessions internally and externally for some staff.

Those requiring mandatory supervision internally are:

Safeguarding team	EBS staff	Frequent Caller team
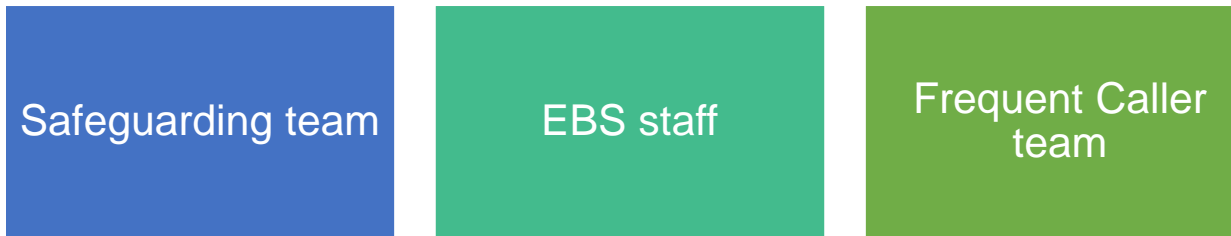
If a safeguarding issue is identified they can be referred for safeguarding supervision.

The Safeguarding Team were **100% compliant** with safeguarding supervision target for 2019/20. With Covid-19 and remote working the safeguarding team are currently setting up a process for virtual safeguarding supervision.

 Clinical supervision is provided to:

Clinical Staff	Mental Health Team

Youth violence

Safeguarding referrals for Youth Violence

The Trust has raised **357 safeguarding referrals** with Local Authority/ MASH partners across London in 2019-20 and increase of 88.

Since December 2017 the Trust has shared information with Red Thread who support and enable young people to lead healthy, safe and happy lives, working with them in the "teachable moment" after a serious injury. We have made **209 notifications to Red Thread.**

Prevention activity

The Trust's Patient and Public Education Team receive requests and manage the delivery of our knife crime presentation from many different agencies across London. Our knife crime presentation covers information on the injuries and potential fatal consequences of knife crime staff discuss their personal experiences of dealing with stabbings. On some occasions we incorporate basic first aid advice about how to safely deal with stab wounds and what to do when someone stops breathing. The sessions last up to an hour, and is delivered up to 6 times a day depending on the total number of children.

Some of the organisations we engage with include:

Title	Partnership	Audience	Area/Borough
Your Life You Choose	Local Magistrates/ Police/Prison Service	Year 7 and 8	Brent, Barnet, Ealing and Hillingdon
The Prince's Trust	none	Age 16 to 25	London wide
One Life	LFB	Age 16 to 18	West London
PRUs	none	Age 14 to 18	West and North West London
Youth Offending Teams	none	Age 16 to 19	Ealing
Community Centres	none	Age 14 to 17	Croydon
East Area Knife Crime Workshops	Met Police/Robert Levy Foundation	Age 13 to 14	Redbridge, Havering, Romford and Barking and Dagenham

Care Home Review Group

The Care Home Review Group is an internal group that was set up in July 2018 and meets to review all safeguarding concerns raised by ambulance staff relating to incidents in care, nursing or children's homes.

All concerns are sent to the LA and the group considers the quality of care being provided by the staff in the home and whether there are concerns that should be investigated further or escalated to the CCG, CQC or professional bodies.

During Covid-19 we also reviewed all Datix reports daily relating to care homes from staff and following review relevant concerns were raised promptly with CCG & CQC in order that the relevant bodies could review and support could be provided where issues were potentially arising in care homes.

Serious Case Reviews (SCR) now known as Local Child Safeguarding Practice Reviews (LCSPR)

A SCR/LCSPR is commissioned by the local Safeguarding Children Board and undertaken when abuse or neglect of a child is known or suspected; and either, the child has died or the child has been seriously harmed and there is a cause for concern about partnership working.

				Serious Case Reviews (SCR)					
Borough	Gender	Age	Type of abuse	Type of Case	Borough	Gender	Age	Type of abuse	Type of Case
Brent	Male	16	Stabbed	SCR	Redbridge	Male	17	Suicide	Internal Learning Review
						Female	16	Suicide	Internal Learning Review
Croydon	Female	4 Months	Parental Neglect	SCR	Southwark	Female	8 Weeks	Parental Neglect	SCR
	Male	1 Month	Parental Neglect	Safeguarding Practice Review					
Ealing	Male	5 Months	Unknown	SCR	Sutton	Male	3 Months	Unknown	SCR
Hackney	Male	15	Stabbed	SCR					
Haringey	Male	15	Stabbed	SCR					

Safeguarding Adult Reviews (SAR)

A SAR is commissioned by Local Safeguarding Adult Boards and is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently to prevent harm or a death from taking place. The purpose of a SAR is to promote effective learning and improvement to prevent reoccurrence of future deaths or serious harm, not to apportion blame.

	Safeguarding Adult Reviews (SAR)				
Borough	Gender	Age	Borough	Gender	Ag e
Brent	Male	47	Harrow	Female	46
	Male	75			
Bromley	Care Home	N/A	Hounslow	Female	96
Camden	Female	57	Havering	Male	61
Greenwich	Female	81	Lewisham	Female	10 2
	Male	38		Female	
					73
Hackney	Male	89	Redbridge	Male	34
	Male	63		Female	23
Haringey	Female	34	Tower Hamlets	Female	33
				Female	52
Out of London Essex	Male	73			

Domestic Homicide Review

A DHR is a review commissioned to consider the circumstances in which the death of a person, aged 16 or over has, or appears to have been as a result of violence, abuse or neglect by a person to whom they were related or with whom they had been in an intimate personal relationship.

The LA commission the DHR, our Safeguarding Specialist's local managers attend when requested:

Domestic Homicide Review				
Year	2016-17	2017-18	2018-19	2019-20
Number LAS has supported/attended	5	5	11	18

The Trust received notification of 18 DHRs this year which is an increase of 7. The boroughs requesting participation were:

Barnet

Bexley x2

Brent x2

Bromley x2

Islington

Lambeth

Lewisham x2

Redbridge x2

Southwark

Tower Hamlets x2

Out of London x2

Multi-agency Risk Assessment Conference (MARAC)

MARACs are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a risk focused MARAC, coordinated safety plans can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55000 cases a year. The Trust does not attend MARAC meetings but provides information to support discussions. In 2019/20 the LAS has supported 3411 cases which is an increase of 137% in the last 4 years:

Multi-Agency Risk Assessment Conference (MARAC)				
Year	2016/17	2017/18	2018/19	2019-20
Number of cases LAS have provided information for.	1439	1910	2343	3411

The Trust currently provides information to 9 Boroughs:

| Bexley | Ealing | Greenwich | Hammersmith & Fulham | Haringey | Hillingdon | Kensington & Chelsea | Lewisham | Westminster |

Child Death

Following the recent changes in the Child Death Review Process in line with the latest Working Together to Safeguard Children (2018) statutory guidance the statutory responsibility for child death reviews is now held by the child death review partners. In order to contribute to this process, the Trust provides appropriate information relating to the death of the child through the meetings that precede the Child Death Overview Panel (CDOP) meeting.

	Child Death Overview Panel Requests			
Year	2016/17	2017/18	2018/19	2019/20
Numbers information provided to	206	230	241	228

All child deaths where the Trust recognise life extinct (ROLE) a child death notification form is completed (Form A) these are reviewed by the Trust Child Death Review process and where any concerns are identified these incidents are escalated to the Trusts Serious Incident Group.

Trust Child Death Reviews 2019-20	
Number reviewed	151
No further action	136
Number referred for Serious Incident Group Consideration	15
Number declared	6

Learning from reviews

MCA & consent has been highlighted in a couple of reviews.

Action taken:

- Trust has produced a poster on MCA principles,
- Issuing pens with MCA stages on.
- Trust also agreed an MCA strategy for 2021.

Incidents of youth violence continues to rise. Number of missed referrals has decreased due to continued focus on area.

 Action taken:

- Article in Safeguarding Newsletter.
- Discussions with Incident Response
- Officers who attends these scenes

There have been a couple of cases where domestic abuse in pregnancy was not referred to child social services.

Action taken:

- Article written and published in Safeguarding Newsletter.
- Added to safeguarding refresher training.

From the themes from SI's.
Action taken: Quality bulletin issued on Learning Disabilities

111 SE Call handing error. Feedback, reflection and training provided and case study used in future training

Safeguarding adult a risk
Feedback from safeguarding adult concern

Call details

Call received for a female fallen 30 mins ago pain all over in a funny position. Son on scene. Call came from the patient.

Chub call back and son said he lived with his mother and she has Carer twice a day. CMC records held.

On LAS arrival the son was with the patient, he told LAS crew that his mother has dementia and learning disability and is confused and that she had fallen, it happens a lot and she blames him.

Observations

Patient was very distressed. Alert, observations within normal range. Patient had bruising to her face which was not consistent with a fall. Her speech was difficult to understand.

History

Initially patient was hard to understand due to dysphagia. Patient had history of CVA and paralysis on right side, Residual dysphagia. HTN, Basal ganglion implant, chronic back pain.

Patient disclosed Son had pushed her to the ground and hit her on the face. Son has just been evicted from his shelter, now "no fixed abode" She said he occasionally pops round with other people/friends and tells them she has dementia and a learning disability.

She disclosed she was scared of her son and afraid to be left with him.

It was unclear if son had keys to property.

The patient stated she does not have dementia or a learning disability.

Crews Actions

The Crew requested police to scene as concerned for patient's safety & as this was criminal matter.

Discussed safeguarding concerns with patient who consented to safeguarding concern being made, (although not required as sufficient evidence of coercion) for multiple incidents of domestic violence and physical abuse.

Patient was not conveyed as no medical concerns.

The crew had a discussion with the daughter (next of kin) and patient was left with the Carer.
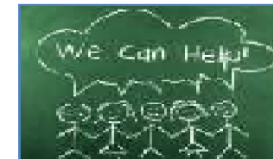
Outcome

Police arrested the son and also agreed they were submitting a Merlin (their vulnerability alert to local authority). Crew also discussed with them that if released the son may have access to the property again.

EBS immediately passed the referral to the Duty Social Worker as this was a Sunday.

They confirmed that they had instigated a Section 42 Safeguarding Enquiry. Had met with the patient and confirmed she did not have dementia or a learning disability.

A protection plan was put in place immediately.

The patient has been taken to a sheltered housing scheme as a place of safety, where she can stay for 72 hours.

Her locks were changed.

The son was still in police custody at time of feedback.

Feedback

The local authority praised the LAS for their quick response (Crew & EBS) to notifying them out of normal office hours.

This enabled them to put into place appropriate protective measures to safeguard the adult at risk.

The crews' diligence in spotting the signs of abuse and checking information was key to safeguarding this lady.

By acting on concerns straight away, by calling the police, enabled the son to be arrested and the police to secure the evidence they required.

The lady has been given the option of moving permanently into sheltered housing.

Her allocated social worker was visiting to ascertain what she would like to do going forward.

Well done to this crew and the EBS call taker and to all crews who are regularly acting on concerns of abuse and neglect. Your actions really do help protect the most at risk in our society

Safeguarding Allegations Against Staff

The Trust has an HR Safeguarding Allegations Policy that outlines the process to be followed when the Trust receives or is made aware of a potential allegation against a member of staff.

The Trusts Head of Safeguarding & Prevent works closely internally with relevant local managers and the Director of People & Culture and the Chief Quality Officer to review case and recommend action to be taken. Externally the Head of Safeguarding & prevent liaises with the relevant LADO (usually Lambeth) or Safeguarding Adult Manager for the area. During 2019-20 there were 7 investigations and 1 dismissal from service. Most cases were around professional conduct.

Prevent

The Head of Safeguarding & Prevent is the Prevent Lead for the Trust and the Trust has a Prevent policy and concerns are raised by staff via our safeguarding processes. We have a requirement to ensure all staff are trained to the required level in Prevent. The Trust completes a quarterly report for NHSE covering all elements of Prevent training and referrals.

During 2019/20 the LAS raised 6 child Prevent concerns and 21 adult Prevent concerns with the LA. The Trust has reported 1 staff Prevent concern to the Police. The Trust currently raises concerns with the local authority as opposed to Prevent Channel Panels, in accordance with London Prevent.

Key Achievements

- Training compliance above target of 90%
- Quarterly returns completed within timescale
- Trust attendance at Prevent Conference
- Attended workshop with Uni of London to look at Prevent and challenges/ pathways

Top Priorities

- Continue to raise profile of Prevent as safeguarding
- Work with partners to improve pathways

Private Ambulance Service (PALS) and Voluntary Ambulance Service

The Trust commissions support from a number of private ambulance services to assist with increases in workload.

- The Trust uses 2 CQC registered providers at this time;

- Falck UK Ambulance Service

- St John Ambulance

- SSG (until August 2019)

In the last 18 months the Trust has reviewed all policies as part of the contract review. For the new contract the Trust provided training, to the providers training teams, on how to run the LAS PIN course. This included a session on how to report by EBS for Datix and safeguarding.

The external providers all use the Skills for Health online statutory-mandatory training to ensure it meets the Trusts standards. In the coming year we will be discussing how they can meet the 50% face to face requirement safeguarding training.

The Trust have completed a rolling schedule of quarterly audits which includes a HR dip sample of staff deploying, including checking the DBS status and currency of safeguarding training of each member of staff audited; this is 4 personnel per quarter per site audit (1 site each for SJA, 2 sites for Falck).

PAS/VAS Crews completed 50 safeguarding referrals/ concerns. This is consistent with a similar sized station. The Trust commissions 10 frontline vehicles from Falck on late shifts per day through the weekend and 6 through the midweek, and 2 bariatric vehicles and 1 frontline vehicle per 12 hr day/night from SJA. During Covid-19 a number of private ambulance companies were commissioned for a short period of time to assist with the increase in calls.

Private Ambulance Service (PALS) and Voluntary Ambulance Service cont…

Key Achievements

- A dedicated PAS/VAS manager oversee contract and compliance
- Regular performance reviews

Top Priorities

- Reduce PAS &VAS to zero usage
- St John to do 50% face to face delivery of Safeguarding level3 training by end of quarter 1
- Scoping volunteer ambulance deployment

Information Sharing/Partnership Working

The Trust has a duty to share information to protect children and adults at risk. The Trust shares information on staff concerns for a vulnerable person to the local authority and works in partnership with a number of agencies to support best practice in safeguarding.

The Trust adopts the Pan London Information Sharing Agreement and shares information with several safeguarding partners.

National Ambulance Safeguarding Group   *London Safeguarding Adult & Prevent Provider Network*   *Child Death Overview Panel Reviews*

NHSE Named Professionals Group   *London Safeguarding Adults Network*   *London Safeguarding Children Board*

London Safeguarding Adult Board   *Brent Safeguarding Children Board*   *Brent Safeguarding Adult Board*

Safeguarding referrals and concerns raised by LAS in 2019 - 20

For 2019-20 the Trust raised **23,051** Safeguarding concerns and referrals.

BREAKDOWN OF REFERRALS AND CONCERNS 2019 -20

- Adult Safeguarding
- Adult Welfare only
- Child
- Other outcome

1505, 7%

6031, 26%

10433, 45%

5082, 22%
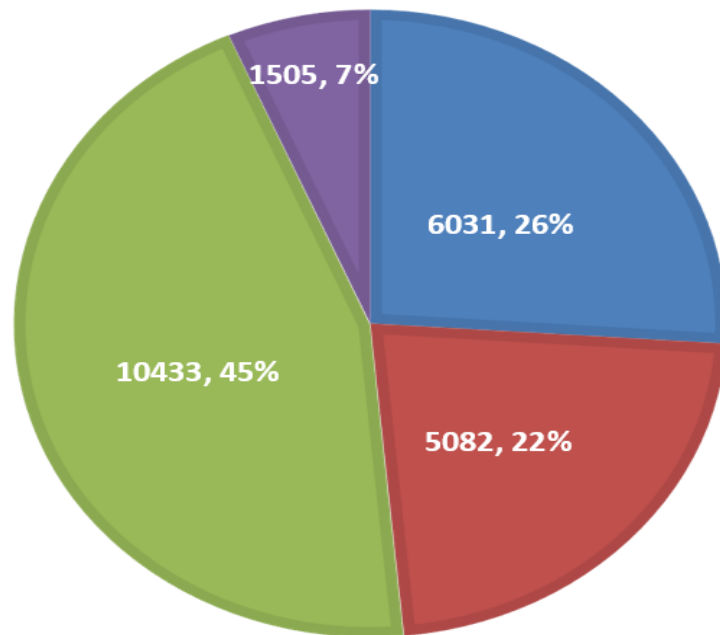
Overall referral volumes

The total number of safeguarding referrals/concerns raised by our staff this year is 23,051 Comparison with 2018-19:

- There is a 2% increase on 2018-19 safeguarding referrals/concerns total of 22,562
- There is an 8% increase in child safeguarding referrals since 2018/19
- There is 1.6% decrease in adult safeguarding concerns since 2018-19
- There is 24% decrease in Adult welfare concerns since 2018-19

1,505 concerns categorized as 'other outcome' were not passed to the local authority, because they were not appropriate. The majority of these were either mental health referrals with no safeguarding aspect, welfare concerns where the person or a carer was advised to refer, or cases where we could not proceed because the person did not consent. All these 'other outcome' referrals are checked, and information is shared where appropriate with other agencies.

The number of concerns/referrals as a percentage of all incidents has remained stable throughout the year at average 1.9%, which is a decrease from last years figure of 2.0%.

Volumes during the year

Yearly comparison by month
2018/19 — 2019/20

Adult referrals 2019-20
■ Adult Safeguarding ■ Adult welfare

Child referrals 2019-20
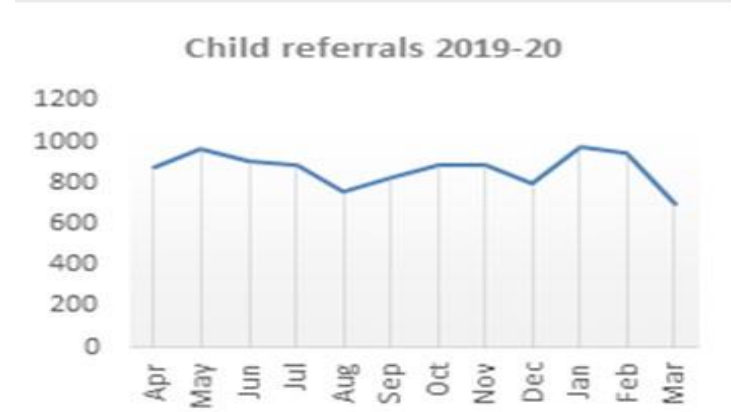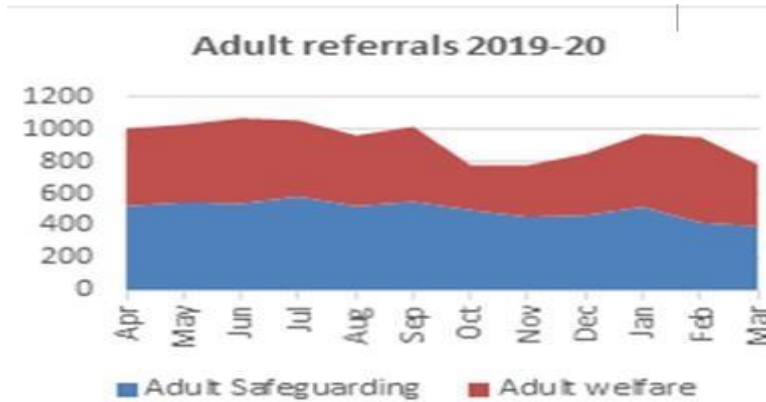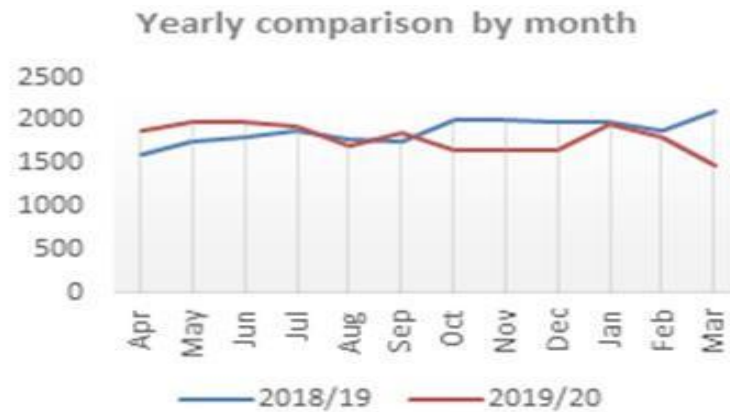
All volumes for this year must be caveated to take note of COVID-19. The Covid-19 impact on referrals took effect around mid-march, and at the time of writing has had the effect of decreasing volumes significantly for the last two to three weeks of the year. This is possibly due in part to effects of the lockdown and in part to changes in the activity of the Trust as a whole.

Adult referrals overall have decreased slightly throughout this year; this is attributable to a change in the way the trust manages welfare referrals. More are managed on-scene by crews empowering carers and relatives to refer themselves: the remainder using a slower, less resource-intensive process. This includes an agreed delay in referral of up to five days, which accounts for the drop in volumes in October when this was implemented. Adult safeguarding referral methods are unchanged, and volumes remain stable at around 520 a month. Child referrals have maintained their historically high volume, now typically accounting for almost half of all referrals and averaging 880 a month.

Referrals /concerns made by LAS Area	
North Central Sector	2488
North East Sector	3713
North West Sector	4230
South East Sector	4287
South West Sector	2738
Other (HART, TRU, NETS, IRO, Events)	1362
EOC	1481
111	1197
PAS/VAS Other	50
Referrals not sent / other outcome	1505
Total (including not sent)	**23051**

Referrals by borough 2019-20

Borough	Referrals
Barking and Dagenham	578
Barnet	763
Bexley	684
Brent	700
Bromley	804
Camden	563
City of London	12
Croydon	1095
Ealing	819
Enfield	771
Greenwich	862
Hackney	657
Hammersmith and Fulham	366
Haringey	645
Harrow	446
Havering	616
Hillingdon	703
Hounslow	745
Islington	552
Kingston upon Thames	332
Lambeth	1006
Lewisham	929
Merton	518
Newham	777
Redbridge	678
Richmond upon Thames	379
* Royal Borough of Kensington…	346
Southwark	901
Sutton	501
Tower Hamlets	622
Waltham Forest	695
Wandsworth	625
Westminster	531
Other borough not listed	325

Borough ranked by volume, 2019-20

Borough	Volume
Croydon	1095
Lambeth	1006
Lewisham	929
Southwark	901
Greenwich	862
Ealing	819
Bromley	804
Newham	777
Enfield	771
Barnet	763
Hounslow	745
Hillingdon	703
Brent	700
Waltham Forest	695
Bexley	684
Redbridge	678
Hackney	657
Haringey	645
Wandsworth	625
Tower Hamlets	622
Havering	616
Barking and Dagenham	578
Camden	563
Islington	552
Westminster	531
Merton	518
Sutton	501
Harrow	446
Richmond upon Thames	379
Hammersmith and Fulham	366
* Royal Borough of…	346
Kingston upon Thames	332
Other borough not listed	325
City of London	12

*Royal Borough of Kensington and Chelsea

Adult / child by borough 2019-20

Borough	Adult	Child
Croydon	518	577
Lambeth	514	492
Southwark	465	436
Bromley	451	354
Ealing	447	372
Lewisham	419	510
Barnet	416	347
Hackney	393	266
Newham	390	389
Hounslow	383	362
Haringey	382	263
Brent	379	321
Bexley	377	307
Greenwich	375	487
Enfield	375	396
Waltham Forest	367	329
Westminster	366	165
Camden	366	197
Hillingdon	362	341
Redbridge	351	327
Wandsworth	348	278
Islington	337	215
Havering	329	290
Tower Hamlets	289	333
Merton	263	255
Sutton	257	244
Hammersmith and Fulham	236	130
Harrow	231	215
Royal Borough of Kensington and Chelsea	220	126
Richmond upon Thames	203	176
Barking and Dagenham	200	378
Kingston upon Thames	173	159
Other borough not listed	60	315
City of London		

☐ Adult ☐ Child

Referrals/concerns by borough

The pattern of referrals across London is familiar from previous years; Croydon for example has been the highest borough receiving referrals or concerns from the Trust since our records began in 2010, and Richmond, Kingston and Kensington & Chelsea among the lowest.

Child referrals

Child referrals by category 2019-20

Category	Value
Mental health / Self-harm /...	2554
Parental mental health	2228
Parental capability	1398
Domestic violence / abuse	1237
Intoxication	1168
Physical abuse	937
Neglect	795
Emotional abuse	513
On plan / Looked after only	448
Possible Gang Involvement	357
Disclosure of historical abuse	165
Sexual abuse	147
Child death	50
Child Sexual Exploitation	38
FGM	20
Prevent / Radicalisation	6
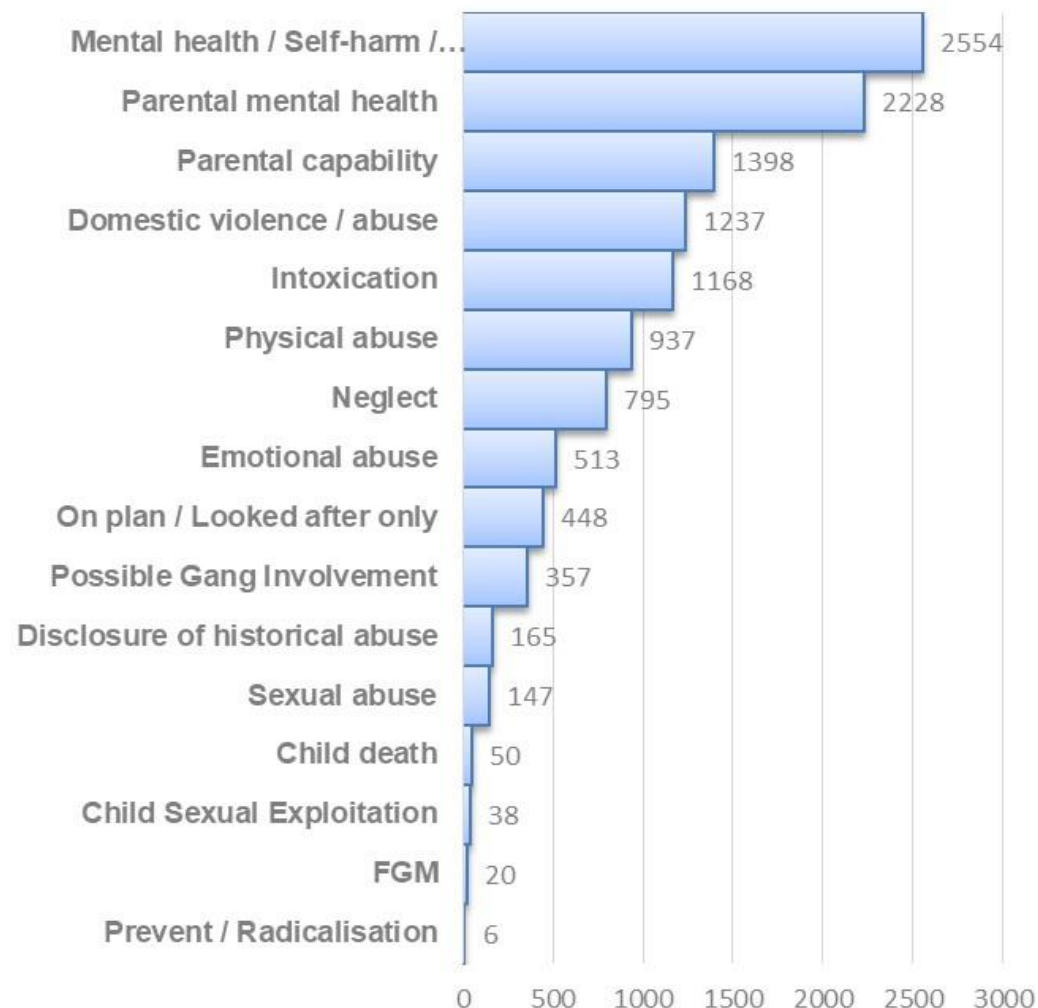
This chart shows the categories of concern the Trust recorded. Multiple referral categories can be selected for an individual referral.

Mental health, self-harm and suicidality are the highest category, this and Parental Mental health and Parental Capacity remain the top child safeguarding concerns identified by staff. This is consistent with previous years.

The 20 concerns relating to FGM did not include any instances of directly observed or disclosed FGM of a child (which requires reporting to the MPS). They were concerns relating to children of mothers who had FGM, or other indirect concerns. For some of our 'possible gang involvement' referrals, where the child is conveyed to a Major Trauma Centre, we also refer immediately to Red Thread, a third sector youth organisation who work to intervene in young people's lives to steer them away from harmful social environments and behaviours. This year, 209 of these referrals have been made.

Adut referrals

Adult safeguarding Concerns by category 2019-20

Category	Value
Self-neglect (including...	2771
Neglect and acts of omission	2558
Physical abuse	627
Psychological abuse	621
Financial or material abuse	490
Organisational abuse	281
Domestic violence	229
Sexual abuse	113
Modern slavery	40
Prevent / Radicalisation	21
Discriminatory abuse	17
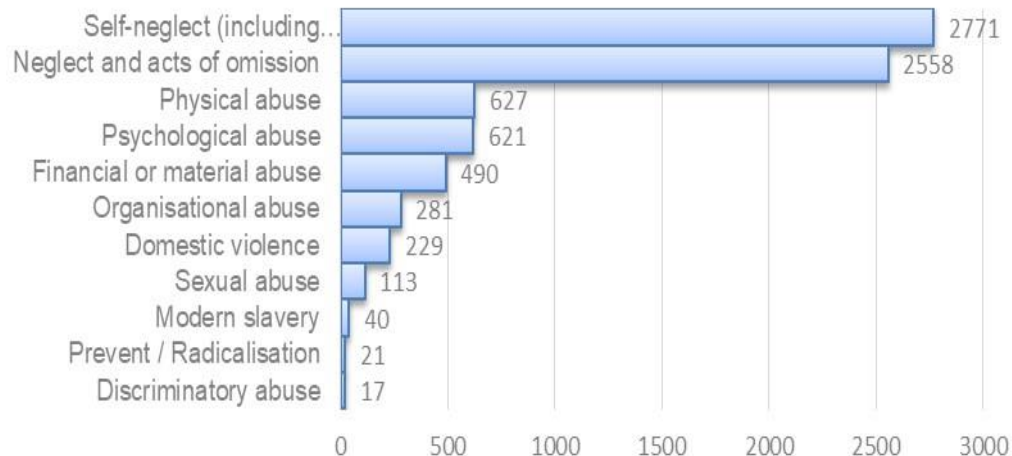
Adult welfare concerns by category 2019-20

Category	Value
Community care assessment	3669
Accommodation concern	2379
Review of existing care...	2061
Other concern	1182
Carer's assessment	1135
Quality of existing care	488
Learning disability care...	127
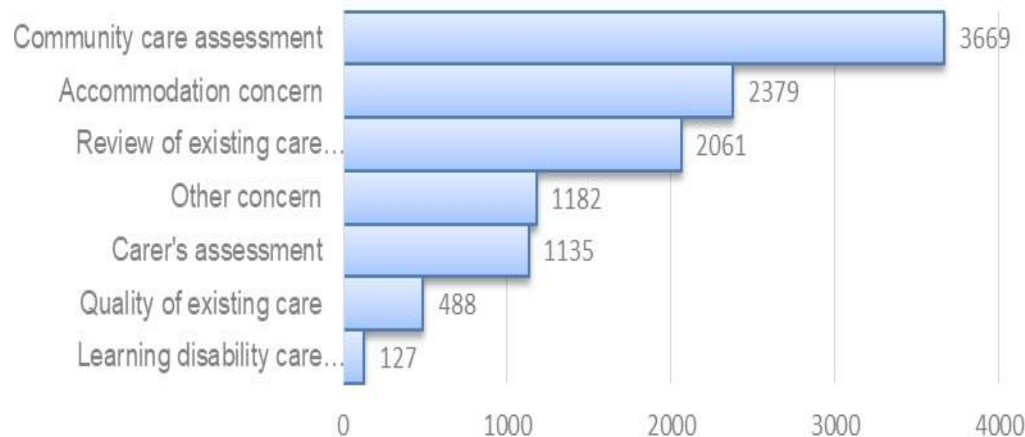
The chart for adult concerns shows self- neglect and neglect as the top reasons for raising the concern. Multiple categories can be selected for an individual referral.

For those referrals where relatively severe hoarding is indicated (scored using a clutter index devised by the LFB as over 4), and where consent is given, it is shared with the LFB. The LFB can then make a fire risk assessment and support individuals. This year we made 1083 such referrals.

In Domestic Abuse cases, staff supply the victim with the telephone number of the Women's Aid Domestic Abuse Helpline number. On rare occasions the victim will ask staff to contract them on their behalf. This has occurred only three times.

For welfare related concerns, crews are encouraged where possible to empower individuals or their families or carers to approach the local authority directly, the Trust does not capture figures on this. Where concerns are raised via the Trust figures are captured and the main reason of concern is the request for a care assessment.

Feedback from boroughs

Feedback received as a % of referrals 2019-20

Borough	%
Havering	31.6%
Tower Hamlets	27.0%
Redbridge	26.1%
Brent	24.0%
Kingston upon Thames	22.5%
Greenwich	17.3%
Richmond upon Thames	14.8%
Enfield	14.5%
Barking and Dagenham	12.9%
Haringey	10.1%
Other borough not listed	9.9%
Camden	9.9%
Bexley	9.5%
Croydon	9.4%
Lambeth	8.3%
Sutton	7.4%
Lewisham	7.0%
Barnet	6.1%
Hackney	5.7%
Hammersmith and Fulham	5.1%
Harrow	4.2%
Merton	3.6%
Ealing	3.4%
Waltham Forest	2.7%
Hillingdon	2.7%
Southwark	2.1%
Islington	1.7%
Wandsworth	1.5%
Westminster	0.0%
Royal Borough of Kensington and…	0.0%
Newham	0.0%
Hounslow	0.0%
City of London	0.0%
Bromley	0.0%

Colleagues in the boroughs provide us with feedback on the outcome of our referrals.

The point of this feedback is to enable us to flag any issues arising from a referral, to gain further understanding and insight into the work of social services, and to learn from the outcomes we receive.

It may be that the feedback enables a staff member to gain closure on an incident they have encountered with the simple yet important reassurance that the matter they have reported is being dealt with.

There will also be times when the person who reported the concern, or even the service as a whole, will be able to learn from the feedback and potentially implement changes to improve the quality of future safeguarding referrals.

Currently the quantity of feedback received is still small – averaging 9% of all referrals, approximately the same as last year. Feedback is marginally better for child referrals, averaging around 14%, with a couple of boroughs feeding back on almost all child referrals

Type of premises

Type	Count
Own home	13871
Other	6526
Care home	566
Warden Controlled	478
Hostel	105
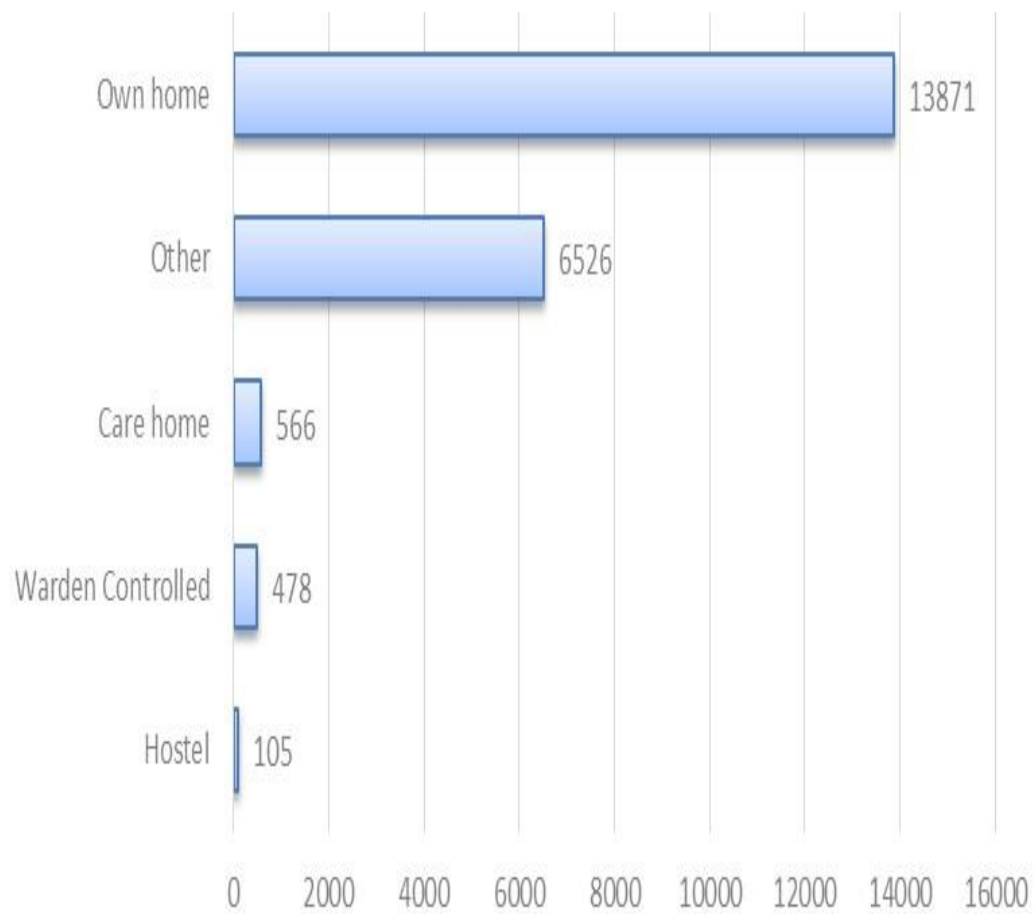
Types of premises

The Trust Safeguarding Team review all concerns regarding quality of care delivered in a residential care facility and take escalatory action where appropriate. This includes sharing relevant concerns to the CQC and or CCG.

GENERAL
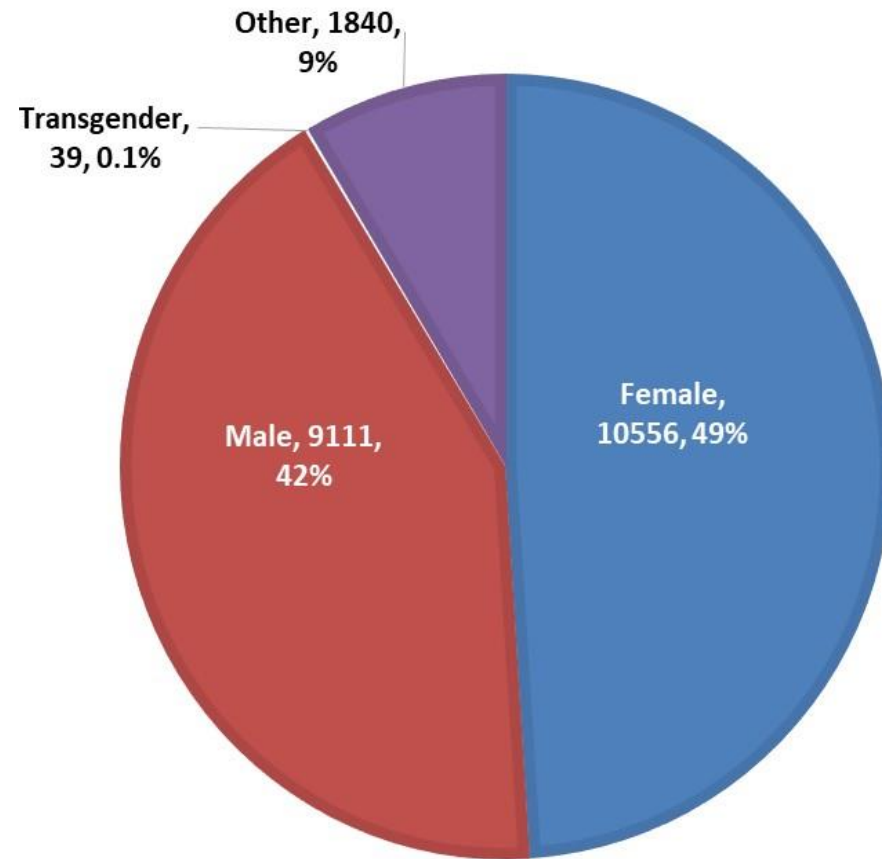
Gender

The majority of the other category are child safeguarding referrals where we are aware that a child is at risk but have not assessed that child face to face (often an unborn child) and have not established their gender.

Ethnicity

The number of cases where no ethnicity is recorded is similar to last year at 28%, and reflects the nature of the incidents that LAS attends. Often crews are unable to discuss ethnicity because patients are semi-conscious or incapacitated. Also third party concerns – for people we did not see or assess, perhaps carers or partners, or those for unborn children, often provide no opportunity for a determination to be made.

Ethnicity pie chart: Black & Minority Ethnic 24%, White 48%, Not known 28%

Black & Minority Ethnic bar chart:
- Black African: 1206
- Black Caribbean: 993
- Other Asian: 608
- Indian: 482
- Other Black: 389
- Other Ethnic Category: 346
- Other Mixed: 344
- Bangladeshi: 213
- Pakistani: 186
- Mixed White and Black Caribbean: 173
- Mixed White & Black African: 85
- Mixed White & Asian: 83
- Chinese: 69
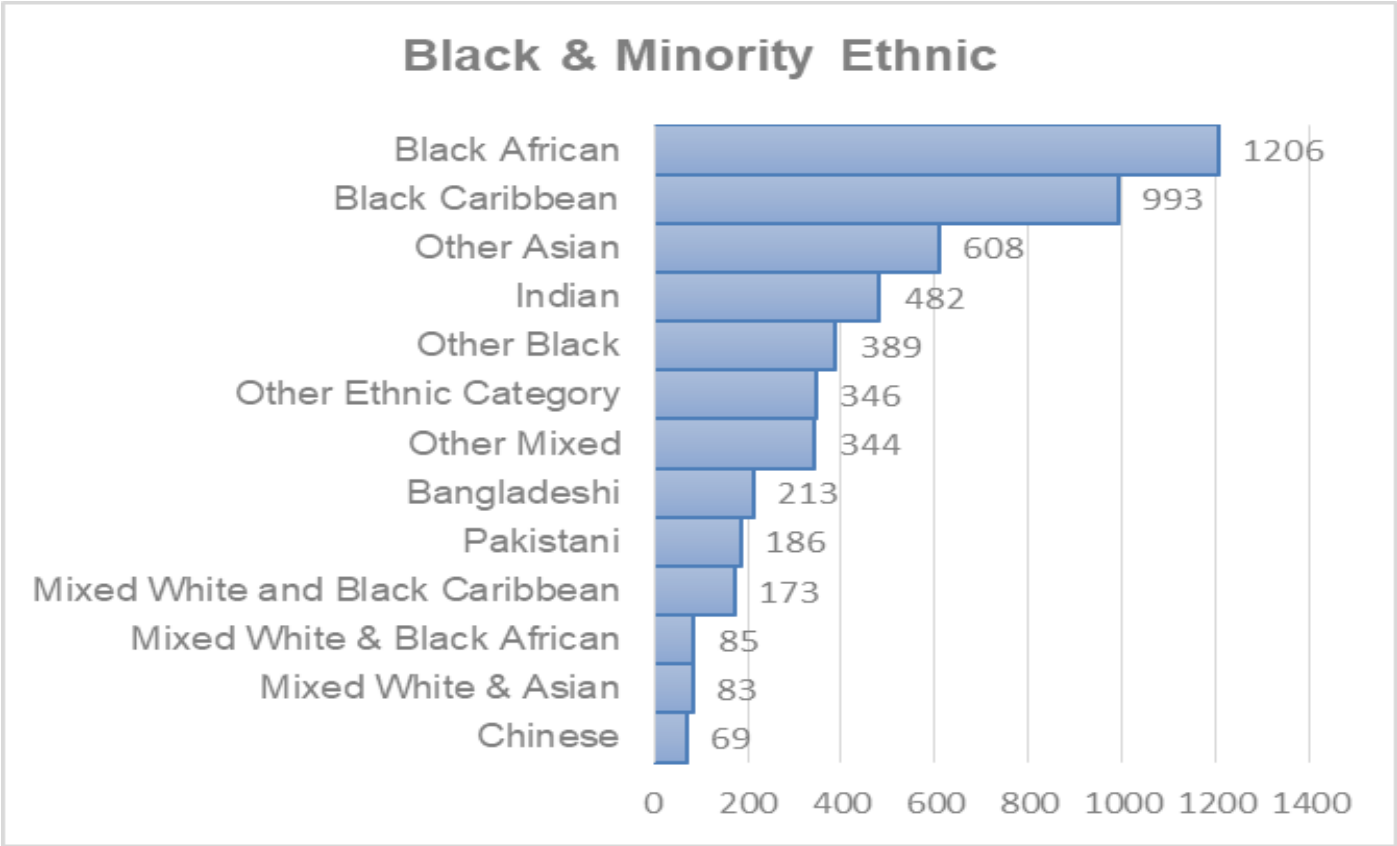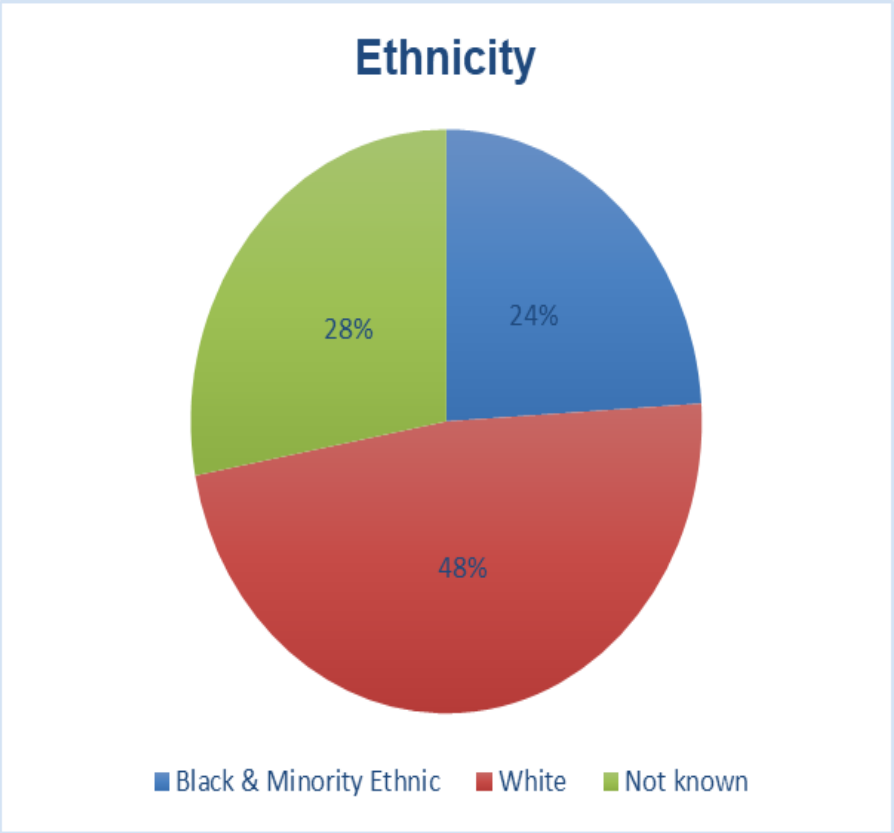
Language

Similar to ethnicity, due to the nature of our incidents it is not always possible to ascertain languages spoken. However in cases where there are communication difficulties relating to languages spoken, the trust has access to live translation services via Language Line.
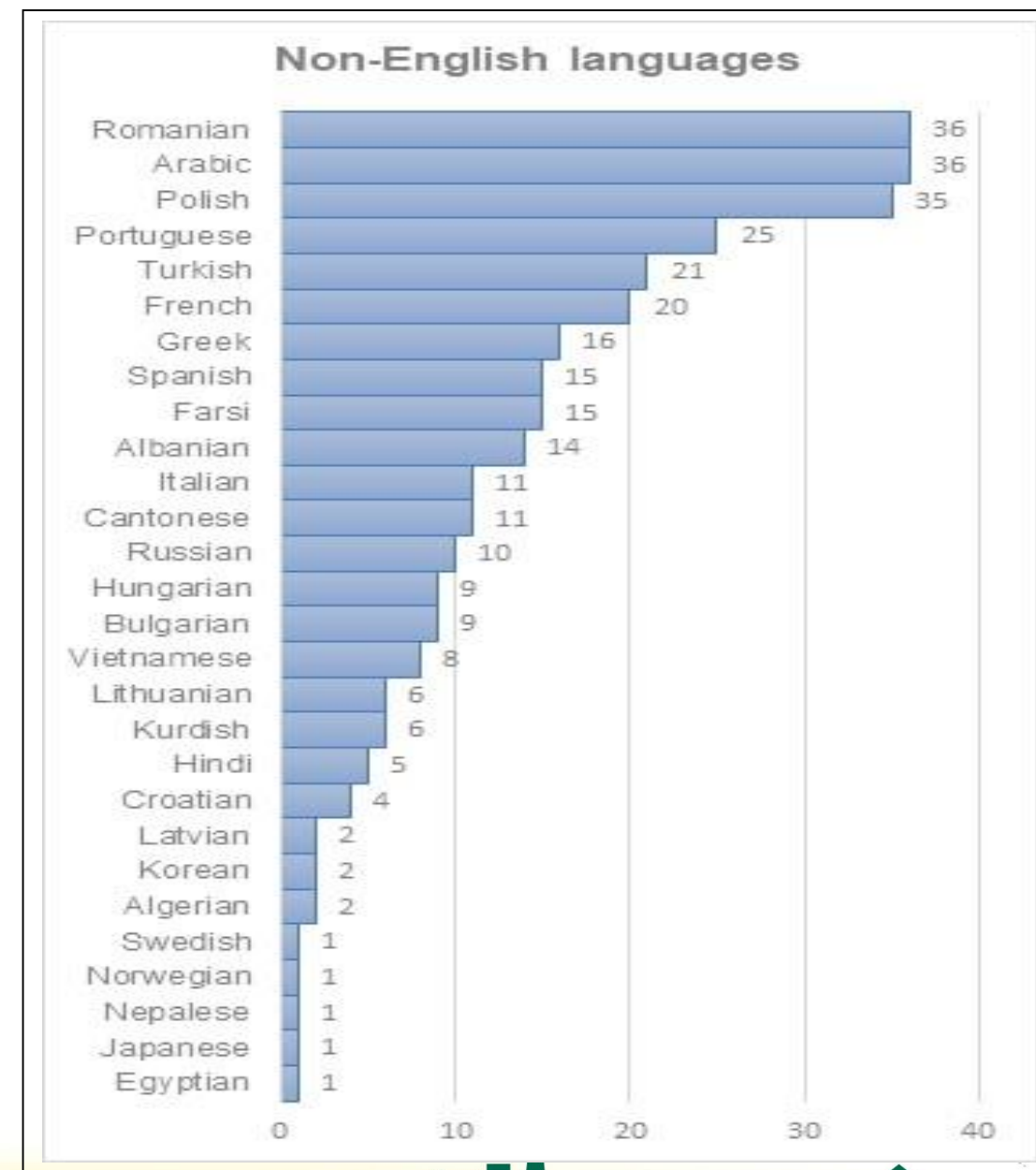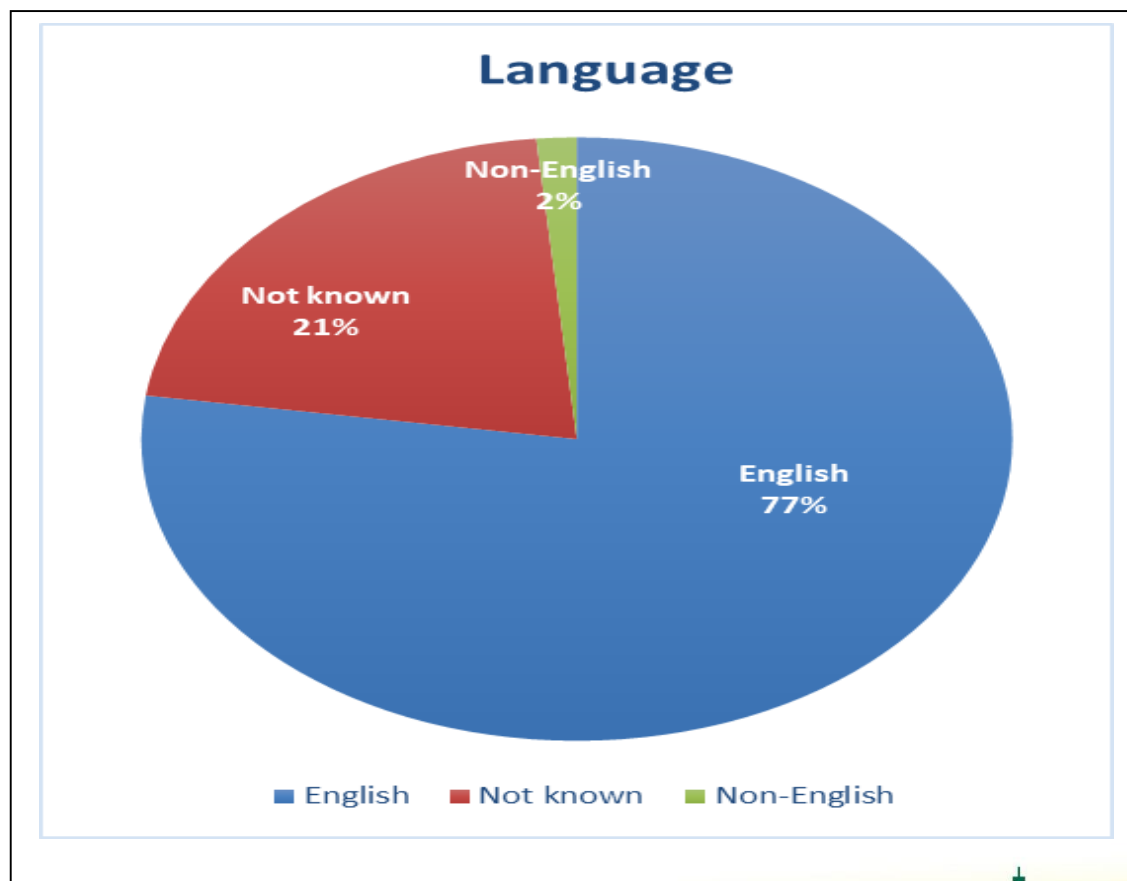
Religion

Religion is not regularly recorded by staff. However these findings will be feed into wider Trust discussions around protected
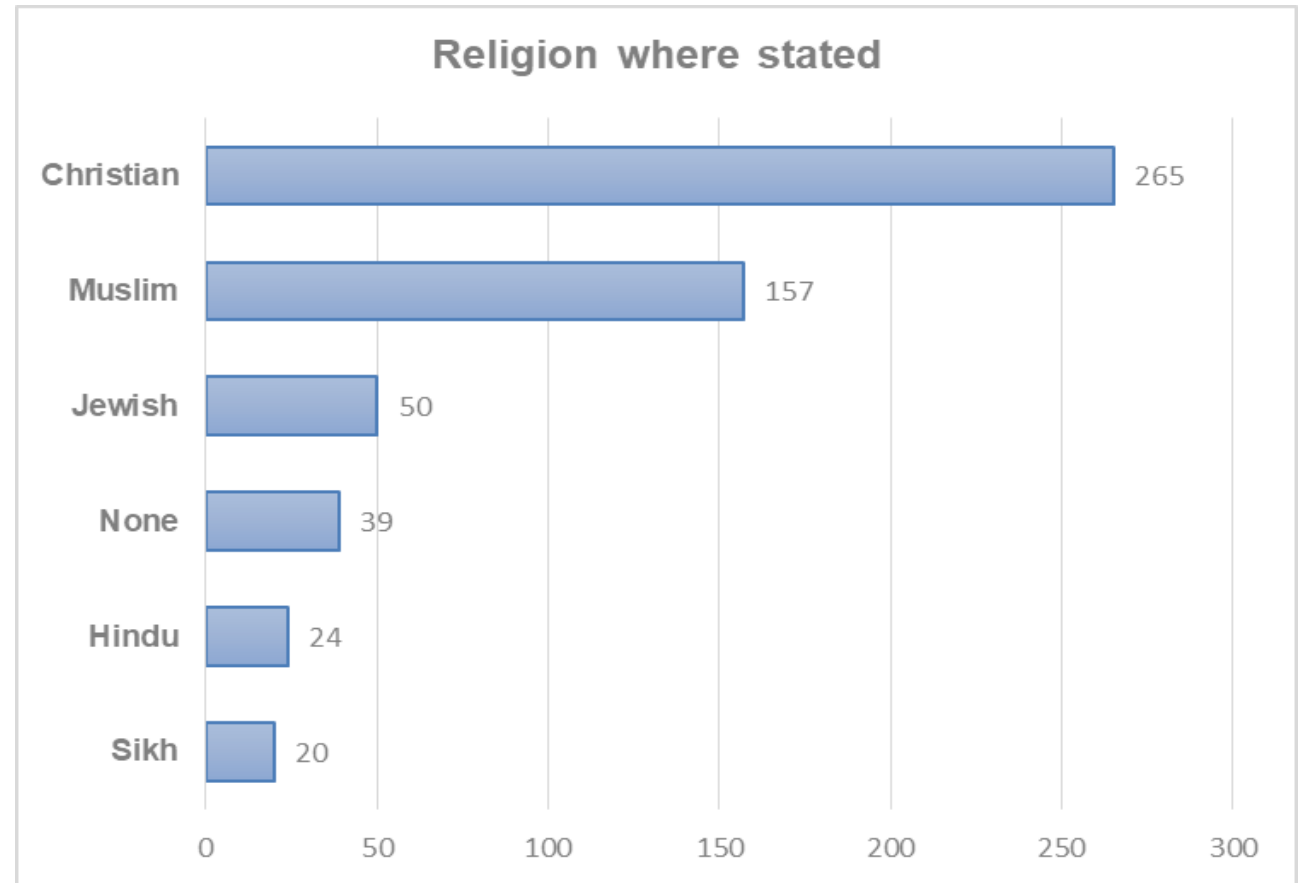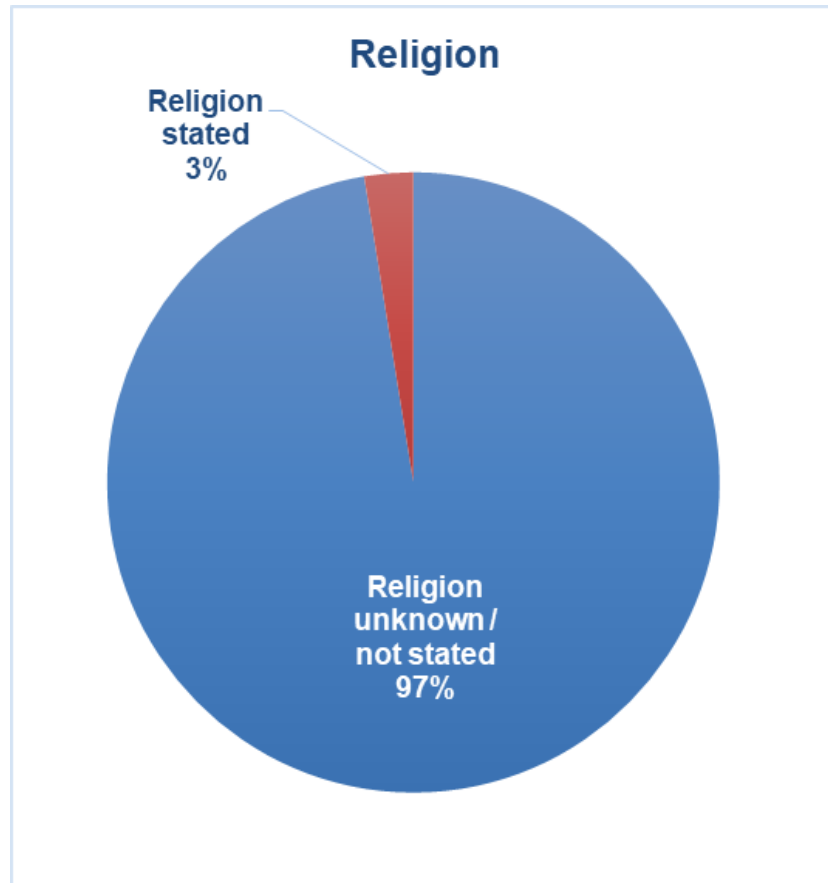
Top priorities for 2020 -21

To rebuild the Safeguarding Team post Covid-19. Consider new Safeguarding practice, opportunities and requirements post Covid-19.

To recruit new members to the Safeguarding Team to enable outstanding safeguarding practice across the Trust.

Introduce a new safeguarding referral process with the Trust moving to Electronic Patient Care Record (EPCR).

To continue to improve the quality of Safeguarding Governance and Assurance.

Work with partners to:

Develop contextual safeguarding arrangements following pilot Improve safeguarding response to Prisons and referral process Improve feedback from referrals/ concerns.

Provide a varied safeguarding educational program across the Trust as well as Safeguarding Specialists delivering training at a variety of levels in line with intercollegiate documents and trajectory agreed with commissioners.

Embed new legislation and best practice. Particularly Domestic Abuse, Liberty of Protection Safeguards & Child Death processes.

Contact details

Should you wish to know more about safeguarding in the London Ambulance Service, have any questions about this report or would like more details on referrals per borough please contact the London Ambulance Service NHS Trust Safeguarding Team on Safeguarding.las@nhs.net

2019/20 has been a busy year for the LAS with an increase in the resources within Safeguarding Team. 2020/2021 looks to be an exciting year as the Safeguarding Team adjusts to what business is like after Covid-19 and how we might need to adapt and change our practice to maintain outstanding safeguarding practice in the "new norm" post Covid-19.

Thank you to all staff in the Trust who day in and day out do the right thing to protect those at risk and to everyone who has contributed to Safeguarding throughout the year and to the Safeguarding Boards, NHSE Safeguarding Team and Commissioning partners.

Alan Taylor
Head of Safeguarding & Prevent

London Ambulance Service
NHS Trust

Report to:	**Trust Board**
Date of meeting:	28 July 2020
Report title:	Serious Incidents (SIs) and SI Thematic Reviews
Agenda item:	Report for Information
Report Author(s):	Helen Woolford, Head of Quality Improvement & Learning
Presented by:	Trisha Bain, Chief Quality Officer
History:	Approved from the Quality Oversight Group (QOG)
Purpose:	☒ Assurance ☐ Approval
	☒ Discussion ☒ Noting

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

These papers provide an update on Serious Incident Investigations, themes and learning include:
- Executive summaries of SI's closed in April and May 2020
- Q4 SI thematic report
- Long Delays Thematic Review

The executive summaries provides an overview of the 1 Serious Incident Investigation in April and 4 in May 2020 which were closed by the Clinical Commissioning Group.

The Q4 thematic report provides an overview of the 22 Serious Incident Investigation declared. Of these, 13 were level 2 comprehensive investigations and 9 were level 1's concise investigations. The Trust's compliance with the 60 working day target for submitting SI reports to the CCG was 100%. In this quarter the CCG approved and closed 48 SI investigations, with the main theme from both declared and closed SIs being delays. As a result, a thematic was commissioned, which has since been completed.

The team are reviewing all learning outcomes from SIs in 2019-2020 in order to share key messages via a one page infographic and to ensure that vital messages were not missed during the pandemic.

The long delays thematic review found that 31% of SI declared in 19/20 were attributed to a form of delay. This review found that delays were more complex than crews simply not arriving to a patient in a timely manner and often occurring due to multiple system and process failings. Identified themes from the review were:
- Call handling
- Service demand
- Resource
- Staffing
- Process issues
- System issues e.g. CAD failures

Many actions have been taken to address these issues. It is also noted that COVID19 has led to Trust-wide changes in systems and processes regarding resource, staffing and capacity demands.

Recommendation(s) / Decisions for the Board / Committee:

The Trust Board is asked to note and consider the information provided within these reports.

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer**
Quality	Yes	x	No		Chief Quality Officer and QOG
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		

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Executive Summary for 1 Serious Incident closed by the Clinical Commissioning Group in April 2020

Incident description:	**2019/28184 – ID 35041** At 14:06 on 20th December 2019 a 999 call was received from a care line provider for an 84 year old male who had fallen at home and had been found by a neighbour. The call was triaged through the Medical Priority Dispatch System (MPDS) and resulted in a Category 5 response (referral for a telephone assessment by a clinician). At 14:22 the call details were entered into the Adastra system (computer data base) and the call was sent to the Clinical Hub for a clinical review by a clinician. A Clinical Advisor from the Clinical Hub contacted the patient's son by telephone 88 minutes after receipt of the initial call (within 90 minute target response) and conducted an assessment of the patient using the Manchester Triage System (MTS). Following the MTS assessment the patient was referred for further telephone clinical assessment by a GP or an Advanced Clinical Practitioner (ACP) and at 15:54 the call was sent electronically to the North East London (NEL) 111 queue to facilitate this. Within NEL this call initially received a priority 3 (call back within 60 minutes) but at 16:10 the priority of the call was changed from Priority 3 to Priority 2 (call back within 30 minutes) At 17:00 an Advanced Clinical Practitioner (ACP) started assessment of the patient via speaking to the patient's son. During the call it became clear that the patient was not breathing and CPR (cardio-pulmonary resuscitation) instructions were given by the ACP and a 999 referral was made. At 17:13 a 999 call was received from NEL111 and was triaged as a Category 1 response. At 17:18 a paramedic on a Fast Response Unit and a double crewed ambulance arrived at the patient's address. The patient was found to be deceased. Resuscitation was not attempted as the patient's Coordinate My Care (CMC) record stated that the patient was not for resuscitation. The patient was recognised as life extinct 17:20.
Immediate risk mitigation:	Clinical Hub clinicians involved in the assessment of the patient have undergone a quality assurance review of the handling of the call. They identified areas of learning around active listening and self-reflected on the incident. Review of the referral process from Clinical Hub to Integrated Urgent Care (IUC) was undertaken and subsequently updated to include direct electronic referrals.
Findings of investigation:	The original call was appropriately triaged from the information given as a Category 5 and the system followed the set procedure which led to the call being reviewed by a Clinical Hub clinician with the 90 minute timeframe. The initial call handler had no reason to suspect that certain demographic details provided by a 4th party caller were incorrect and similarly assumed the care line operative had appropriate information on the patient's condition therefore did not try to contact the patient directly.

The patient demographics entered initially into the Adastra system were not complete and this possible impacted on the efficacy of the subsequent clinical assessment. It has not been possible to establish why full patient details were not entered into the system.

The assessment completed by the Clinical Advisor was not satisfactory and 'Red Flag' discriminators were missed. The patient was incorrectly triaged on the Manchester Triage System. This resulted in the patient's details being sent to 111 to await a further telephone assessment by a senior clinician. It is not possible to comment on the potential outcome of an assessment based on the verbal cues identified as further questioning was not completed. A more urgent and timely clinical face to face assessment may have resulted.

The patient was referred electronically to NEL 111 for an advanced clinician ring back / assessment. This was not an approved referral pathway at the time of the incident even though it was a commonly used method of referring patients to NEL111. It is reasonable to surmise that this in isolation had no detrimental impact on patient outcome. It is important to note that had the patient been referred to another healthcare professional (e.g. his own GP or the falls team) using the established process via DOS, it is unlikely that he would have been assessed more quickly compared to a NEL111 advanced clinician telephone assessment.

This electronic referral pathway from LAS Clinical Hub to IUC has since been formalised and approved. It is now a recognised way of referring appropriate patients to the IUC and not deemed to impact negatively on patient outcome.

The actions taken on identification of the cardiac arrest were appropriate both by the clinician undertaking the telephone assessment and by the ambulance crews that attended scene.

Recommendations:

The findings of this investigation should be used as shared learning via established structures across the Trust where appropriate.

The newly established direct electronic referrals to (IUC) 111 should be reviewed to ensure it doesn't compromise patient safety.

London Ambulance Service NHS

NHS Trust

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Executive Summaries of 4 Serious Incidents closed by the Clinical Commissioning Group in May 2020

Incident description:	**2020/1048 – ID 34896** A 999 call was received from the wife of a 68 year old male who was reported to be a Type 2 diabetic and be suffering from problems related to his diabetes. The call was triaged and obtained a Category 2 priority which has a target mean response time of 18 minutes and 40 minutes on the 90th centile (9 out of 10). An Operational Placement Centre (OPC) Ambulance (comprising 3 staff) was dispatched and arrived on scene achieving an overall response time of 7 minutes. The patient was clinically assessed and treated for hypoglycaemia. IV glucose was administered in two separate doses to good effect, returning the patient's blood sugar level to a normal level, which resulted in a return of the patient's behaviour to what was normally expected of him. The ambulance crew expressed concern over the extent of his medical history and his presentation at the attendance of the call and explained that hospital would be the safest and advisable course of action. The patient declined conveyance to hospital against advice upon the information given to him at the time. The patient was left with worsening advice and confirmed that he would contact he GP when the surgery opened the following day. The patient was left in care of the wife. Approximately 13.5 hours after the original call, the wife made a further 999 call to report that the patient was very cold and not responding. The call received a Category 1 response which has a mean target response time of 7 minutes and 15 minutes on the 90th centile. Multiple resources were dispatched with the first arriving on scene achieving a response time of 5 minutes. The patient was found lying on the floor, unresponsive and not breathing. Resuscitation was immediately commenced however after a consultation with the Clinical Hub the decision was made to cease resuscitation.
Immediate risk mitigation:	Paramedic A and Paramedic B were seen by their manager and received feedback on the referral of diabetic patients and protocol for post hypoglycaemic patients.
Findings of investigation:	Both 999 calls were correctly received, handled and received a timely response within their target mean response times. The patient was appropriately treated for hypoglycaemia with IV glucose and made a recovery to their normal cognitive state. The patient chose to decline conveyance to hospital against the lead clinician's advice. There were no capacity concerns, and the patient was informed of the risks of not attending hospital. The crew did not use the Known Diabetic Hypoglycaemic Referral Flowchart or Patient Referral Tool (v2) in their decision making. A welfare ring-back was considered for the patient, however it was understood that this would not be accepted due to the patient being left in care of their wife. This is not the case and a referral should have been made.

	The patient declined conveyance, and this was documented in the free text of the LA4 PRF. In contradiction to this, the non-conveyance checklist indicated that the patient was not refusing transport against advice. This was recognised as an error of Paramedic B (completing the documentation) and also Paramedic A (the mentor). It is not believed that the outcome would have been different had the referral for a welfare ring back been made. The ring back would have taken place within two hours of the referral and the patient was identified as being deceased but without signs unequivocally associated with death 11 hours later.
Recommendations:	Learning arising from this and further investigations be shared across the Trust through the LAS Serious Incident & Assurance Learning Group. A thematic review of OPC related incidents should be undertaken by the London Ambulance Service to identify themes regarding the non-use of decision support tools when making decisions regarding non conveyance The Know Diabetic Hypoglycaemic Referral Flowchart to be reviewed and made available to all staff. The Education and Development Team to consider the topic of Hypoglycaemia on future mandatory training.
Incident description:	**2019/28187 – ID 34749** A 999 call was received via an alarm service of an 85 year male, who reported that the patient had activated his alarm and was shouting for help. The call was triaged and obtained a Category 5 priority as an "unknown problem". The call was closed by the Clinical Hub and entered into the Adastra system in order for an enhanced clinical assessment to be undertaken. A second 999 call was received 26 minutes later via the daughter of the patient who had arrived at the address and advised that her father was laying on the floor and was deceased. The call was triaged and obtained a Category 1 response priority which has a mean target response time of 7 minutes. Two fast response units (FRU) and a double crewed ambulance (DCA) were dispatched and arrived on scene achieving a response time of 3 minutes and 46 seconds from the origin time of the second 999 call. The total response time from the first 999 call was 30 minutes and 2 seconds. The clinicians identified that the patient unresponsive and beyond help with the presence of rigor mortis.
Immediate risk mitigation:	An incident report was completed by the Clinical Hub staff. The call handler was meet with as part of the investigation and feedback provided.
Findings of investigation:	The limited information available meant that it was very difficult for this call to receive a high priority response. MPDS does not prioritise alarm activations where the patient has been heard to talk.

	MPDS makes no allowance for someone who has been heard talking and is now not responding. ECH A did not follow procedure and should have asked further questions and attempted to make contact with the patient. Their rationale for this alluded to a combination of confirmation bias and assumptions made about what the gains would be. ECH A was not a regular call taker and had not taken a 999 call for 15 months prior due to undertaking a secondment in another area of the EOC. Despite receiving refresher training, ECH A was unfamiliar with some of the policy and procedure relating to call taking. It is not possible to conclude whether the response priority would have been different had the call been complaint. The Assistant Medical Director highlighted that the outcome for the patient would have unlikely been different considered the high mortality associated with a ruptured aortic aneurysm.
Recommendation:	A request be made to the MPDS academy for guidance on what to do in the event a patient is heard talking, but then not responding when the call comes from a 3rd or 4th party (Based on that advice consider assigning a higher response to calls of this nature) Ensure that all call taking staff are fully aware of the guidelines within OP60 regarding the management of 3rd and 4th party calls Call handlers who have had a prolonged period absence or extended time away from taking calls should attend a refresher course on call taking/handling
Incident description:	**2019/28184 – 35041** At 14:06 on 20th December 2019 a 999 call was received from a care line provider for an 84 year old male who had fallen at home and had been found by a neighbour. The call was triaged through the Medical Priority Dispatch System (MPDS) and resulted in a Category 5 response (referral for a telephone assessment by a clinician). At 14:22 the call details were entered into the Adastra system (computer data base) and the call was sent to the Clinical Hub for a clinical review by a clinician. A Clinical Advisor from the Clinical Hub contacted the patient's son by telephone 88 minutes after receipt of the initial call (within 90 minute target response) and conducted an assessment of the patient using the Manchester Triage System (MTS). Following the MTS assessment the patient was referred for further telephone clinical assessment by a GP or an Advanced Clinical Practitioner (ACP) and at 15:54 the call was sent electronically to the North East London (NEL) 111 queue to facilitate this. Within NEL this call initially received a priority 3 (call back within 60 minutes) but at 16:10 the priority of the call was changed from Priority 3 to Priority 2 (call back within 30 minutes) At 17:00 an Advanced Clinical Practitioner (ACP) started assessment of the patient via speaking to the patient's son. During the call it became clear that the patient was not breathing and CPR (cardio-pulmonary resuscitation) instructions were given by the ACP and a 999 referral was made. At 17:13 a 999 call was received from NEL111 and was triaged as a Category 1 response. At 17:18 a paramedic on a Fast Response Unit and a double crewed ambulance arrived at the patient's address. The patient was found to be deceased. Resuscitation was not attempted as the patient's Coordinate My Care (CMC) record stated that the patient was not for resuscitation. The patient was recognised as life extinct 17:20

Immediate risk mitigation:	Clinical Hub clinicians involved in the assessment of the patient have undergone a quality assurance review of the handling of the call. They identified areas of learning around active listening and self-reflected on the incident. Review of the referral process from Clinical Hub to Integrated Urgent Care (IUC) was undertaken and subsequently updated to include direct electronic referrals.
Findings of investigation:	The original call was appropriately triaged from the information given as a Category 5 and the system followed the set procedure which led to the call being reviewed by a Clinical Hub clinician with the 90 minute timeframe. The initial call handler had no reason to suspect that certain demographic details provided by a 4th party caller were incorrect and similarly assumed the care line operative had appropriate information on the patient's condition therefore did not try to contact the patient directly. The patient demographics entered initially into the Adastra system were not complete and this possible impacted on the efficacy of the subsequent clinical assessment. It has not been possible to establish why full patient details were not entered into the system. The assessment completed by the Clinical Advisor was not satisfactory and 'Red Flag' discriminators were missed. The patient was incorrectly triaged on the Manchester Triage System. This resulted in the patient's details being sent to 111 to await a further telephone assessment by a senior clinician. It is not possible to comment on the potential outcome of an assessment based on the verbal cues identified as further questioning was not completed. A more urgent and timely clinical face to face assessment may have resulted. The patient was referred electronically to NEL 111 for an advanced clinician ring back / assessment. This was not an approved referral pathway at the time of the incident even though it was a commonly used method of referring patients to NEL111. It is reasonable to surmise that this in isolation had no detrimental impact on patient outcome. It is important to note that had the patient been referred to another healthcare professional (e.g. his own GP or the falls team) using the established process via DOS, it is unlikely that he would have been assessed more quickly compared to a NEL111 advanced clinician telephone assessment. This electronic referral pathway from LAS Clinical Hub to IUC has since been formalised and approved. It is now a recognised way of referring appropriate patients to the IUC and not deemed to impact negatively on patient outcome. The actions taken on identification of the cardiac arrest were appropriate both by the clinician undertaking the telephone assessment and by the ambulance crews that attended scene.
Recommendations:	The findings of this investigation should be used as shared learning via established structures across the Trust where appropriate. The newly established direct electronic referrals to (IUC) 111 should be reviewed to ensure it doesn't compromise patient safety.
Incident description:	**2020/1055– ID 35714** On 8th January 2020 at 05:56 a 999 call was received from the father of 35 year old male who was suffering from auditory hallucinations, was reported to be talking to himself and was on the ledge outside the window on the top floor. The call was categorised as a Category 3 with a target mean response time of 120 minutes.

	A resource was dispatched and, whilst the Double Crewed Ambulance was arriving on scene, a further call was received advising that the patient had jumped from the fourth floor of the building. Further resources were sent to assist including London Air Ambulance (LAA). The patient fell approximately 50 foot and the attending clinicians found the patient to have multiple injuries including to his head and back. The patient was escorted by LAA to the nearest Major Trauma Centre (MTC).
Immediate risk mitigation:	ERD B was informed of the circumstances of the call and was provided with supportive feedback from their line manager.
Findings of investigation:	Both 999 calls that were received were correctly handled, triaged and received the correct determinants and corresponding response. The investigation did not identify any delay in the dispatch of resources beyond that which would normally be expected. The investigation identified assumptions from ERD B regarding recording resource availability and contacting MPS. There no was no clinical safety net provided by the Clinical Hub which may be attributable to the time of day this incident occurred and shift change over. It was highlighted that no Mental Health nurse was on duty in EOC which could have further assisted with an enhanced telephone assessment. The clinical treatment on scene was delivered in line with LAS policies and national protocols and guidelines.
Recommendations:	The key learning points from this incident with regards to human factors (namely assumptions) and contacting the MPS should be shared amongst EOC staff. The Trust should undertake a review of shift change over to ensure that suitable mitigations are in place The findings of this investigation should be shared across the Trust.

Serious Incident (SI) Thematic Report
Quarter 4 – 2019/20

1. Introduction and Background

1.1. This paper provides an overview of the Serious Incidents (SI's) reported and declared to the Clinical Commissioning Group (CCG) as well as a thematic review of those SI's which were closed by the CCG in Quarter 4 (Q4) of 2019/20. This thematic review specifically focuses on SI's by category and key contributory factors.

2. Context

2.1 During Q4, a total of 1,528 patient safety incidents were reported on the Trust's Risk Management system, Datix. Of these, 22 incidents (1.4%) were declared as SI's following review at the Serious Incident Group (SIG). Of those declared, 13 were declared Level 2 comprehensive investigations and 9 were declared Level 1's concise investigations.

2.2 The Trust's compliance against the 60 working day target for submitting SI reports to the CCG was 100%.

2.3 The CCG approved and closed 48 SI reports, approved two SI de-escalations from incidents which had been declared in Q3.

3. Serious Incidents Declared in Q4

3.1. This section considers the SI's declared in Q4, the majority of which are still under investigation and so final outcomes, root causes and contributory factors are not yet known. This information will be provided in subsequent reports when the investigation reports have been approved and closed by the CCG.

Graph 1. SI's Declared by Sector in Q4

SIs Declared by Sector in Q4
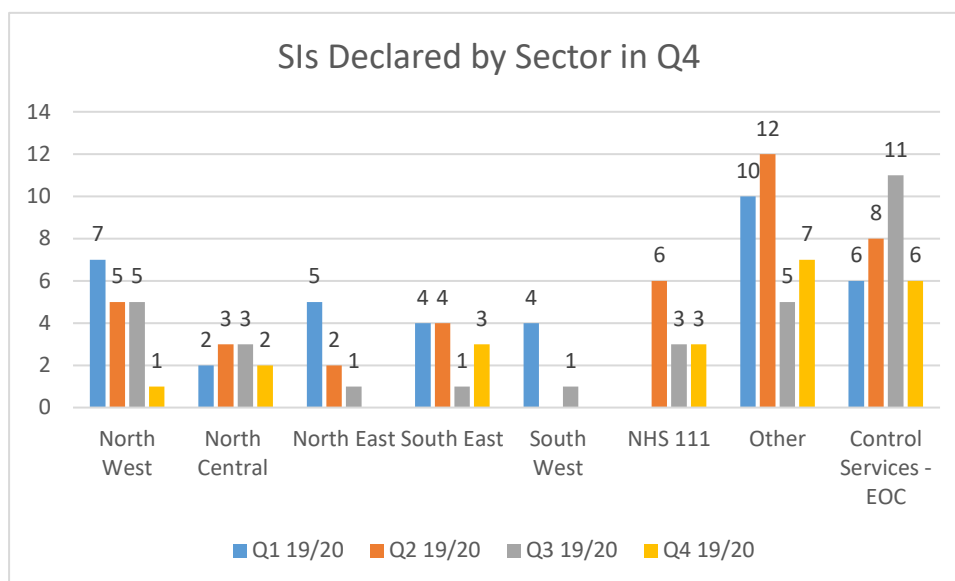
Figure 1

	Q1	Q2	Q3	Q4
Trust Total	38	40	30	22

3.2. Graph 1: The overall number of SIs declared in Q4 has reduced from 30 (reported in Q3) to 22.

3.3. There has been a reduction in the number of SIs declared in Q4 across Sectors, EOC and NHS 111. Whilst there has been a slight increase in the number of SIs under "Other" when compared to Q3. "Other" includes Performance which has been introduced as a category to reflect SIs where the Trust did not meet the target mean or 90th centile response timeframes. "Other" also includes Information Management and Technology (IM&T) and Clinical Hub (CHUB) related SIs. Historically this data was classed under EOC or Sector Services and breaking these categories down allows for more stringent monitoring and identification of themes. In Q4, Performance was the only "Other" lead sector/area identified.

3.4. These categories and numbers are monitored by the central team and the Safety Investigation Assurance and Learning Group (SIALG).

Graph 2. SI's Declared by Department/Area in Q4 – Levels 1 and 2 breakdown
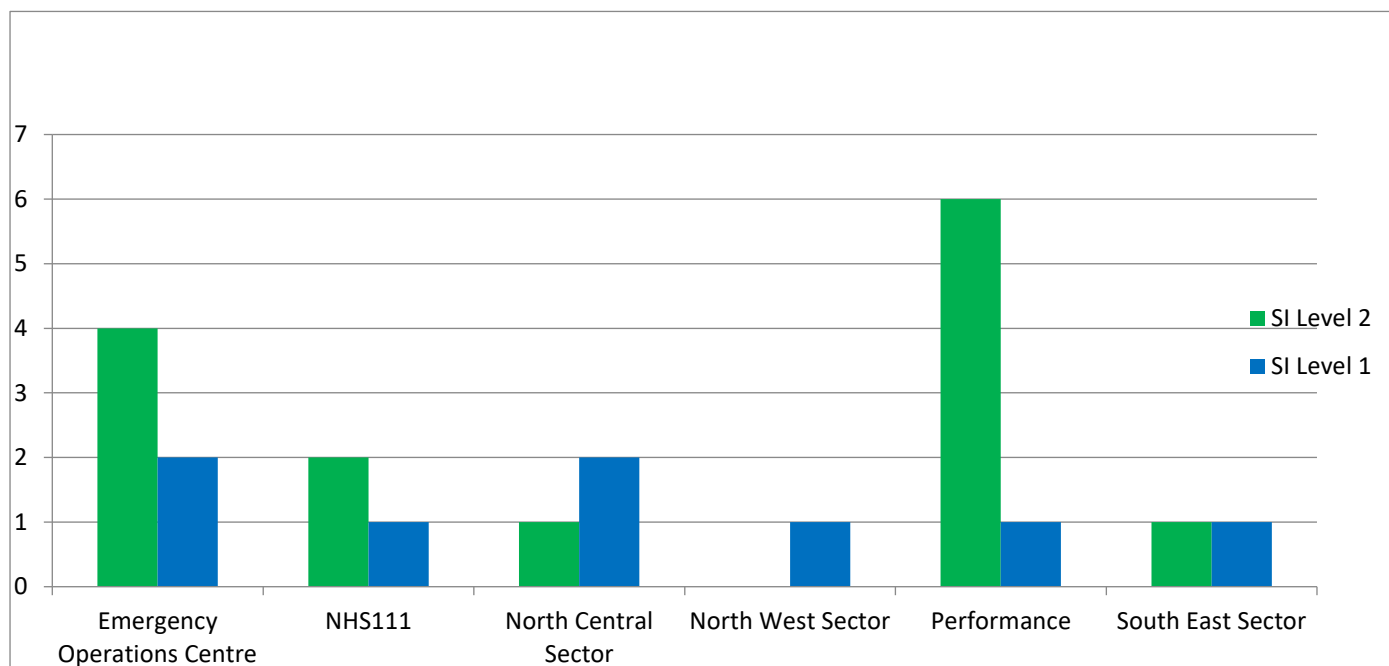
3.5. Graph 2 shows the breakdown of both Level 1 and Level 2 investigations declared in Q4 with the expansion of the "other" category from graph 1.

Graph 3. SI's Declared by CCG distribution
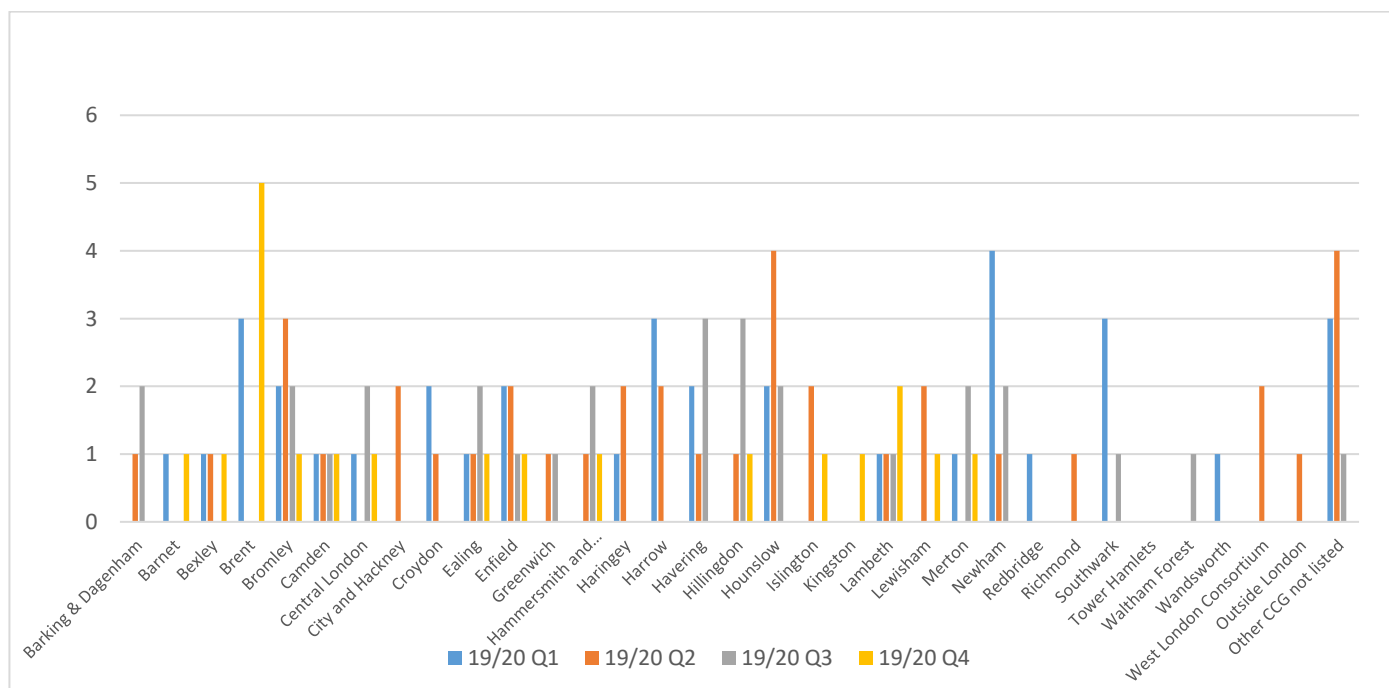
Graph 4. SI Categories
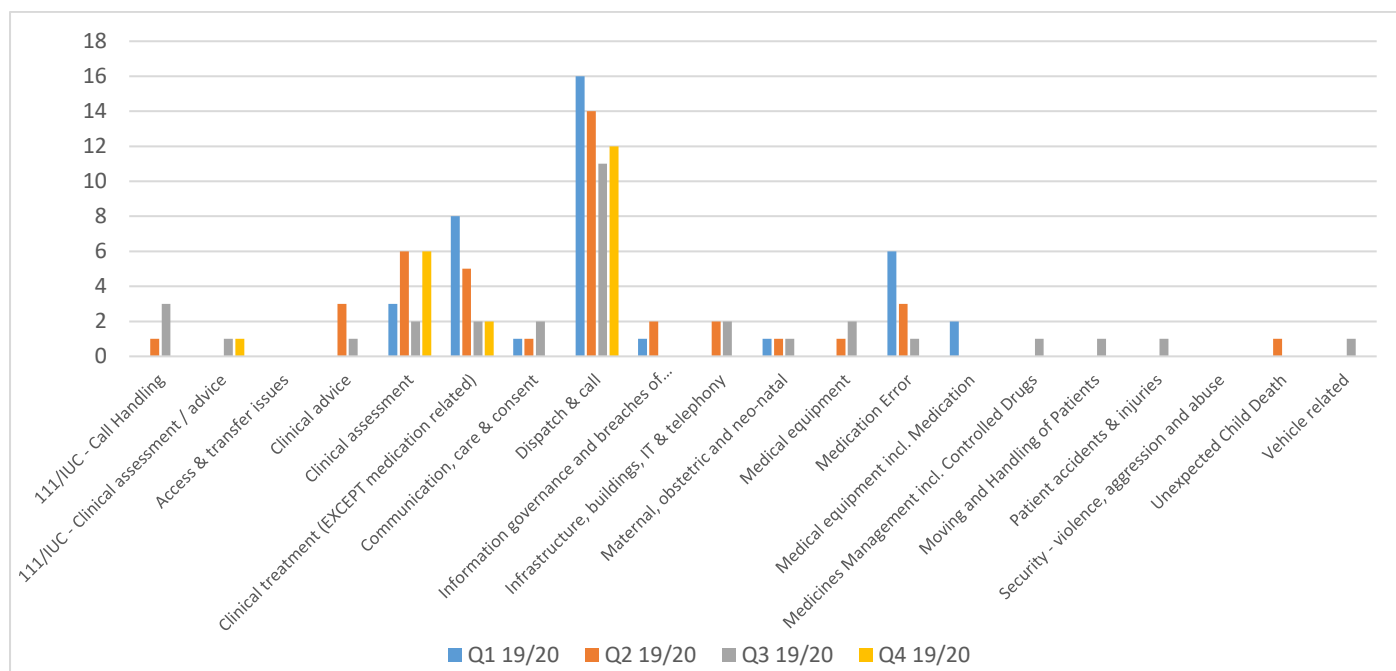
3.6. Graph 4 shows the categories of incidents being declared as SIs. The top three categories continue to be around Clinical Assessment, Clinical Treatment and Dispatch and Call issues.

Graph 5. SIs declared by Department/Area in Q4 – Category Breakdown

Respectful | Professional | Innovative | Collaborative

SI Thematic Report – Q4 2019/20
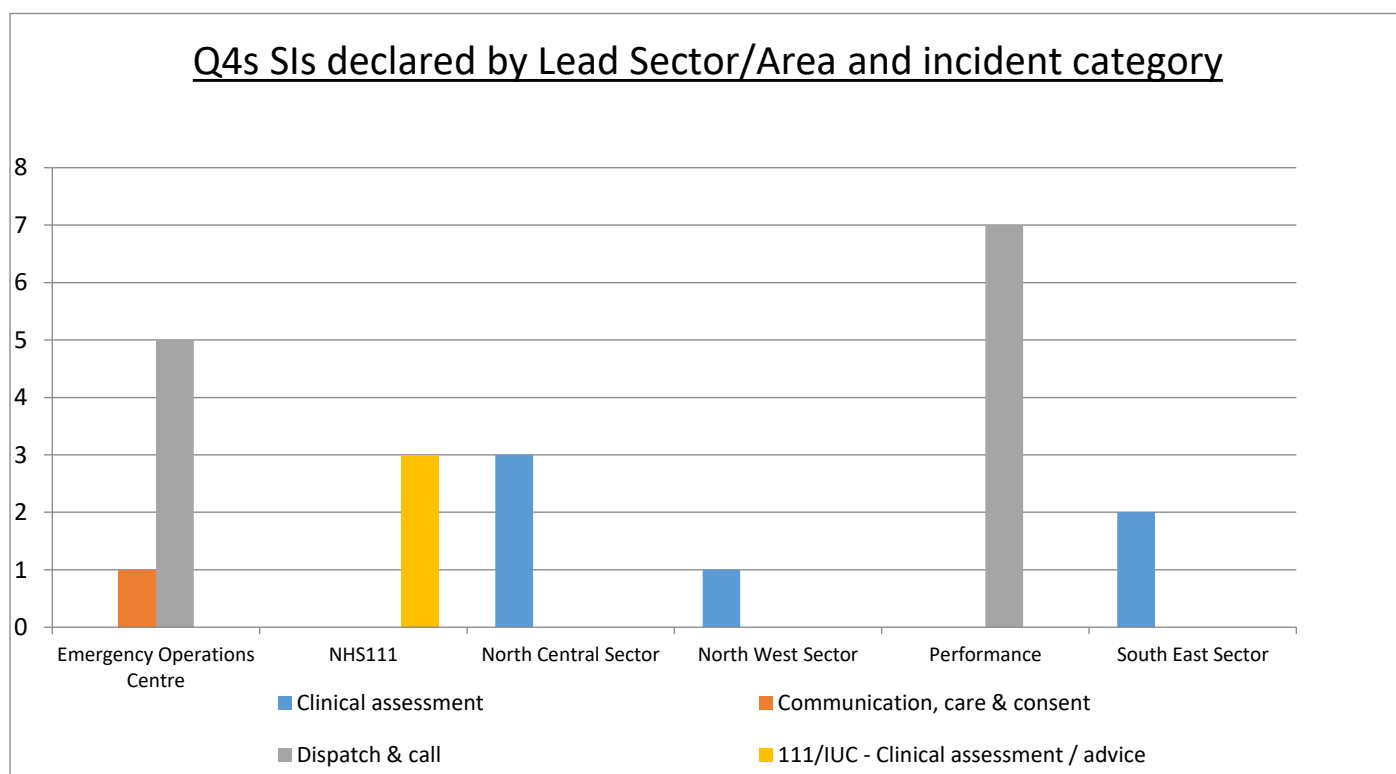
3.5   Types of the SIs declared in each Department/Area for Q4

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There was 1 SI declared in the ***North West*** in Q4:

- A ECG was not undertaken for a patient with history of heart failure and diabetes. The patient was not conveyed and died within 24 hour of the initial contact.

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There were 3 SIs declared in the ***North Central*** in Q4:

- A patient was not conveyed to hospital who presented with a PR bleed and was identifed as being on blood thinners.
- A patient sustained a fall down a flight of stairs and was not immobilised. A quality alert was received from the hospital who identified that the patient had spinal fractures.

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There were 2 SIs declared in the ***South East*** in Q4:

- Both were patients who presented with hypoglycaemia and were not conveyed. Both were found deceased within 24 hours of the initial contact.

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There were 3 Serious Incidents declared in ***111/IUC*** in Q4:

- There was a missed opportuniry by a NEL GP to have obtained a Category 2 response priority for an elderly patient. A subsequent 999 call was received reporting that the patient was in cardiac arrest.
- A patient was inappropriately referred to a GP Hub by Taxi.
- An assessment of a patient undertaken by the clinician fell short of the required standards and missed an opportunity to recognise that the patient had the symptoms of sepsis.

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There were 6 Serious Incidents declared in ***Control Services-EOC*** in Q4:

- 3 incidents involved calls which were incorrectly triaged and received the incorrect response priority.
- 1 incident highlighted that incorrect advice had been provided with regards to the management of severe haemorrhage
- 2 incidents involved the management of the call whilst it was held including the use of welfare ring back, consideration to call the MPS and the management of a potential collapse behind locked doors.

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There were 7 SIs declared regarding ***Performance*** in Q4:

- All of these incidents involved the Trust breaching its target response time for a Category 2 and 3 priority calls.
- All of these incident there was identifed likely harm caused by the prolonged response time.

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3.7.   The LAS has a tiered system for incident learning, which encompasses individual learning via specific support and feedback, sector level monitoring and action on incidents to higher level thematic / strategic learning within sectors, and across the Trust.

3.8. The team have used an internal closed social media platform to promote key learning messages from incidents. Specifically promoting messages about defibrillation. The number of cases of delayed defibrillation has significantly reduced since the completion of the Thematic Analysis in December 2019 and the implementation of a number of actions. This has been shared widely across the Trust including the LiA post below via our dedicated learning page:

3.9. A Serious Incident Case Review Evening was scheduled for March 2020 and was fully subscribed before being cancelled due to COVID-19. The team is currently exploring other avenues to share the learning from SIs including the introduction of the case review event over MS Teams and other media platforms.

3.10. Learning messages were reduced in the latter part of Q4 in order for the Trust to focus its messaging on the changing and evolving guidance in relation to COVID-19. The team are reviewing all learning outcomes from SIs for 2019-2020 in order to share key messages in a one page infographic and to ensure that vital messages were not missed during the pandemic.

Identified Themes in Q4:

3.11. Q4 declared SIs covered the Trusts response to Christmas and New Year's. Additionally Q4 covered the Trust's initial response and change in demand during the COVID-19 pandemic. Consequently a key theme from Q4 is delays in dispatch, specifically a number of incidents experienced a delay of more than two times the 90th centile response time (long delay) for that category of call. Q4 saw eight SIs involving delays in dispatch with four being classified as long delays.

Identified Themes in Q3:

3.12. Due to recent high demand, delays in call and dispatch has been identified as a patient safety theme and the Chief Medical Officer maintained daily oversight of delays to assess any potential harm.

3.13. In addition patients falling from trolley beds and the inappropriate non conveyance of patients have been identified as emerging themes in Q3 and will be monitored by SIALG.

4. Thematic Review of closed SI's in Q4.

4.1. The following provides information on the outcome and contributory factors identified in completed investigations which have been closed by the CCG in Q4:

North Central
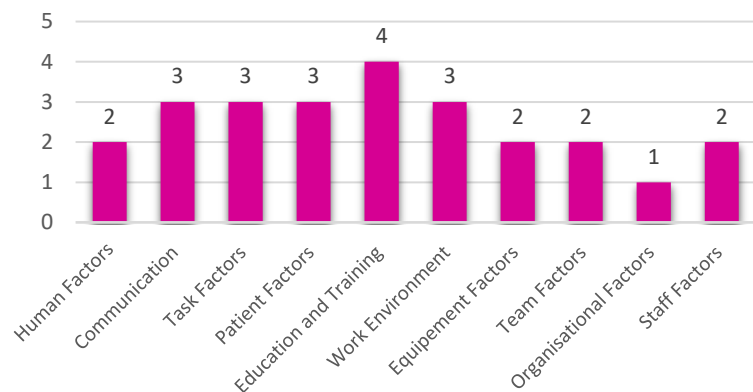
There were 5 serious incidents closed by the CCG from the North Central sector during Q4. Key contributory factors identified from the SI reports included:

<u>Communication</u>: the provision of explicit and clear worsening care advice provided to patients when making decisions regarding not being conveyed to hospital.

<u>Task</u>: The JRCALC guidelines for ROLE and the language used to describe the massive *injury was* ambiguous and open to interpretation.

<u>Patient</u>: Patients presenting with atypical symptoms not normally associated with requiring conveyance.

<u>Education and Training</u>: The association of clinical findings to formulating impressions and appropriate management plans for patients.

<u>Work Environment</u>: working in confined spaces and associated challenges in obtaining 360 degree access.

Key learning and actions taken across the SIs in relation to these contributory factor included:

- *The Trust continues to promote the role of effective communication during assessment within mandatory training.*
- *JRCALC+ has the ability to include LAS specific guidance.*

North East
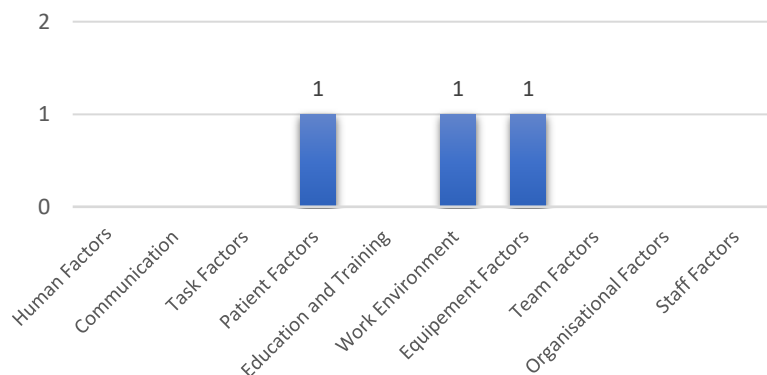
There was 1 serious incident closed by the CCG from the North East sector during Q4. Key contributory factors identified from the SI report included:

<u>Patient</u>: The patient's physical airway attributes presented the clinicians with a difficult airway to manage. The patient's original positioning made access difficult and similarly the airway was heavily soiled with blood tinged fluid.

<u>Work Environment:</u> The patient's original positioning made accessing the airway challenging.

<u>Equipment</u>: The initial BVM was found to be faulty as identified once an advanced airway circuit was established.

Key learning and actions taken across the SIs in relation to these contributory factors included:

- Learning and improved guidance shared with all frontline staff members about the challenges presented with the management of difficult airways
- The investigation was shared with the relevant equipment supplier.

North West

Contributory Factors North West
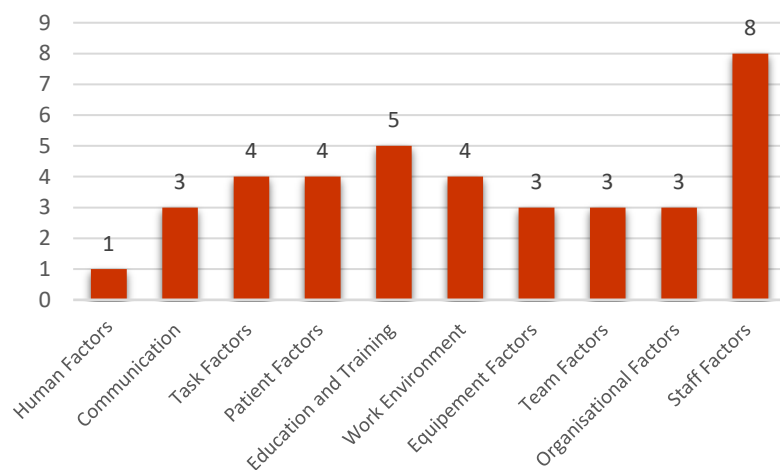
There were 7 Serious Incidents closed by the CCG for the North West sector during Q4: Key contributory factors identified from the SI reports included:

Task: Staff using old versions of clinical practice guidelines.
Education and Training: Staff in the EOLC team were unaware of Health Partner Alerts (HPA). Email received from Team Leader Palliative Care was not recognised as an HPA and so the correct processing for reporting was not initiated.
Work Environment: Dark and wet environment with narrow hallway made challenging for staff to be able to positioned at each corner of a scoop stretcher
Staff factors: Confirmation bias with regards to the patient presentation, staff focused and fixated on the machines being faulty as oppose to working through other causes i.e. chest preparation.

Key learning and actions taken across the SIs in relation to these contributory factors included:
- The Trust is in the process of developing the EOLC medication guidance, including drug calculations to be shared with all clinicians via the JRCALC + app,
- The internal Paramedic programme education was reviewed to ensure that the administration of medication for the EOLC patients includes the drug calculations requirements of JRCALC 2019.

South West

Contributory Factors South West
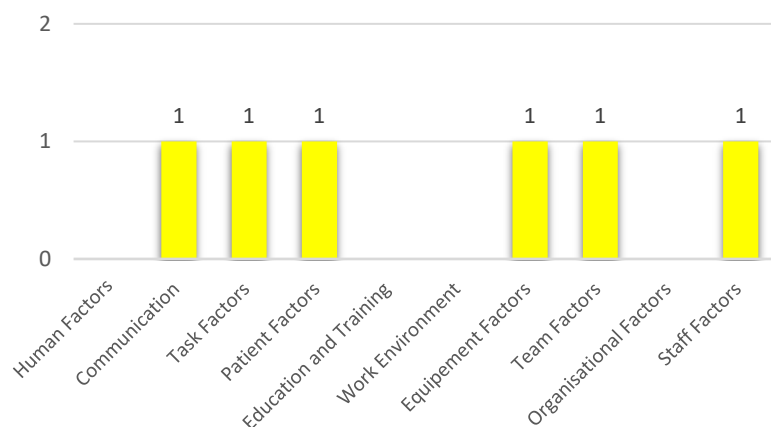
There was 1 Serious Incident closed by the CCG for the South West sector in Q4. Key contributory factors identified from the SI report included:

Communication: Communication challenges between EOC and front line clinicians.
Patient: At the time of the initial 111 call the patient did not know that she was pregnant, the pre-arrival information was limited. The patient had not had any antenatal care, no maternity records and the gestational age of the baby was unknown.
Equipment: There were issues accessing the equipment in Paediatric Life Support (PALS) Pack.
Team: Challenges in defining and assigning clinical leadership
Staff: Stressful situation involving an unexpected pregnancy and a premature baby born requiring resuscitation. Stressful situations led to the non-use of decision making tools.
Key learning and actions taken across the SIs in relation to these contributory factors included:
- Attendance at joint maternity training and NLS training on CSR 2018.3 for the staff involved.
- Organisational learning with regards to the new-born resuscitation guidelines. Specifically focusing on the importance airway management and aerating the lungs prior to chest compressions.

South East

Contributory Factors South East
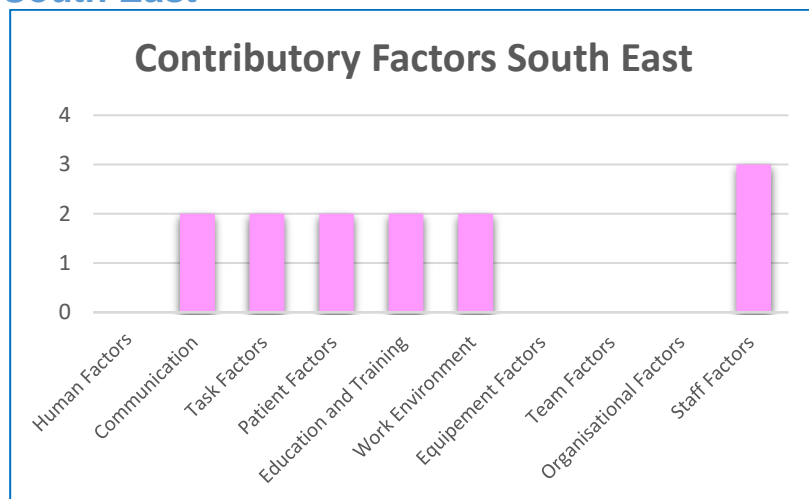
There were 4 serious incidents closed by the CCG for South East sector in Q4. Key contributory factors identified from the SI report included:

Communication: insufficient information provided to clinical staff.
Task: The available guidance on how to arrange an emergency ambulance for an HPC was unclear and lacked clarity.
Education: Lack of knowledge in the use of Naloxone was covered in the drugs module on the LAS crew course. Staff was trained internally by LAS, training course had not covered the management of patients with internal defibrillators.
Environment: Lack of breaks during work hours and Shifts.
Staff: Patient was delayed for being transported sooner because the attending clinician did not accept the GP's diagnosis around limb ischemia. Inadequate decision made by the LAS crew on scene and collectively agreed the decision to leave a prefilled syringe of Naloxone on scene with the patient's partner.

Key learning and actions taken across the SIs in relation to these contributory factors included:
- The LAS continue to support and train staff via the new core skills refresher training programmes.

Control Services (EOC)

Contributory Factors Control Services (EOC)
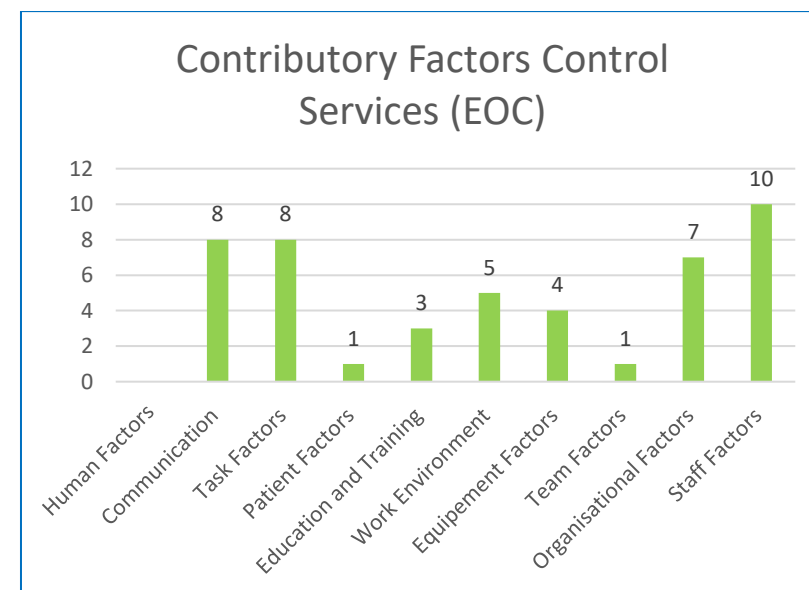
There were 14 Serious Incidents closed by the CCG for Control Services in Q4. Key contributory factors identified from the SI reports included:
Communication: Ineffective communication between Dispatcher and Watch Manager whilst reporting the issue with Airwaves text messaging services.
Task: The Inter hospital Transfer flow chart was slightly ambiguous and open to different interpretation and discrepancy.
Environment: There was minimal staffing in the Clinical Hub therefore the patient was not called back within the 90 minute timeframe.
Organisational: The LAS control room was operating on paper due to the planned CAD system and lead to EOC staff being unable to validate the address given by the MPS.
Staff: Staff did not recognise that there may be alternative spellings for the address given, and therefore did not think to ask for the spelling to be clarified.
Key learning and actions taken across the SIs in relation to these contributory factors included:
- Safeguarding and Chub departments to collaborate on the development and publication of guidance on actions to take in the event that a child's record cannot be found on Summary Care Record
- EOC to deliver planned paper operations and CAD with Limited Functionality events in 2020/21
- The Trust is to review the performance trajectories and the staffing levels.

NHS 111/IUC Services

Contributory Factors IUC 111
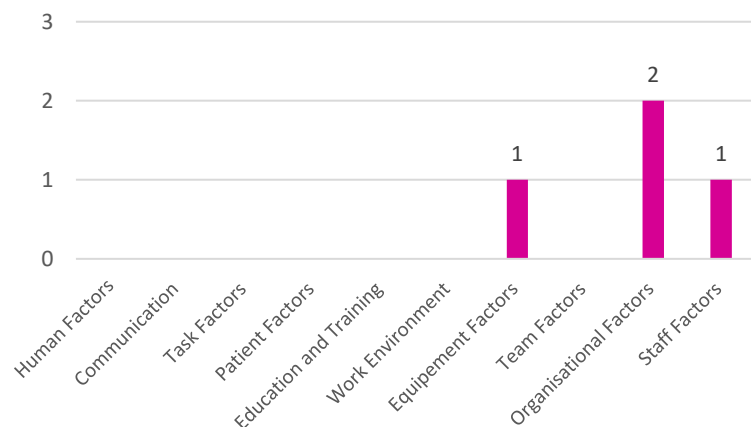
There was 1 Serious Incident closed for 111/IUC by the CCG in Q4. Key contributory factors identified from the SI report included:

Organisation: External reported risks - The Service lost frontline ambulance provision due to queuing at Emergency Departments to hand over patients, which delayed ambulances returning to being available for patients in the community.

Staff: GP A assumed that the quickest option to organise an ambulance would be for Nurse A call the 999 directly. GP A did not follow the correct procedure for passing the call from 111 IUC to 999, and did not correctly categorise the call on the 111 IUC system.

Key learning and actions taken across the SIs in relation to these contributory factors included

- The IUC Manager to provide feedback to GP 'A' regarding their use of SCM and how to categorise and pass calls to 999.
- Head of CHUB to undertake a review of CHUB structure, staffing and rostering.
- The Head of 999 Quality and Continuous Improvement to implement the EOC call handling improvement plan which, as part of the plan, will review staffing levels within EOC.

Other

Contributory Factors Other
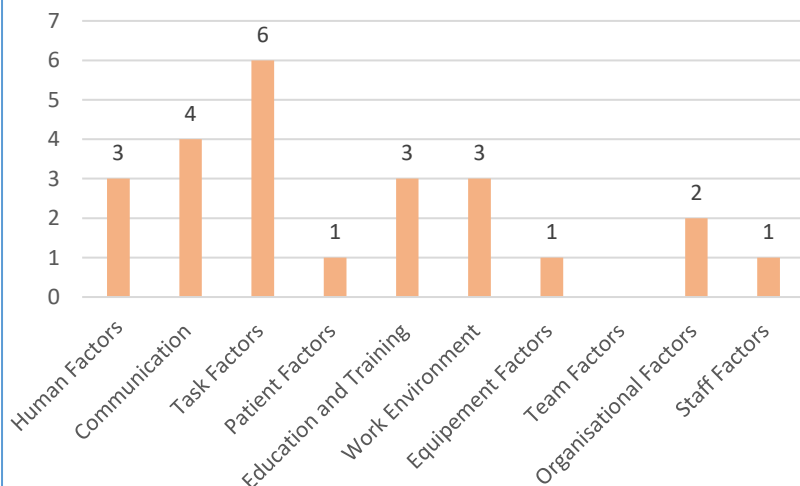
There were 6 serious incidents closed for by the CCG for Other in Q4. Other includes the CHUB, IM&T, EPRR, OPC. Key contributory factors identified from the SI report included:

Human: Task focused on patient's need to go to the hospital, did not complete the assessment that would have helped them reach a decision and to advise the patient's mother on the urgency required to transport the child to the hospital.

Communication: Ineffective communication cascade relating to the skill mix and dispatch criteria of PAS/VAS staff.

Education and Training: St John Ambulance Service (SJA) crews were not familiar with the LAS ways of working including the process of non-conveying of an HCP admission call.

Environment: The volume of calls and the demand on the Trust meant that EOC Watch Managers were not able to succeed in managing the SJA vehicles once the NETS desk had closed.

Key learning and actions taken across the SIs in relation to these contributory factors included:

- Develop dedicated Call signs to distinguish between SJA volunteer and frontline capable crews should be explored, for example, NETS capable SJA crews use the call sign SJ30-39 and frontline capable SJ40-49.
- VAS crews to undertake similar training to what the PAS crews receive before being deployed to do LAS work.

Due to the large number, the contributory factors relating to Performance have been explored in the section below

Performance

Contributory Factors Performance
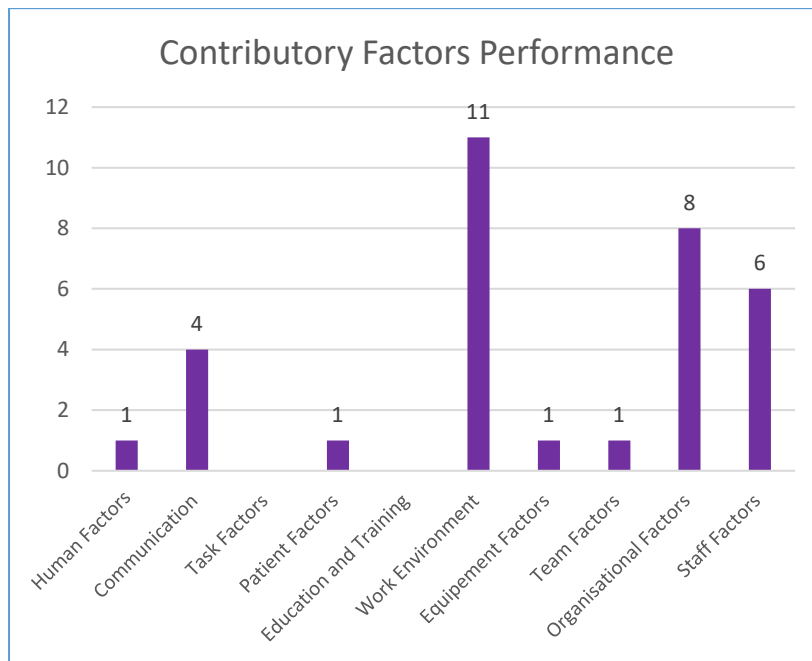
There were 9 serious incidents closed for by the CCG for Performance in Q4. Key contributory factors identified from the SI reports included:

Communication: Information given was not recorded in the call log and so was not available to those later making the decision in regards to forced entry.

Environment: Increased demand on the service resulted in the associated response time for a category 3 call not being met. The number of DCAs required to attend Category 2 calls outweighed the Trusts capacity to provide this. The ambulance and EOC staffing were plan due to sickness and short notice absence.

Organisational: Long handover wait times at EDs: Ongoing significant waits to handover patients from ambulance to EDs. These waits were longer than the national target times. Waiting at EDs for extended periods of time meant that the number of crews on the road was impacted severely.
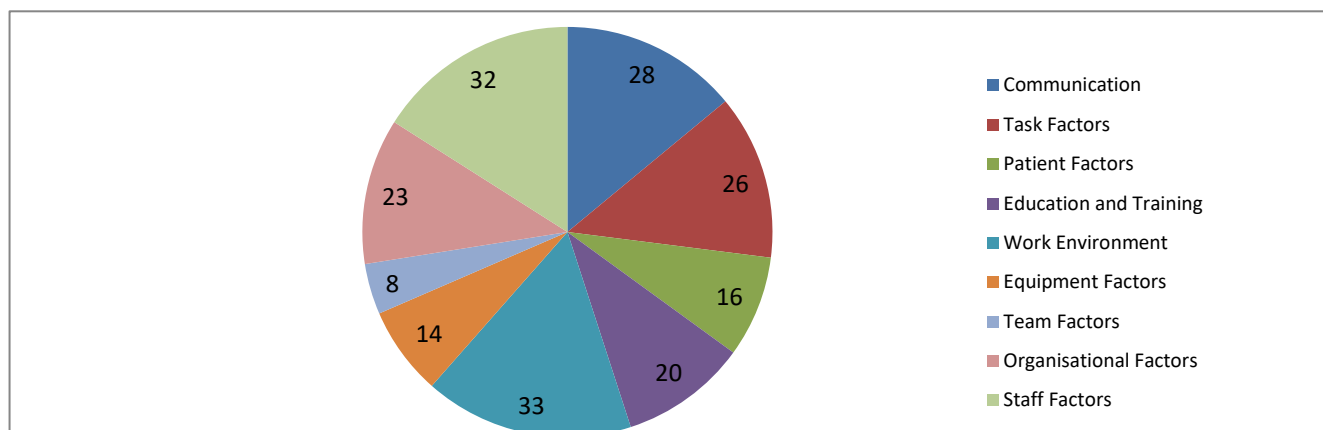
Staff: Excessive demand and large numbers of calls waiting to be both answered and dispatched this undoubtedly increased the pressure on dispatch staff and increased the possibility of specific actions being missed.

Key learning and actions taken across the SIs in relation to these contributory factors included:

- The London Ambulance Trust to work in conjunction with other NHS provider Trusts to ensure compliance and address the actions within the NHS Improvement Hospital Handover Document.
- Undertake athematic analysis of the attendance delays in order to establish a robust action plan.
- The findings of the report must be shared with the Trusts forecast and planning team to ensure adequate DCA cover during busy periods.

4.2. Trust wide contributory factor themes

Graph 6. Trust-wide Contributory Factors

Legend:
- Communication
- Task Factors
- Patient Factors
- Education and Training
- Work Environment
- Equipment Factors
- Team Factors
- Organisational Factors
- Staff Factors

Pie chart values: 28, 26, 16, 20, 33, 14, 8, 23, 32

4.3. 48 SIs were closed by the CCG in Q4 which is an increase from 34 closures in Q3.

4.4. Graph 6 shows Work Environment (*workload and hours work, staffing administrative factors and design of physical environment)* to be the highest occurring contributory factor (17%) in Q4. The change in Q4 comparable to Q3 where Task factors were more prevalent is due to the increase in SIs reporting a delayed response. Staff involved in these incidents report a surge in workload being a significant challenge.

4.5. There has been an increase in the use of case studies of SIs for the purpose of shared learning across the Trust. The Trusts INSIGHT Magazine is used to share case studies and reflections of staff involved in incidents. Case studies are also shared via case based learning events, internal closed social media and departmental newsletters.

4.6. The Trust also ensures that those involved receive face to face discussion, personal reflection and feedback. The Quality Governance and Assurance Managers (QGAMS) support learning alongside Senior Sector Clinical Leads with local operational team meetings and Sector Quality Meetings. All teams are now thinking differently with regards to how the learning from SIs can be shared whilst adhering to social distancing measures.

5. Conclusion

5.1. The Quality Improvement and Learning Team continue to support the robust investigation of SIs and analyse and monitor themes via this report and ensuring that themes are discussed at the Serious Incident Assurance & Learning Group (SIALG). SIALG is providing improved ownership within the operational teams, trend analysis and assurance that the organisational learning has been embedded which will improve the quality and safety of the care delivered to patients.

Dr Trisha Bain
Chief Quality Officer

Long Delays Thematic Review

Quality Improvement and Learning Team
June 2020

SIs Featuring Delays in Review

- Following the declaration of a number of Serious Incidents (SIs) which resulted in delays in attending to and treating patients, a request was made to undertake a review of all SIs that had been declared in financial year 19/20 which met the "delays" criteria.

- For the purpose of this report a "delay" is considered to be any factor which resulted in a patient being attended to, or assessed outside of the Trust's agreed time parameters.

- A search for delays on Datix yielded a return of 42 incidents. These cases were reviewed to identify any themes and learning. 4 incidents are still under investigation therefore learning has not yet been identified from those cases. 38 cases have therefore been assessed to identify themes.

SIs Featuring Delays in Review

Year	Total SIs Declared	SIs featuring the delay aspect
19/20	132	42

- Of the SIs declared in 19/20; 31% of these were attributed to a form of delay.

- This review found that delays were more complex than crews simply not arriving to a patient in a timely manner, often occurring due to multiple system and process failings.

- 19/20 saw demand on the service reach extremely high levels culminating in the COVID 19 pandemic.
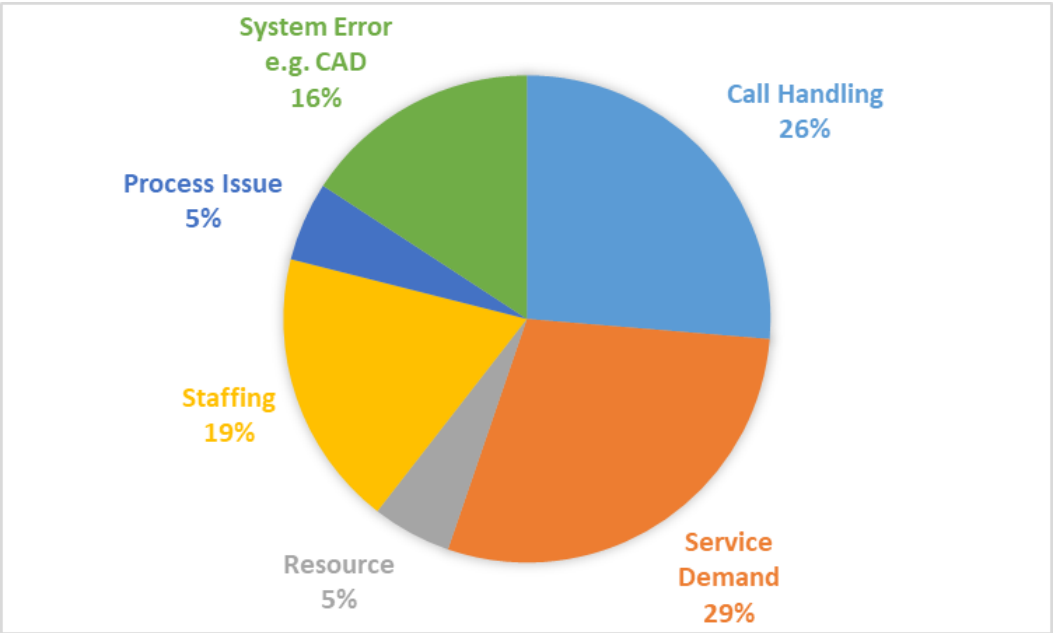
Delay themes

38 cases* were reviewed as part of this lookback. These incidents can be broken down into 6 main themes.

The following themes were identified:

Call Handling	Service Demand	Resource	Staffing	Process Issue	System Error e.g. CAD
10	11	2	7	2	6

*Four cases are still under investigation therefore themes cannot be confirmed.

Identified Themes

Call Handling

- Issues were identified relating to call handling, for example, patients being placed on the incorrect pathway.

- Lack of welfare call backs.

- Human factors e.g. not confirming spelling of the patient's address.

- CHUB review of C5 calls/call backs. From the cases reviewed these did not always occur in a timely manner.

- Investigation findings showed there were some issues in particular in re-categorising patients when their condition had worsened.

Service Demand

- A high demand on the service was frequently referred to in the submitted reports.

- In the reports review the level of demand was frequently cited as above expected/planned levels.

- Emergency Department (ED) waits for handover of patients was cited as frequent issue which led to less crews on the road due to LAS crews queuing at local EDs. These delays are proven to effect the Trust's ability to maintain response standards.

Resource

- This relates to the Trust having the capacity to perform to the agreed standards and is heavily linked to staffing and service demand particularly the queuing of ambulances at Emergency Departments.

Identified Themes continued.

Staffing

- The ability to match our resource with this increased demand was frequently cited as a cause or contributory factor in the reports reviewed.

- Staff shortages effected the Trust both operationally and in the EOC and was cited as an issue in several of the reports reviewed.

Process Issue

- A number of cases reviewed involved Inter-hospital transfers. Issues were caused regarding the wrong categorisation of patient's transfer level.

- Some problems were identified in relation to patients not being re triaged when they have specified a change in their condition.

System issue e.g CAD failures

- CAD outages and IT systems issues were also a factor in multiple reports reviewed during this lookback.

- There were Command Point/CAD system failures which meant that EOC had to use a contingency of paper based operations which impacted on the Trust's ability to respond to calls effectively.

Update on Progress

- In response to COVID19, there has been changes to systems and processes across the Trust which have address the resource and capacity issues.

- Likewise operational resource planning across the Trust has also been developed and as a result we are seeing no complaints or incidents of delays at present.

- The HCP/IFT was updated in September 2019 regarding categorisation and associated Event Types. This sought to provide conveyance in a timeframe that was equitable with other patients accessing 999 ambulance services.

- There is a review underway in the Trust to ensure that lessons are learnt from CAD outages and IT systems issues.

- Action plans from these SIs will be monitored through SIALG, as per process.