London Ambulance Service NHS Trust

**MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST PUBLIC BOARD OF DIRECTORS**

Tuesday 29 September 2020 at 9.30am – 12.00pm 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 28.7.20 | HL | Enclosed | *Approval* |
| | 4. | Matters arising | HL | Enclosed | |
| **9.35** | 5. | **Report from the Chair**<br>5.1 Staff and Volunteer Advisory Panel Terms of Reference | HL | Enclosed | *Information*<br>*Approval* |
| **9.45** | 6. | **Report from the Chief Executive** | GE | Enclosed | *Assurance* |
| **9.50** | 7. | **Report from the Chief Operating Officer** | KM | Enclosed | *Assurance* |
| **Director and Board Committee Reports** | | | | | |
| | 8 | • Integrated Performance Report | | Enclosed | *Information* |
| **10.00** | | **8.1. Quality and Clinical Care**<br>• Directors Report (Quality)<br>• Directors Report (Clinical Care)<br>• Quality Assurance Committee meeting | TB<br>FW<br>MS | Enclosed<br>Enclosed<br>Enclosed | *Assurance* |
| **10.15** | | **8.2. People and Culture**<br>• Directors Report | GE | Enclosed | *Assurance* |
| **10.25** | | **8.3. Finance & Audit**<br>• Directors Report<br>• Finance & Investment Committee<br>• Audit Committee | LB<br>FC<br>RP | Enclosed<br>Enclosed<br>Enclosed | *Assurance* |
| **10.35** | | **8.4. Logistics and Infrastructure**<br>• Logistics and Infrastructure Committee | SD | Enclosed | *Assurance* |
| **10.45** | | **8.5. D999 Programme Assurance Group** | SD | Enclosed | *Assurance* |

| Timing | Item | | Owner | | Status |
|---|---|---|---|---|---|
| **Finance** | | | | | |
| **10.55** | 9. | **Finance**<br>9.1. M4 Finance Report<br>9.2. Financial Plan 20/21<br>9.3 Capital expenditure and programme | <br>LB<br>LB<br>LB/ KM | <br>Enclosed<br>Enclosed<br>Enclosed | <br>*Information*<br>*Approval*<br>*Information* |
| **11.10** | 10. | **Business Plan** | RF | Enclosed | *Approve* |
| **Stakeholder Engagement** | | | | | |
| **11.20** | 11. | **Engagement Strategy** | AT | Enclosed | *Approval* |
| **People and Culture** | | | | | |
| **11.30** | 12. | **Trust response to Black Lives Matter** | GE | Enclosed | *Discussion* |
| **Governance and Risk** | | | | | |
| **11.40** | 13. | **COVID Lessons Learned Report** | RF / KM | Enclosed | *Information* |
| **11.50** | 14. | **Governance and Risk**<br>14.1. Strategic Risk and the Board Assurance Framework | SDa | Enclosed | *Approval* |
| | 15. | **Any other business** | HL | Verbal | *Information* |
| **12.00** | **Meeting close** | | | | |

***Additional reports, circulated for information only:***

- Corporate Risk Register
- CQC IPC Framework
- Quality Report
- SI Report
- Caldicott Guardian Report
- Register of the Seal
- Training action update

# TRUST BOARD: Public meeting – Tuesday 28 July 2020

## DRAFT Minutes of the public meeting of the Board held on 28 July 2020 at 09.30am, via Video Conference

| Present | | |
|---|---|---|
| **Name** | **Initials** | **Role** |
| **Heather Lawrence** | HL | Chair |
| **Jill Anderson** | JA | Associate Non- Executive Director |
| **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 | 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 |
| **Ross Fullerton** | RF | Director of Strategy and Transformation |
| **Ali Layne-Smith** | ALS | Director of People and Culture |
| **Antony Tiernan** | AT | Director of Communications and Engagement |
| **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 continues to function by virtual means and that this would be the first time that the meeting was available to the public for viewing on YouTube.

### Declarations of interest

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

## Minutes of the meeting held in public on 28 July 2020

3. The minutes of the meeting held in public on 28 July 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 to present a report on national category 2 response times. It was acknowledged that this action had been superseded by COVID-19 response and that category 2 response times were addressed in the Chief Operating Officer report.

6. Progress in respect of youth forum establishment had paused during the required pandemic response but would be pursued as appropriate.

7. The Board discussed the action in respect of training. This action related to the review of total abstraction required to deliver the Trust's training requirements and the finite costs of Clinical Education standards. The Board concluded that it was appropriate to consider this in two parts and that a further update would be provided at the 29 September Board meeting.

## Report from the Chair

8. The Chair welcomed Jill Anderson, Associate Non-Executive Director (NED), to their first Board meeting. She explained that Jill's appointment follows on from Amit Khutti as the former Associate NED who was successfully appointed to the Board as an NED in March 2020. The Chair noted the wealth of experience and knowledge that Jill brings to the positon.

9. Throughout the COVID-19 pandemic, it had been increasingly important for Chairs of Boards to liaise and contribute to the national debate, share experiences and to listen and learn from others experiences. The Chair shared some of the activity she had contributed to and that there had been repeated themes of focus within the groups which included staff welfare.

10. Further to this, the Chair spoke about the importance of Black Lives Matter and emphasised the significance of the Equality and Diversity and Cultural Transformation programme within the London Ambulance Service NHS Trust (LAS).

11. Noting that, the impact of COVID-19 and the death of George Floyd in America had highlighted the work required to ensure that the LAS is able to address the issues experienced by its Black, Asian and Minority Ethnic (BAME) staff.

12. It was acknowledged that these were issues that the Trust is addressing as a priority and that it would be essential to ensure that a 'Board to Ward' approach is taken to consult with staff and to ensure that actions taken are effective and embedded.

13. The Chair reported that she had joined facilitated sessions held by Melissa Berry, Race Equality Consultant, and listened to staff sharing their experiences of being a black person in London and as an employee of LAS. Following this, Melissa had been invited to brief the Non-Executive Directors and share the staff response. This was followed up with a Board seminar, attended by Yvonne Coghill, Equality and Diversity Advisor to NHS London, who advised on best practice and provided support in developing the Trust's specific action plan to address Black Lives Matter.

14. Finally, the Chair emphasised that it is essential to get the culture right at LAS and noted that 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 organisations culture would be changed. The Chair committed to writing to all LAS staff on behalf of the Board to emphasise the importance of the issue and the expectation that matters are addressed accordingly and appropriately.

## Chief Executive's Report

15. 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.

16. The report provided 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 taken 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.

17. In response to the COVID-19 challenge, London's health and care system is being transformed to meet the changing needs of its patients. The Trust now has 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.

18. In February 2020, the Trust set its ambition to transform the culture of the Service and build a 'world-class workplace'. It was recognised that organisationally, the Trust has made significant progress 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 and this will continue to be an area of focus.

19. Further to this it was reported that the LAS was delighted to host a visit by the Prime Minister to 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. During his visit, the Prime Minister announced the Government's consultation on plans to increase the maximum sentence for assaults on emergency workers.

## Report from the Chief Operating Officer

20. The Board received the first presentation of a report from the Chief Operating Officer, it was noted that the purpose of this report was 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.

21. The Chief Operating Officer reported as the Trust emerges from the first COVID-19 peak, it is necessary to recognise the extraordinary environment in which it has operated in this year. The efforts to rapidly mobilise a pandemic response involved radical changes across the operational teams and required fundamental shifts to existing ways of working in order to maximise operational capacity to meet unprecedented levels of demand.

22. Acknowledging that within a short period of time, and with the support of urgent investment, the Trust was able to quickly recover from a potentially critical situation and have exceeded national performance targets every day since the beginning of April 2020.

23. 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.

24. The approach for the remainder of 2020/21 is to focus our efforts to delivering those 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.

25. The Board discussed the paper as presented and discussed proposed improvements in the logistics supply unit and Medicines Healthcare Regulatory Agency (MHRA) Compliance, noting the capital investment required to enable the proposed changes and the reasoning for the proposed actions.

26. Additionally the Board discussed the Estate and the work to transform the consolidated estate to ensure that it meets the needs of the service and its staff. It was acknowledged that the pace of change had caused some issues and that these were being resolved at pace. The benefits of the consolidation were also recognised.

27. Further to this the Board discussed leadership and support of staff and managers to lead the organisational changes; it was noted that leadership programmes and training are being revisited to ensure they are suitable to develop skills required.

## Director and Board Committee Reports

28. The Board would receive reports from the Directors and Board Assurance Committees noting any key issues, risks and items for escalation.

## Quality and Clinical Care

### Directors Report

29. The Chief Quality Officer presented the Quality Directors report noting that 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.

30. 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 broader proactive response to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk and that at a subsequent review the Trust PSIRF was shared and received with great interest and compliments. The Trust has seen its position on the early adopter programme affirmed with the team working towards full sign off and implementation in the coming months.

31. 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 broader proactive response to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk. At a subsequent review the Trust PSIRF was shared with commissioners across the system, NHSE/I and the CQC and received with great interest and compliments. The Trust has seen its position on the early adopter programme affirmed

NHSE/I Patient Safety team with the team working towards full sign off and implementation in the coming months.

32. Further to this it was reported that the new Violence Reduction Policy would be approved at the Health and Safety Committee on 30th July 2020. There had been a decrease in incidents during the peak COVID period but these are now increasing.

33. The Chief Medical Officer presented the clinical directors report noting that 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.

34. The Board were informed that the trial of pre-conveyance video conferencing for suspected stroke patients in North Central London has begun and shown some early patient benefits. 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 locally. The trial, which has been in a collaboration with UCLH, is set to expand more widely in North Central London later this month.

### Quality Assurance Committee meeting & Terms of Reference

35. 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 and that the Committee had assured by the volumes of work that had been carried out during the Pandemic response and the maintenance of quality throughout with good patient outcomes.

36. 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 a clear plan in place and it was acknowledged that it was essential to ensure that it is delivered to rescue additional strain.

37. Additionally 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 and the Annual Quality Report was recommended to the Board for Approval.

### Resolution:

- Quality Assurance Committee Terms of Reference were approved
- Annual Quality Report Approved.

## People and Culture

### Directors Report

38. The Director of People and Culture echoed the report of the Chair in respect of Black Lives Matter and introduced the work that is being carried out within the Trust to address these issues.

39. Further to this, Staff wellbeing was discussed recognising that the Trust had always seen its staff's health and wellbeing as a priority but acknowledging that 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, it was reported that a "Wellbeing Hub" had been established which consolidates a range of welfare and wellbeing support streams so staff have a single point of access to these important services.

40. Finally the Board were asked to recognise the work that continues in respect of resourcing; to meet current and future organisational requirements, the People & Culture Director is finalising the restructuring of the directorate.

41. The People and Culture Committee will receive a report 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 and focus will continue to be placed on its compliance rate regarding appraisals which was put on hold during the COVID pandemic as per the national team's instruction.

42. Work continues 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.

### People and Culture Committee

43. 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 the substantial agenda which reflected the volume of activity being carried out across the Trust.

44. Members received a paper which demonstrated the current operational recruitment position of the Trust. The paper outlined the current position, current approach, impact on headcount, action plan, risks, identified next steps and further support required, and 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 due to commence Merton CCG to test the proposed model.

45. Proposals to recruit 497 ambulance staff in 2020/21 from existing positions 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.

46. 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.

47. The Committee received substantial assurance around Freedom to Speak Up, Equality and Diversity Plans, Health and Safety and Flu.

48. Members discussed their concerns in respect of the 9 reports that staff received detrimental treatment when raising freedom to speak up concerns, it was agreed that this was not acceptable and that work continues to identify and address these issues.

## Finance & Audit

### Directors Report

49. The Chief Finance Officer reported that 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 and the Trust has a cash balance of £57m at the end of June.

50. Interim national financial arrangements have been extended until end August and likely end September resulting in high likelihood of breakeven for half year 1, though uncertainty remains for half year 2.

51. 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. The Board extended their thanks to the teams involved for the significant achievement.

## Finance & Investment Committee

52. 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.

53. The Trust is operating under a financial framework that reimburses COVID-related expenditure and ensures a breakeven; this has recently been continued into August and seems 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 Committee recommends adoption by the Board of a proposal to extend this approval to the end of September. Arrangements for the full year have yet to be finalised; it is expected that budget proposals will be discussed in September.

54. The Committee reviewed the proposed capital budget and recommends it to the Board. Expenditure of £44.2m is planned, of which £21m is to be funded via COVID allocations.

55. Further to this two business cases were recommended for approval: (1) replacement of 37 ambulances (DCAs) at a cost of £6.5m and (2) the fitting out, at a cost of £1.7m, of a replacement medicines packing unit.

## Resolution

- Proposal to extended approval of business plan budgets to end September approved
- Capital Budget approved
- Replacement of 37 ambulances (DCAs) at a cost of £6.5m approved
- Medicines Modernisation, fitting out, at a cost of £1.7m, of a replacement medicines packing unit approved.

## Audit Committee

56. 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 had received and considered the 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, Audit Committee requested that Quality Assurance Committee and Finance and Investment Committee consider particular areas in more detail followed by a discussion at the Board.

57. The Board were also notified that the Audit Committee had requested and internal audit of COVID-19 2020/21 expenditure to be programmed for the autumn and that an audit of Equality and Diversity is planned pending agreement of scope. Further to this the Audit Committee discussed the scope of a Public and Patients audit in 2021/22 once the new committee has been in operation.

58. The Committee also noted SFI breaches and that hiring managers have not always followed legacy processes for non-permanent staff. Members asked that “No Purchase Order, No Pay” be mandated and that other supporting controls be put into place.

## Logistics and Infrastructure

### Logistics and Infrastructure Committee & Terms of Reference

59. 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 members expressed concern regarding the level of foundation work that is required in order to bring the IM&T technology estate in line with other Ambulance Trusts.
60. The Committee considered the factors contributing to what appears to be under investment in IM&T and recommended that the CIO is invited to present the Technology Improvement Plan to the Board.

61. Further to this, 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.

62. Members requested assurance on how the new Project & Program structure will be embedded within the Trust. Recognising that this may involve culture changes, adjustments to ways of working, investment in skills development and new roles. Members recommended closer alignment between the Projects and Programmes 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 Trust.

63. Additionally 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.

### Resolution

Logistics and Infrastructure Committee Terms of Reference were approved.

### Digital 999 Status Update

64. The Board received a paper which provided assurance across the D999 Programme, including recent developments and status of electronic Patient Care Records (ePCR) and Computer Aided Dispatch (CAD) projects.

65. It was noted that the D999 Programme covers ePCR and the new CAD systems, with the status for both projects reported as green; it was noted that both are on track for their respective go-live dates (ePCR to launch in September 2020 and new CAD in May 2021).

66. 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.

67. 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. 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.

68. CAD Project mobilisation is complete with the contract passing through final stages of sign off. 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.

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

### Programme Assurance Committee

70. SD, Chair of the Digital 999 Programme Assurance Committee, presented a report of the most recent meeting of that Committee to the Board, noting that 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.

71. Additionally 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.

72. The Board discussed change fatigue and emphasised the need to ensure that change is managed and that staff are not being asked to make changes all at the same time, this is echoed with training fatigue and it is essential to ensure that staff engagement is strong and robust to ensure successful delivery of such changes.

## Annual Financial Plan 2020/21

73. The Chief Finance Officer presented the Annual Financial Plan 2020/21 noting that 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.

74. 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 paper set out the Financial Plan to the end of September and sought Board approval for the issuing of revenue budgets to the end of September and the Capital plan for 20/21.

75. Following discussion, the capital budget was approved subject to clarification of key points: The Board required further presentation of the plan to spend the additional £6m funding that the Trust had recently been notified of; The Board required confirmation of the capacity within the Trust to deliver the capital program as outlined and confirmation of whether funds would need to be spent during 2020/21 financial year and what the implications would be should they not be spent.

### Resolution

- Capital budget was approved subject to clarification of key points: The Board required further presentation of the plan to spend the additional £6m funding that the Trust had recently been notified of; The Board required confirmation of the capacity within the Trust to deliver the capital program as outlined and confirmation of whether funds would need to be spent during 2020/21 financial year and what the implications would be should they not be spent.
- Issue of revenue budgets until end September 2020 approved.

## Stakeholder Engagement

76. The way we deliver care is changing and the services the Trust provide to the people of London is expanding. To this end, the Trust has 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.

77. The Board received an update on the formation of the LAS Public and Patients Council (LASPPC), as well as plans to host a series of significant 'town hall' events with our NHS, health and care partners.

78. Members were asked to Review and agree the findings of the independent review of public and patient engagement, Review and agree the updated LASPPC Terms of Reference and to note the minutes of the first meeting of the LASPPC.

### Resolution

- Content of Independent review approved
- Updated LAS Public and Patients Council Terms of Reference were approved.

## Governance and Risk

### Board Assurance Framework

79. This Board Assurance Framework was presented to the Trust Board for review and approval. Changes made since the last Board meeting on 28 July 2020 were highlighted. The Trust Board were asked to note the review of BAF 45 and 58 and the increased score. These have been reviewed by the Logistics and Infrastructure Committee.

80. The Board were also asked to recognise the score reductions against the COVID-19 sub-strategic risk assessments reviewed by the Board Assurance Committees and reduced due to the reduced demand and additional capacity.

### Resolution

The Board approved the Board Assurance Framework.

### Corporate Risk Register

81. The Corporate risks were presented and the Board were directed to relevant changes. It was noted that future presentations would mirror that of the BAF and highlight changes in red text.

82. The Board asked which committee would review Brexit and associated risks; it was concluded this would be Finance and Investment Committee.

### Resolution

Finance and Investment Committee to review Brexit risks.

## Any Other Business

83. There was no other business.

## Additional Reports

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

- Safeguarding Annual Report
- Serious Incidents Update

## Meeting Close

The next Trust Board meeting in public will take place on 29 September 2020

# TRUST BOARD - Public Meeting: ACTION LOG

| Ref. | Action | Owner | Date raised | Date due | Comments / updates<br>*(i.e. why action is not resolved / completed)* |
|---|---|---|---|---|---|
| **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<br>Defer | This has been delayed due to the impact of the COVID-19 response. |
| **Training abstraction** | What is the total abstraction for training (in patient facing hours) remembering 24 hours are CSR | Khadir Meer | 28/07/2020 | 29/09/2020 | The Board are presented a report for information which provided the response to this action. |
| **Training - cost** | What is the finite cost of CES services, and we can help define how much abstraction is needed for our programs (Clinical Education) | Fenella Wrigley | 28/07/2020 | 29/09/2020 | The Board are presented a report for information which provided the response to this action. |

London Ambulance Service NHS Trust

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|---|---|---|---|---|
| **Report to:** | **Trust Board** | | | |
| **Date of meeting:** | 29 September 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.

The report includes approval for a revised Terms of Reference for the LAS Staff and Volunteer Advisory Panel.

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

The Board is asked to note this report. The Board is asked to discuss and approve the revised Terms of Reference for the LAS Staff Advisory Panel.

**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. Highlights since the last Board meeting

1.1 August has been an unusual month as although there has been a gradual increase in people returning to work, there are still a number of colleagues working away from their office due to Covid-19, resulting in a continuation of meetings and networking of chairs via video conference calls at national, regional and local levels. The themes of the meetings are similar with agenda items relating to resuming elective surgery, cancer care and discussions on finance, and with a particular emphasis and concern for us all being Black Lives Matter and the strategic reset of the NHS.

### External meetings

1.2 I have attended the following meetings where the above matters have been discussed in addition to business as usual:

- 28 July: Sir David Sloman – London Chairs meeting
- 29 July: South West London (SWL) Provider Chairs' meeting. The SWL chair has set up a capital group that Non-Executive Director Audit and Finance Committee Chairs have been invited to attend. Our NED Audit Committee Chair, Rommel Pereira, has agreed to attend for the Trust. Although our capital allocation is not agreed through SWL, I formed the view that it is important to know what could impact on us from the wider system.
- 4 August: North West London (NWL) STP Chairs' meeting, chaired by Dr Penny Dash, ICS Chair, and Lesley Watts, Chair NHS CEOs Group. The focus of the discussion was to discuss transitional governance structure during the pandemic.
- 6 August: Follow up meeting with Mike Bell, Chair Croydon Health to discuss Paramedics in Primary Care Networks. We are preparing a paper to discuss the wider potential roles paramedics could play in primary care.
- 26 August: SWL Provider Chairs meeting with Yvonne Coghill, Director, Workforce Race Equality, NHS London, with discussion around Black Lives Matter.
- 8 September: NWL Chairs' meeting chaired by Dr Penny Dash and Lesley Watts to discuss proposed governance arrangements.
- 10 September: AACE engagement session: Together with the LAS CEO I joined the AACE strategy development session looking at the priorities for AACE; we considered workforce, system-working and digital transformation. Further work will now occur to refine the priorities and determine the most appropriate means of delivery.
- As a follow up to this meeting I spoke to Daren Mochrie CEO of North West Ambulance Service NHS Trust and the new Chairman of CEOs at AACE to discuss what we can do to influence the proposed governance reset proposal. We agreed to hold a meeting between NWAS and LAS chairs and CEOs involving Lena Samuels who is the chair of the AACE Council.
- 15 September: Integrated Care System (ICS) governance project. I have been invited to join a group led by Lord Prior on a proposal being developed for a governance reset.

## Internal Visits

- 13 August: I was invited to an induction session in order to welcome our newest group of international paramedics to LAS, which included colleagues from Namibia, Australia, New Zealand and South Africa.

- 1 September: I was invited by an administrative member of the Resilience and Specialist Assets Unit to the first day of the Resilience & Special Assets Administration Staff Away Day. This was part of her development plan following on from her appraisal. I have since met with her again to hear about her long employment at LAS, her role as a magistrate and an industrial tribunal panel member, something she has done for nearly two decades. She is a BAME member of staff with rich experience and I have connected her to the LAS CEO as I believe that she is one of many internal staff who could bring her expertise to add value for her and for LAS.

- 14 August: The Mayor, Sadiq Khan, visited us at Barking, to open our new training centre and meet with staff in the NHS111 centre.

## 2. Black Lives Matter

2.1 I enclose a copy of the email sent to all staff as agreed at our last Trust Board meeting. This followed a Board seminar where we received a draft plan of action for Black Lives Matter and input from Yvonne Coghill, Director, Workforce Race Equality, NHS London, who is leading on Equality and Diversity. I have received many positive comments from staff who have voiced 'it is the right thing to say and will give all our strategic managers the confidence to be brave and have difficult conversations'. I want to applaud the LAS for standing up and doing something about racism and reaffirm that, as the Chair, you have my full support.

2.2 Several members of staff from the BAME ethnicity group have contacted me to share their distressing experiences whilst being our employees. If they so wished, I held video conferencing calls with them and, in some instances, we were joined by Melissa Berry, Equality and Diversity Consultant, for expert race equality advice; that said they were not all about race. Where appropriate I have made the LAS CEO and COO aware so that they can follow up. I asked one member of staff if they would be willing to attend a Trust Board meeting to share their story and, in an anonymised way, be involved in a training session.

2.3 On a positive note, one black member of staff said they now felt less angry, just frustrated, but empowered to speak up. This person has now become an ally. There were a few members of staff who raised questions such as 'Does this apply to all minorities?' To be truly unbiased everybody needs to be all inclusive and support each other.

2.4 We are at the beginning of a journey and we need to keep focused on implementing our action plan for Black Lives Matter and the wider equality, diversity and inclusivity work that should be central to the culture of LAS. To that end I have asked all Trust Board members to have an agreed organisation wide objective in relation to this.

## 3. Board Development Session

3.1 The Trust Board met informally and spent time exploring and understanding capital, IT infrastructure, strategic opportunities and lessons learnt from the Nightingale Hospital where change occurred at pace and how LAS could learn from this. The output of these

discussions will be brought forward for decision and approval at formal Trust Board meetings starting with a business plan for the second six months of the year with clear objectives.

## 4. Non-Executive Appraisals and Terms of Office

4.1. Non-Executive Director (NED) appraisals were recently completed. The Senior Independent Director, Fergus Cass, shall commence my own appraisal in due course and in line with governance requirements.

4.2. I am pleased to report that the outcome of the NED appraisals was very positive and highlighted the tremendous work that the Non-Executive team have done not only for the Trust, but also in terms of Board effectiveness. I would like to formally thank my Non-Executive colleagues for the significant amount of time they commit to the Trust and the valuable contribution they have made particularly during the COVID peak; indeed our CE Garrett Emmerson shares my appreciation and notes that NED input and support has been invaluable to the Executive Team.

4.3. However, I am sorry to report that in the next few months we will be losing two of our NEDs: Jayne Mee and Fergus Cass. Although this is not their last Board meeting, I would like to express my sincere gratitude to both colleagues for their enormous contribution over the years.

4.4. Jayne Mee joined the Trust Board in January 2017 and leaves at the end of her term in January 2021. Jayne as the NED lead for People and Culture has helped guide and advise the Board on such important matters in her role as the Chair of the People and Culture Committee. During her term, Jayne also occupied additional NED responsibility in Emergency, Preparedness, Response and Resilience (EPRR) and more recently, as the NED lead for Staff Wellbeing.

4.5. Fergus joined the Trust Board in March 2014 and leaves in February 2021 following an extension to his second term in order to provide continuity on the Board. He is currently the Senior Independent Director; responsible for conducting my appraisal and being my trusted confidante. In addition to his role as the Chair of the Finance Investment Committee, Fergus has devoted a lot of his time to his position as the Freedom to Speak Up NED lead.

4.6. On behalf of the Board, Executive and staff members, I would like to thank both Jayne and Fergus for their exceptional work and note that they will be sorely missed.

4.7. In light of their upcoming departure, the Trust must commence a search and selection process for two NED roles. Prior to any recruitment process starting, the Remuneration Committee will need to consider the balance of the Board and complete a skills matrix to help inform that discussion. This approach is deemed good practice by governance standards in order to ensure the Board has the skills and capability to successfully deliver its strategic objectives.

## 5. Staff and Volunteer (Emergency Responder) Advisory Panel

5.1 Board members will recall that in January 2020 we established a Staff and Volunteer (Emergency Responders) Advisory Panel (“the Panel”) to provide a direct channel of communication between the Board and staff; in an acute hospital this is commonly described as ‘Board to ward’.

5.2 Several meetings have now taken place with ‘Staff Survey Champions’ which has been incredibly helpful in terms of understanding staff concerns and work experiences and particularly during the COVID-19 peak period.

5.3 However, it is clear from my discussions with staff attending the Panel meetings, and also from discussions with Board colleagues, that 'Culture', 'Equality, Diversity and Inclusion' are key areas of focus. With this in mind, the Terms of Reference for the Panel have been reviewed to reflect the significance of these issues.

5.4 There are also other key matters for the Board to consider:

- The appointment of a Co-Chair who is a staff member as opposed to management; and
- The wider invitation for all staff and volunteer (emergency responder) members to express an interest in becoming a member of this Panel as well as the Chair's from the Trust diversity networks.

## 6. Annual Public Meeting 2020

6.1 In light of COVID-19, I will be hosting our Annual Public Meeting online on Tuesday 29 September at 6pm.

6.2 Staff, volunteers and the public are invited to virtually attend our meeting which will focus on our ground-breaking 'Perfect Day' pilot in North East London last autumn and our response to COVID-19. There will also be an update on our financial position and our performance against national quality standards.

The evening will also hear from the Trust's leadership about the successes and challenges of the past year and our plans for the future; and virtual attendees will be able to ask questions of senior leaders.

For more information about the event, including how to register, please visit our website: www.londonambulance.nhs.uk.

**Heather Lawrence OBE**
**Chairman**

**Maureen Williams**

**From:** Heather Lawrence
**Sent:** 03 August 2020 10:48
**To:** .All Active Users
**Subject:** Black Lives Matter

**Follow Up Flag:** Follow up
**Flag Status:** Completed

Dear Colleagues,

Over the last two months the Trust Board has been listening to feedback from our black staff on their daily experiences of living in London as a black person and of their experience as an employee of LAS. A number shared their experiences of being abused in the workplace, in the office, on the front line or over the phone by members of the public, as well as in their personal lives. This experience is also shared by BAME colleagues.

As a Board we want to apologise to all of you who have suffered racial abuse as an employee of LAS and to thank you for being brave and sharing your experiences. If members of the public or work colleagues racially abuse you we want you to report this to the police. If you are at work, speak with a manager who we expect to support you.

We now call on all white staff to stand with us in this apology, and I ask you all to walk in the shoes of your colleagues and listen to their stories and reflect on how you can join us in living our values so that everyone feels respected and valued. Together we need to learn, be open and reflect on our behaviours, the behaviours of others and act. Do not be a bystander.

There is no going back, we as a Board are resolute in our determination to stamp out racism. To this end we received and approved a programme of work to engage with you all to help us all become an inclusive organisation where we can truly say, and evidence, that equality and diversity is paramount at LAS.

Whilst it has been COVID-19 and the death of George Floyd that has focused our attention on black and BAME colleagues, we know that all staff can experience discrimination and it's important that as a Trust we tackle this together for everybody.

Kind regards

Heather

Heather Lawrence OBE
Chair

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

London Ambulance Service NHS
NHS Trust

# Staff and Volunteer Advisory Panel
## Terms of Reference
### (September 2020-September 2021)

## 1. Purpose

1.1 The London Ambulance Service Staff and Volunteer Advisory Panel (the Panel) will bring together a range of staff and volunteer (emergency responders) representatives from across the Trust and relevant diversity groups to:

- Invite staff members and volunteers to share their views, work experience and concerns with the Chair of the Trust in an open forum and across a range of matters (excluding personal and individual issues) as they, or the Chair, see fit;
- Discuss the culture of the organisation and how the Board can help shape this as well as be made aware of any issues; considering how the Board can help embed Trust values;
- Consider Equality and Diversity and what strategic changes staff and volunteers would like to see implemented;
- Reflect on the results of the Staff Survey and areas for improvement but also praise and recognition.

1.2. The SVAP is a Board advisory group of the Board which provides a 'Board to floor' approach on key issues and is intended to enhance, rather than replace, Trust staff and volunteer engagement activities and working arrangements with trade unions. The Panel therefore has no decision making authority.

## 2. Membership

2.1. Membership will include:

- Chair of the Trust;
- Director of Corporate Governance (DCG);
- Head of Internal Communications;
- Director of Culture, Equality and Inclusion;
- Head of Wellbeing;
- Staff and Volunteer representatives; and
- Chairs of the Equality and Diversity Groups.

At the Chair's discretion and approval, additional attendees may be invited to meetings or sessions of meetings on an ad-hoc basis to provide opinion, information and evidence on specific matters.

Non-members outside of the Panel i.e. all other staff and volunteers, may raise any points for discussion / concerns or questions to their member representative and / or the Chair / DCG.

1.4. Staff representatives

The DCG will invite expressions of interest from each sector and department to join the SVAP. The Chair of the Panel will then confirm staff representatives and will consider the diversity of age, gender, background and experience of those working within the London Ambulance Service to ensure a diverse Panel.

Staff representatives will be members of the group for 12 months and may continue as members beyond this period for another 12 months in the event there are no other expressions of interest from their respective area.

The rationale for this approach is to ensure staff representatives rotate to bring a broad range of staff insights and experience to discussions, without the group becoming too unwieldy in line with good governance standards.

1.5. The DCG will work with the Director of Communications and Engagement to ensure Volunteer (emergency responders) representatives are invited and become members of the Panel.

## 3. Meeting administration

3.1. A member of the Corporate Governance Team will act as the secretary to the Panel, taking minutes and keeping a formal record of matters arising and issues carried forward.

3.2. The draft minutes and action points will be available to the Panel within ten working days of the meeting.

## 4. Notice of meetings

4.1. Meetings of the Panel shall be called by the secretary of the Panel at the request of the Chair.

4.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be circulated to each member of the Panel, any other person required to attend, no later than seven calendar days before the date of the meeting.

## 5. Frequency of meetings

5.1. Meetings of the full Panel will be held every two months.

## 6. Review and reporting responsibilities

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

## 7. Equality and diversity

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

**Approved by the Board at its meeting on 29 September 2020**

**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
- Not misuse information gained in the course of their membership of the Panel 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
- 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 Panel. When engaging in other political activities, members should be conscious of their public role and exercise proper discretion
- Help promote inclusivity.

Any relevant interests must be declared by members / attendees at the start or during the meeting.

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 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 update on the key activities and internal and external engagement by the London Ambulance Service NHS Trust (LAS) since the last time the board convened in July 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

Over the summer period we have continued to work to reinforce our operational resilience in preparation for any second COVID spike along with the seasonal winter increase in demand. Our operational performance continues to be strong, as outlined in the Chief Operating Officer's report to the Board, which also provides an update on our Winter Plan to date. In addition, we have continued to work with our system partners at a London-wide level to ensure the Trust continues to play a full and active role in the NHS reset.

## 1. System Engagement

1.1. My report to the July 2020 Trust Board gave a high level update on the Trust's continued response to COVID-19, including discussions and actions we are progressing with partners to ensure the Service remains able to effectively and sustainably respond to the changing needs of our patients, and deliver our ambition to create a better working environment for our staff and volunteers.

1.2. We are continuing to engage with our North West London Health and Care Partnership colleagues (NWL HCP) to agree the funding that the Trust needs for the remainder of the 2020/21 financial year, as well as the investment support required that will allow us to deliver a portfolio of work over the 5 year period. We have an ambition to achieve a financially balanced position over the next five years, by delivering substantial efficiencies across the Trust's portfolio. We also aim to radically transform our operations and deliver an updated model of care which supports patients, ensuring they receive the right care, first time. To do this successfully we need to have a secure foundation in place, backed by investment and the support of our system partners, and to build our capability and capacity to realise this ambition.

1.3. Some of the programmes that we have identified to support the delivery of the efficiencies required include trust-wide modernisation and efficiency programmes as well as system efficiencies delivered through new contracts in Integrated Urgent Care, PCN Paramedics and Pan-London Critical Care Services. As part of realising our ambition, we will also modernise our ways of working to enable our staff to deliver the best care for our patients as we transform our service.

1.4. As outlined in further detail in the Chief Finance Officer's report, the business plan for the remainder of 2020/2021 has been submitted for Trust Board approval. This assumes funding in line with our month 4 forecast but remains subject to confirmation (which we anticipate to be confirmed after 30 September 2020) and equates to a total funding envelope of £527m, inclusive of COVID-19 funding (and an anticipated COVID surge over the winter) of £75m and a total Trust capital plan of £50.3m. The capital funding would be one of the largest capital settlements in our history.

### Primary Care Networks (PCNs)

1.5. A key part of the NHS Long Term Plan is the introduction of Primary Care Networks (PCNs) to support General Practices (GPs) and to deliver a broader service to patients and enable wider system integration. PCNs were established in 2019 and consist of GPs grouped broadly along geographical lines. A number of additional allied health professional roles have been introduced to support this development, which includes Paramedics. The NHS Long Term Plan further advocates the use of paramedics in primary care and the 5-year framework for general practice contracts outlines funding support for 'first contact community paramedics' to be employed within primary care settings from 2021. It is expected that

PCNs will be a key vehicle for delivering many of the commitments in the NHS long-term plan and providing a wider range of services to patients.

1.6. We are looking to work with PCNs to provide a solution to recruit this new workforce of first contact community paramedics in PCNs pan-London. This will have the advantage of providing our workforce with career development opportunities and enable them to work across other clinical settings, whilst retaining clinicians in an ambulance-based career. We also recognise that GPs across London have different needs. We are therefore seeking to engage with individual PCNs, or groups of PCNs, so that we can tailor our offer to meet specific requirements.

1.7. We are continuing our work to launch a pilot at Merton Health (an NHS organisation that provides community based healthcare for patients in Merton, South West London) in October 2020. This will see a total of 12 paramedics working part time at the six PCNs that make up Merton Health. Each PCN will have the equivalent of one full time paramedic (two paramedics working 50% of their time at LAS and 50% of their time at the PCN). We will evaluate the rotation of the LAS- employed paramedics into the PCN from a clinical strategy and transformation perspective, including by seeking the views of the paramedics involved, and assessing the sustainability, efficiency and cost effectiveness of the approach in respect of improving our “hear and treat” capabilities and delivering an efficient service overall to Londoners. It is hoped that with paramedics forming part of the expanding PCN multidisciplinary team, this will provide greater flexibility for new models of care and support for local communities, enabling the PCN to be more proactive in meeting patients’ needs closer to patients’ homes and out of the hospital setting.

## 2. Transforming our Culture - Building a World-class Workplace

2.1. We have restarted our programme of engagement with the core leaders of the organisation to help us better understand what we need to focus on to deliver cultural transformation and what support our managers needed to help them deliver change. Following up on the Sector Leadership Conferences we held with our Clinical Team Managers (CTMs) in North West London North East London earlier in the year, we’ve now held conferences in South West and South East London, and with our Resilience and Specialist Assets Teams. The sessions focussed on getting the basics right; communicating better; and empowering our managers and all were positively received.

2.2. We continue to hold thrice weekly LAS TV Live sessions providing our staff and volunteers with the opportunity to ask live questions of me and Trust senior managers via the LIA Facebook Group and Microsoft Stream.

2.3. As part of our journey towards building a world-class workplace and delivering the cultural transformation of the organisation, I am clear that the Executive Leadership Team must lead the way, leading collaboratively, building capability, and influencing the culture of our teams and success across the whole Trust. To support this, I held a socially-distanced Executive Team Away Day in August, which focussed on this ambition and how we as an Executive would lead this, create a high performing team, and deliver real change. I envisage holding further sessions with the Executive Team, making use of appropriate coaching resource as necessary.

### Black Lives Matter – Improving Race Equality and Diversity

2.4. With London being one of the most diverse parts of the country, it is vitally important that we take every step we can to tackle racism when we see it across the organisation and make

sure we are as fair and inclusive as we can be, both in terms of how we support our colleagues and the way we treat our patients.

2.5. I am pleased to join Chief Executives, Chairs and leadership teams across UK ambulance services in making a public pledge to play a fundamental role in the achievement of positive and lasting change in stamping out racism – acting at both national and local levels. We stand with our colleagues in a pledge to follow the Five Rs: Raise Awareness, Respond, Represent, Respect and Responsibility. More information about the campaign, which has been led by the Association of Ambulance Chief Executives (AACE), can be found at: https://aace.org.uk/stamping-out-racism/.

2.6. I continue to participate in the Steering Group for the King's Fund's 'Leading for Race Equality in London' programme, which is exploring with Chief Executives and accountable officers of NHS organisations in London our role in overcoming race inequality.

2.7. As a Trust we are continuing our 'big conversation' to better understand the experiences of our black and minority ethnic staff and volunteers. We have hosted nine virtual events for our core leaders (the most senior leaders from across the Trust) to have safe, open and frank discussions about race and racism. To date, more than 700 managers have attended the virtual sessions, with colleagues receiving an 'allyship pack' after the events to support them in having similar conversations with their own teams and volunteers.

2.8. Reflecting on our learnings, we are continuing to develop and progress a Trust-wide 'Black Lives Matter Action Plan', aimed at delivering a significant improvement in the workplace experience for our BAME staff. A more detailed update on progress to date will provided at today's Board meeting.

## 3. Public and Patient Engagement

### London Ambulance Service Public and Patients Council meeting

3.1. On 26 August, the London Ambulance Service Public and Patients Council (LASPPC) had its second meeting. The meeting, which was chaired by Dame Christine Beasley, focused on our ambulance operations modernisation programme, our ongoing response to COVID-19 and the introduction of our new Electronic Patient Care Record.

3.2. Members also agreed to create a number of sub-groups to support a range of Trust initiatives, including plans to improve the 'platforms' we use to triage patients calling our 111 and 999 services.

3.3. We welcomed representatives from Healthwatch England and our Commissioners, North West London Collaboration of Clinical Commissioning Groups, to the meeting with both providing very positive feedback.

### Healthwatch in London Network

3.4. On 18 August, our Director of Ambulance Services, Pauline Cramner QAM, and Director of Communications and Engagement, Antony Tiernan, joined the Healthwatch in London Network meeting to update them on a range of subjects including our response to COVID-19. The Network brings together London's 32 Healthwatch, who each have significant statutory powers to ensure the voice of the patients and local people is strengthened and heard by those who commission, deliver and regulate health and care services.

### Visit by the Mayor of London

3.5. The Chair and I were delighted to host a visit by the Mayor of London, Sadiq Khan, to our Barking site on 14 August, where he joined staff and volunteers to unveil our new training centre which is helping to train more emergency call handlers and boost our response to the COVID-19 pandemic.

3.6. The Mayor also took the opportunity to thank our staff and volunteers for their dedication and commitment during the pandemic, speaking with our call handlers in our North East London NHS 111/Integrated Urgent Care centre.

## Low Traffic Neighbourhoods and Streetscapes Schemes

3.7. Over the summer, London's Boroughs and Transport for London (TfL) have implemented a number of Low Traffic Neighbourhoods (LTNs) and Streetscape schemes across the Capital. We are supportive of the ambition to reduce traffic congestion, improve air quality, encourage active forms of transport and provide for social distancing. However, changes to road layouts, traffic management schemes and road closures all have the potential to impede our response to the most critically ill people and could delay life-saving treatments or conveyance. We wrote to TfL and London's Local Authorities, providing contact details for our area management teams, and asking that we be consulted on, and given time to review the impacts of, any proposed changes. Several LTNs and Streetscape schemes have attracted media interest and prompted complaints from several areas, including concerned individuals and residents' groups.

3.8. As the busiest ambulance service in the country, our focus is on achieving the best outcomes for our patients and ensuring we reach them within our national response times. We have been working hard to review the detail of the schemes we've received and to provide feedback on the impact on our emergency ambulance response. We have already met with 11 London Boroughs and TfL to discuss these schemes. We are also liaising with London's other emergency services and will continue to work with Local Authorities and TfL to ensure emergency vehicle access is properly considered, the impact of any changes monitored, and any concerns raised and addressed as necessary.

## Public Perception Audit

3.9. We are undertaking some public perception research, through a series of tracking surveys conducted by an independent specialist public perception survey company. The purpose of the research is to track changes in satisfaction, reputation and perceptions of Londoners towards the Service and our key messages. The survey is conducted quarterly, tracking responses over time. The first wave took place in January 2020, the second in April and the third in July. I updated on the earlier waves in my report to the July Trust Board, and the latest figures from our public perception audit surveys in July show that:

- the overall feeling of favourability towards the LAS, which significantly increased between January and April to 88%, continues to be felt by Londoners - overall favourability remains high at 85% (with around half of Londoners very favourable towards the Service);
- 82% of those who have used our 999 services in the last 12 months were satisfied or very satisfied with their experience (down 3% on April's survey but still significantly up on January's 79% score); and
- Satisfaction in our 111/IUC services remains high at 83%; up 3% on the April survey.

3.10. In addition, the report shows the public's perception of our service as being one they can trust (89%), with perceptions of our staff as experts in patient care (86%), who treat patients with dignity and respect (87%), remaining high.

### PR Week shortlisting

3.11. The external communications team has been shortlisted for the prestigious 'In-House Team of the Year (Public/Third Sector)' Award at the biggest annual PR awards event, the PR Week Awards 2020.

3.12. The team has been shortlisted along with just two other organisations, London North Eastern Railway and The Royal Free London NHS Foundation Trust, which is a real reflection of the incredible year the team has had.

3.13. It has been an extremely busy year for the team, including supporting the Trust through two terrorist incidents, producing an eight part documentary (Ambulance), providing a 24/7 service to colleagues and responding to COVID-19 in the face of huge external interest and scrutiny.

### Ambulance

3.14. This September, the BBC documentary Ambulance – which filmed our staff and volunteers in late 2019 for its sixth series – started to air in the prime time slot of Wednesday at 9pm on BBC One.

3.15. The documentary, which consists of eight episodes, is showcasing the breadth of what we do, our pioneering services and how these help us provide better care for patients across the Capital. It will also show the commitment of all our staff and volunteers and will give the public an insight into the challenges faced by the NHS amid rising demand.

3.16. As well as following medics and call handlers, the series also reflects the work of other teams across the Service, including those who work in fleet and keep our ambulances on the road. It is hoped that the programme will encourage more people to consider a career in LAS or other ambulance trusts.

3.17. The first episode aired on 16 September 2020, drawing an overnight audience of 3.1 million viewers, including half a million younger people. We saw over 1,000 hits to our recruitment pages, 420,000 Twitter impressions for the LAS account (which usually average around 86,000 a day), and almost 7,000 Facebook engagements (which usually average around 2,000 a day). There has also been a hugely positive reaction from our staff.

## 4. Information Governance

### Data Security and Protection Toolkit (DSPT)

4.1. The Trust has been working hard to compile evidence against the DSPT submission on the 30 September. The DSPT is an annual self-assessment; the submission is to NHS Digital which lets organisations measure themselves against the 10 National Data Guardian (NDG) Data Security Standards, as well as achieve compliance against GDPR and basic cyber hygiene. The assessment has a number of assertions whereby evidence must be provided to deem the standard 'met'. For 2019/20, the final DSPT submission was extended from 31 March to 30 September 2020 due to COVID; an extension which the Trust greatly welcomed.

4.2. The Senior Information Risk Owner (SIRO - Syma Dawson, our Director of Corporate Governance) has reported that key risk areas remain regarding Information Governance (IG) training and the requirement to meet the 95% target; the Trust's position as of 17 September is 86% compliant. The other risk areas relate to cyber security which our Interim Chief Information Officer is leading on as part of a wider programme to strengthen our data security in conjunction with the IG team under the Director of Corporate Governance.

## Information Asset Management

4.3. As part of the DSPT, an enormous amount of work has been done in relation to information asset management. The Trust has identified its 'Information Asset Owner' (IAO) structure i.e. which senior managers are responsible for leading in the protection of certain information assets. This work has resulted in the establishment of a comprehensive Information Asset Register which will continue to be monitored and updated accordingly. Furthermore, all IAOs have completed their data flow mapping which is the identification of all personal data transfers to and from the organisation. The purpose of this work is to reduce our information risks and ensure our patient and staff personal data is protected in accordance with the Data Protection Act 2018.

**The Board is asked to note and discuss this report.**

London Ambulance Service
NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report to:** | **Trust Board** | | | |
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Chief Operating Officer (COO) Report | | | |
| **Agenda item:** | 7 | | | |
| **Report Author(s):** | Khadir Meer, COO | | | |
| **Presented by:** | Khadir Meer, COO | | | |
| **History:** | N/A | | | |
| **Purpose:** | ☐ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

- The COO's report provides an operational level overview of key events and activity within the London Ambulance Service NHS Trust (LAS) since the last time the board convened in July 2020.

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

- The Board are asked to note the content of the COO'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 |

## 1. EXECUTIVE SUMMARY

### Overview

The purpose of this report is to provide the Board with an update on the Trust's performance and delivery against plans for the five operationally focussed Directorates and the preparations for winter. The document provides a summary, by Directorate, of recent performance, current priorities and continued areas of focus in 2020/21.

Since the last Trust Board update, we have maintained strong levels operational performance against national standards, however we are seeing activity rising back to pre-Covid levels. We are regularly monitoring changes in demand relating to pandemic activity and have in place the COVID-19 response plan that will trigger deployment of our operational resilience plans when necessary.

We must continue to prepare the Trust for possible further COVID-19 demand waves in 2021. For that reason later in this meeting we shall consider business cases to establish new Training facilities that will allow us to maintain our current consolidated estate and also the business case for a new Logistic Supply Unit that will improve resilience in case of increased demand for stock or supply disruption.

Alongside core business as usual operations, there has been significant progress made in each of the COO Directorates. Key highlights include:

i. Substantive appointments made to the roles of Head of Estate and Head of Fleet.

ii. Joint working with the national team and local providers to deliver the 111 First model to increase referral into downstream services.

iii. Launching testing phase of the new 999 Contact Centre and Clinical Assessment Hub at Waterloo HQ to improve and increase call handling capacity and secure DDA compliant facilities.

iv. A significant milestone was achieved with the first live patient record generated through ePCR in August.

v. Continued development of business cases to support the capital investment priorities for the remainder of 2020/21 and mobilising of works where cases have been approved.

vi. Collaborative working with health service partners in the development of London's Primary Care Networks (PCNs). As part of this, the Business Case for the Merton Trial has been approved and will go live in October 2020.

We are now focussing our attention towards a response to the *NHS Phase 3 Recovery* plan (see section 2), continued engagement with commissioners in the development of our support in pan-London urgent and emergency care services, driving forward delivery of the capital

programme, and contributing to the group established by NHS England to agree arrangements in advance of the UK's exit from the European Union.

## 2. LEADERSHIP & GOVERNANCE

There is continued focus and priority to fill key posts within the COO senior leadership team. Recent appointments have included Simon Thwaites as the Head of Fleet, and an external offer made to fill the Head of Estates role by a highly experienced Head of Estates who is currently working in the wider NHS system. I would like to thank Justin Wand for his support during his interim assignment as Director of Strategic Assets and Property and I know his experience will be invaluable as he reverts to his substantive role and focusses on supporting the Ambulance Operations Modernisation Programme Team. A further interim will need to be put in place until a substantive is appointed.

In the coming months, I shall be focussed on continuing to recruit substantively to key leadership positions. During September this will include a permanent appointment for each of the following roles: Director of Ambulance Services; Director of Integrated Patient Care. In addition we will be working towards the substantive recruitment of a Chief Information Officer, Director of Strategic Assets and Property and the newly established Director of Business Intelligence and Analytics.

## 3. WINTER PLANNING

At the end of July, NHS England set out three overarching priorities for the third phase of recovery to be delivered before the winter pressures. The priority that has the greatest impact on the Operations Directorate is:

**Priority 2: Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.**

1) Sustaining current NHS staffing, beds and capacity
2) Deliver a very significantly expanded seasonal flu vaccination programme, including providing easy access for all NHS staff promoting universal uptake
3) Expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance
4) Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments
5) Continue to make full use of the NHS Volunteer Responders scheme
6) Continuing to work with local authorities, given the critical dependency of our patients – particularly over winter - on resilient social care services.

We are in the process developing robust demand and capacity plans in order to respond to winter pressures, the ongoing Covid-19 activity including a second peak and any instability associated with Brexit. This includes a governance structure and dedicated LAS team who will act as the main point of contact for external stakeholders, business intelligence information to support daily oversight of activity and tactical decision making, and detailed plans to mitigate against any potential staffing capacity gaps.

## 4. INTEGRATED PATIENT CARE

### NHS 111 / Integrated Urgent Care Services

### Highlights

The LAS has been working closely with system partners to redesign access to the urgent and emergency care system prior to winter 2020/21 and to deliver the 111 First initiative which enables clinicians across the 111 and 999 to refer into a non-ED outcome in collaboration with ICS downstream services.

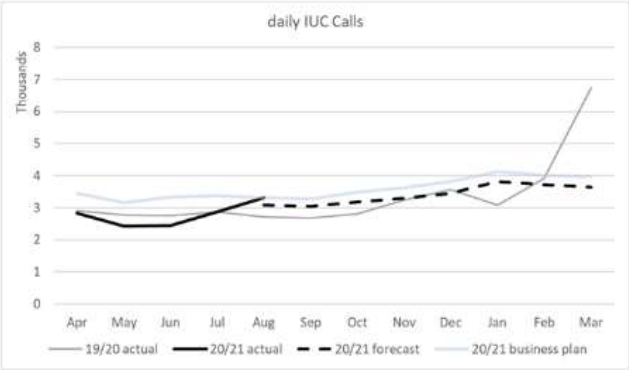
This will be achieved through increased clinical validation and assessment, increased electronic appointment bookings across the NHS system and increased clinician to clinician support. Engagement with local system providers to shape clinical pathways is ongoing, with plans to be implemented by 1 December 2020

### 2020/21 YTD Performance

Strong performance continues across NEL and SEL 111 teams with calls answered within the 60 second target of 95% for SEL (99%) and NEL (98%), as was the abandonment rate of 0.1% against a target of <5%. This resulted in a ranking of 1st and 2nd respectively out of all London providers.

| Indicator (KPI Name) | Target | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Trend |
|---|---|---|---|---|---|---|---|
| 111 / IUC (NEL) - Calls Answered within 60 seconds | >95% | 79.9% | 98.3% | 99.5% | 98.7% | 98.3% | |
| 111 / IUC (SEL) - Calls Answered within 60 seconds | >95% | 77.3% | 98.3% | 99.8% | 99.2% | 99.0% | |
| 111 / IUC (NEL) - Calls Abandoned after 30 seconds | <5% | 7.8% | 0.1% | 0.0% | 0.1% | 0.0% | |
| 111 / IUC (SEL) - Calls Abandoned after 30 seconds | <5% | 8.4% | 0.2% | 0.0% | 0.1% | 0.0% | |

### 2020/21 Forecast Demand




- IUC activity is currently on track to return to forecast plan.
- 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 answer 10,000 calls per day and ensure 95% of calls answered are answered in less than 60 secs. The detail of these plans will be further developed and matured in the winter demand and capacity plans that will be finalised by the end of September.

**Workforce**

A revised forecasting model has confirmed the health advisor requirement for FY2020/21 is 263 WTE, which will provide roster resilience and accommodates a 20% increase in demand.

Work is underway to reduce agency spend by moving agency and managed service staff to the Staff Bank or appoint to substantive positions. To date, 44 Health/Service Advisors have been moved from agency roles to the Staff Bank.

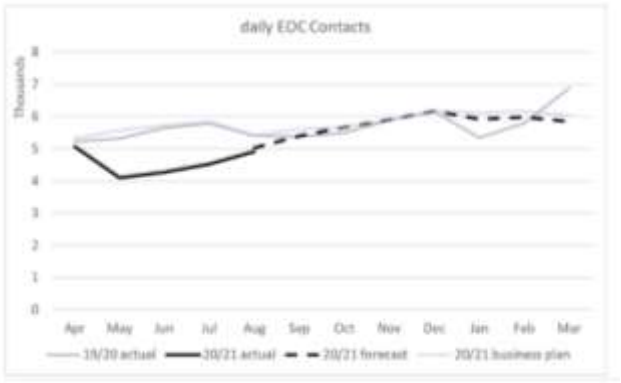
**999 Emergency Operations Centre**

**2020/21 YTD Performance**

999 EOC continues to deliver high levels of performance, with the 999 Mean Call Answering time of 0 seconds being delivered for four months running.

| Indicator (KPI Name) | Target | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Trend |
|---|---|---|---|---|---|---|---|
| 999 Mean Call Answering Time | <5 Secs | 55 | 0 | 0 | 0 | 0 | |

**2020/21 Forecast Demand**




Before the onset of Covid the 2020/21 business plan forecast for EOC Contacts showed a 3% increase, on 2019/20 activity

EOC Contacts volumes are currently expected to return to plan by the beginning of October

Call volumes are expected to be highest in December and January

B

**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. The detail of these plans will be further developed and matured in the winter demand and capacity plans that will be finalised by the end of September.

**Workforce**

Work is underway to enhance and relocate the roles and functions within the Tactical Operations Centre including collocating key roles and optimizing effectiveness of the function. This will continue to provide resilient 24/7 London wide operational command and control over front line services.

The Business Intelligence and Forecasting team are developing a dynamic base plan to support resourcing in EOC, which will reflect minimum staffing per hour aligned to weekly forecast to ensure relief and overtime staffing is more dynamic and only focusses on shifts with the greatest performance challenge.

## 5. AMBULANCE OPERATIONS

### Highlights

Historically, August bank holiday has proven challenging across operations owing to multiple large scale annual events (i.e. Notting Hill Carnival). Whilst the carnival was cancelled due to COVID-19, additional resources were on hand to respond in anticipation of small scale celebrations, delivering strong operational performance throughout the Bank holiday weekend.

Delivery against our business plan objective to recruit and train non registrant Band 4 Associate Ambulance Practitioners (AAP) by spring 2021 is well underway, with the commencement of a rapid recruitment process that aims to recruit an additional c.184 frontline staff over the winter months.

Additionally the Trust is engaging with five partner Universities to continue to allow third year Paramedic students to work with Ambulance Services in weekends and holidays. Initial discussions with Universities indicate at least 70 term time shifts per week (equivalent of 23 WTEs) and 280 shifts per week (equivalent to 88 WTEs) during University holidays. The Trust is developing a new Student Paramedic non-registrant role with job description and two week training course to ensure the students are familiar with LAS equipment and processes.

The Trust are continuing the successful partnership with LFB, with a new operating model beginning on 1 October where firefighters able to work with LAS as overtime. We expect this will lead to 30-50 Firefighters deployed with LAS each day, seven days a week (equivalent to 70 – 100 WTEs). This will maintain a pool of c. 390+ LFB staff with recent experience with LAS who are able to return to LAS full time in the event of a Covid second wave.

To ensure that the Trust can meet the periods of historic peak demand (December to January), the Ambulance Operations Directorate is working with other Directorates to enable non-patient facing clinicians to undertake one or more patient facing shifts. This will support our staff to maintain their clinical skills while supporting the Trust at a historically demanding time of year.

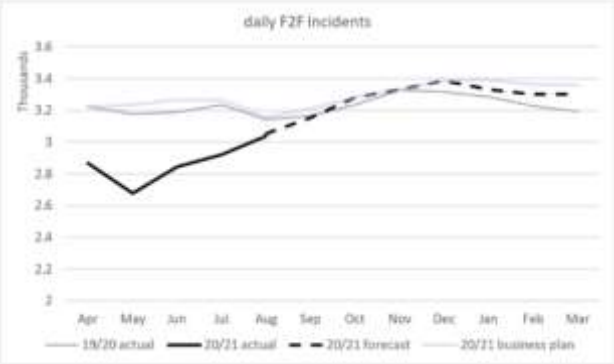
### 2020/21 YTD Performance

Performance in Ambulance Services remains strong, with national standards being achieved across all categories despite rising levels of demand.

We have enacted plans that right-sized our resources to demand and better utilises overtime arrangements to ensure our operations are run efficiently and deliver value for money. For the remainder of FY2020/21 our plan is to maintain a C2 mean performance to an average of 16 minutes every day, which is still within the national performance targets and supports the well-being of our workforce and operational resilience. The detail of these plans will be further developed and matured in the winter demand and capacity plans that will be finalised by the end of September.

| Indicator (KPI name) | Target | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Trend |
|---|---|---|---|---|---|---|---|
| Category 1 Response - Mean | 7 mins | 00:07:10 | 00:05:52 | 00:05:46 | 00:05:58 | 00:06:22 | |
| Category 2 Response - Mean | 18 mins | 00:23:32 | 00:08:54 | 00:09:32 | 00:11:10 | 00:14:12 | |
| Category 3 Response - 90th centile | 120 mins | 01:34:37 | 00:47:32 | 00:51:02 | 01:01:11 | 01:21:15 | |
| Category 4 Response - 90th centile | 180 mins | 02:12:07 | 01:30:16 | 01:39:54 | 02:00:01 | 02:25:10 | |

## 2020/21 Forecast Demand




- Before the onset of Covid the 20/21 Business Plan forecast for daily F2F incidents showed a 3% increase on 2019/20 activity
- Activity is currently forecast to return to plan by October

## 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, London Fire Brigade, Clinical Team Managers, St Johns Ambulance and as a last resort Mutual Aid from other Trusts.

## Workforce

As reported in the highlights, we have mobilised proposals to introduce a new Band 4 (non-registrant) role as a means to mitigate the anticipated frontline workforce shortfall by March 2021 and have plans with Universities and the LFB to bolster our flexible workforce in times of surge.

## 6. STRATEGIC ASSETS & PROPERTY

### Estates

At the start of the pandemic we moved quickly to consolidate the number of ambulance stations to support operational responsiveness. Of our 68 pre-Covid Ambulance Stations we are now operating from 41 Ambulance Stations. Following a detailed review carried out by the Quality team, there has been no quality impact, incidents or serious incidents related to the station consolidation reported.

In addition to securing COVID-19 secure compliance status at all 41 stations, improvements are being made to a large number of sites to improve facilities for staff and volunteers. This includes 17 refurbished or additional mess rooms; refurbished or new toilet facilities at 6 sites; repaired or new shower facilities at 10 sites; and, refurbished locker rooms at 6 sites. Further work is underway to increase car parking provision where possible.

Work continues to consolidate all our education into two new purpose-built facilities, one in North London and one in South London, by the end of the financial year. While this work is under way, during August we secured and set up an interim training facility within East London.

111 IUC: An additional 111 call centre is now in testing phase on the third floor of Maritime House (Barking), increasing our call talking capacity within north London by 50% (circa 70 additional call taking and clinical assessment workstations). An additional circa 30 workstations have been added to Southern House (Croydon) increasing our call taking and clinical assessment capacity by 25% in South London with a plan to increase this by a further 25% by March 2021.

**999 EOC:** The brand new 'state of the art' interactive training centre based at Maritime House was officially opened by London Mayor Sadiq Khan. The new centre offers interactive training for our emergency call handlers to help them better prepare for their challenging role and will support increased training capacity to boost the 111/999 call handling workforce ahead of the busy winter period and potential increase in Covid demand.

As part of enhancing the Tactical Operations Centre (TOC) function, the team will be relocating to permanent, dedicated, and fit for purpose accommodation in Waterloo HQ which is due to be completed in Q4 FY2020/21.

A business case for the redevelopment and refurbishment of the Trust's second site in Bow, is being developed for consideration in October.

### Next Steps

Capital funding has been agreed to continue further improvement works in our current Ambulance Station estate throughout the remainder of the year.

## Fleet and Logistics

Throughout July and August, the Fleet and Logistics teams have maintained the deployment of 536 Double Crewed Ambulances (DCA) alongside ensuring the continued and uninterrupted supply of PPE, medical consumables, equipment, medical gases and medicines.

From September, we will rollout 37 new telematics ambulances with added enhancements for crew safety. This new system has a number of benefits including CCTV video equipment, access to data to monitor our fleet that will support provision of better response times, and the ability to monitor vehicle fuel consumption

## Next Steps

In the next phase of telematics ambulances, Radio-frequency identification (RFID) tagging system will be implemented which will enable improvements in asset management.

Following staff feedback relating to equipment regularly missing from Primary Response Bags, the Logistics team have been working with operational colleagues to identify improvements to the current ways of working and investigating whether unique barcodes can be issued on high-value small items to improve equipment tracking.

A number of business cases are currently being developed and are being taken through the established approval process, including further provision of bunkered fuel, further replacement of DCA's and Resilience & Specialist Assets vehicles, a new Fleet Management System, conversion of DCA chassis and a Drugs Packing Unit to modernise our management of medicines.

## 7. IM&T

### Highlights

The IM&T directorate continues to progress its people plan to establish a substantive Senior Management and Infrastructure Team and reduce reliance on managed service agreements and contract staff. This will help move the Directorate toward being a more stable and effective team with the capability to drive improvements in our IT infrastructure.

We are on track to re-platform our existing CAD system onto new, robust hardware at two external data centres in mid-September. Prior to this go-live, an extensive programme of testing has been conducted that has not highlighted any cause to defer the planned transition.

A significant milestone was achieved with the first live patient record generated through ePCR in August. Following the success of the pre-live launch of ePCR, training dates for all staff has been released to ensure all clinical staff are proficient at using the new system

### Next Steps

Existing telephony and recording platforms are being upgraded to a single system and will include the decommissioning of old systems to ensure consistency across all functions, reducing duplication and building efficiency. This will enable plans to increase clinical staffing in IUC as more clinicians will be able to work remotely

Over 150 users across Ambulance Services (a mix of frontline staff and volunteers) are enrolled onto the pre-live cohort to undertake extensive testing of ePCR to provide assurance that the system meets the needs of staff and patients ahead of the full rollout planned to start in September.

Planned visits with other UK Ambulance Services that use Cleric have been arranged to understand any potential changes required to LAS processes and procedures and to learn from their experience of implementing the system, in advance of the replacement CAD going live in May 2021.

Plans are in place for the Trust to move towards cloud hosted solutions to reduce reliance on data storage hardware, which will include a review of our Wi-Fi networks to ensure they are able to support stable access to cloud based services, ahead of implementing Microsoft Office 365 and InTune as the Trust Mobile Device Management tool and migrating to nhs.net email accounts.

A cyber security monitoring solution is being introduced to provide early detection of emerging threats, reducing technical vulnerabilities and enabling a rapid response.

## 8. PROGRAMMES & PROJECTS (P&P)

### Highlights

In July and August, the P&P directorate has shifted its focus to delivering the FY20/21 capital investment portfolio, and a critical path for each programme has been set out that brings together the collective contributions across the organisation to realise its ambition from scoping through to closure.

Substantial work has been carried out in collaboration with Finance and Procurement to advance the development of business cases with improved financial management. There are currently eight active programmes in the FY20/21 Portfolio with five reporting green and on track, and three with amber status.

Programme management discipline continues to be socialised across the organisation with the design of a new change management approach and methodology to track benefits, and establishment of robust governance across all new programmes.

### Next Steps

There are 24 high priority schemes proposed for the additional capital monies with business cases in development for consideration during September and October.

Some of these business cases have been mentioned earlier in this report.

Schemes of particular high financial values and note are the Drugs Packaging Facility Business Case, Training Centres Business Case, the Bow Modernisation Business Case.

## APPENDIX: WINTER PLANS UPDATE

**Overview**

The LAS Winter and Covid19 Preparedness Plan 2020/21 will include preparations for winter 2020/21; a second Covid peak; and aim to mitigate any emerging risks as the EU Exit transition period ends on 31 December.

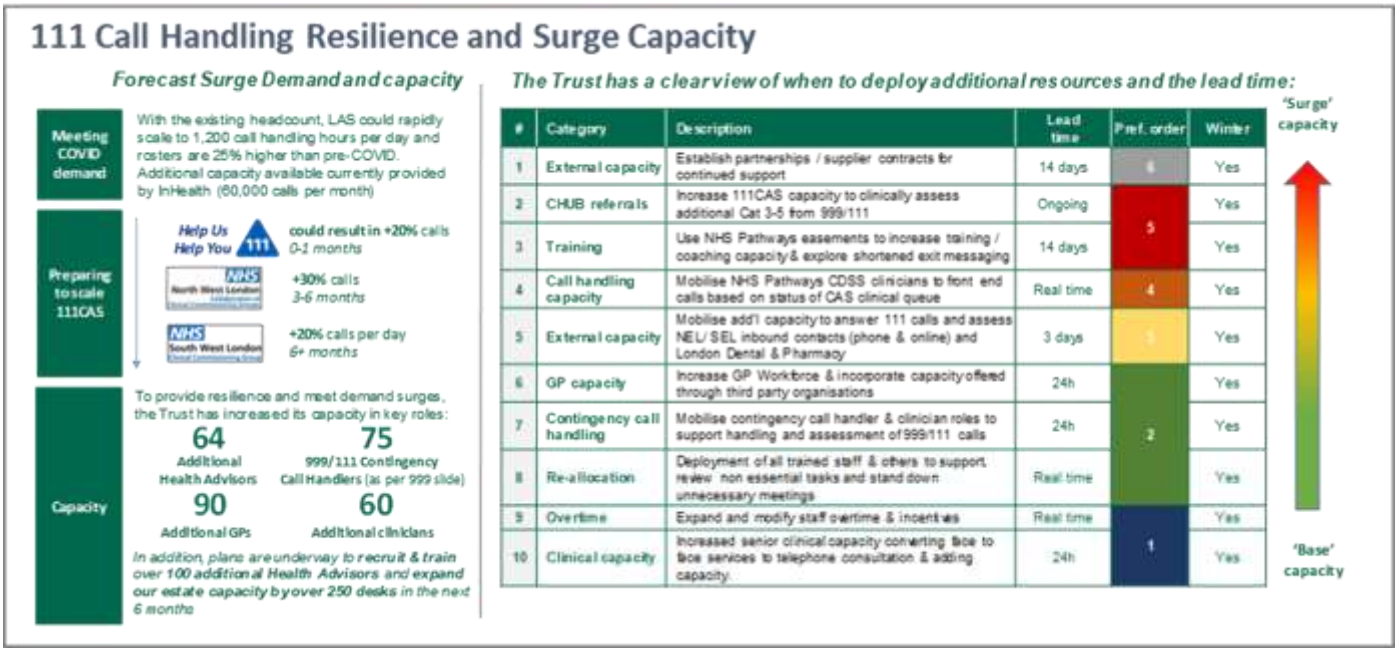
An LAS Winter/Covid19 Team has been established as part of the Winter and Covid19 Preparedness Plan. The LAS team will maintain oversight of system delivery through the daily receipt and review of data and intelligence from internal and system partners

The LAS will maintain oversight of system delivery through the daily receipt and review of data and intelligence from internal and system partners. A set of principles has been developed to inform the manner in which the LAS Winter/Covid19 Team will interact with internal and external partners.

The LAS Executive Committee is due to approve the LAS Winter and Covid-19 Preparedness Plan 2020/21 on 14 October 2020. The plan will be shared with NHS England/Improvement and LAS commissioners as quickly as possible after this date.

**Escalation Plans**

The trust has developed clear escalation plans for each LAS service – including 111, EOC and frontline ambulance services – to show how a significant surge in demand due to Covid-19 will be managed. The trust can increase or decrease capacity to meet demand.




| # | Category | Description | Lead time | Pref. order | Winter |
|---|---|---|---|---|---|
| 1 | External capacity | Establish partnerships / supplier contracts for continued support | 14 days | 6 | Yes |
| 2 | CHUB referrals | Increase 111CAS capacity to clinically assess additional Cat 3-5 from 999/111 | Ongoing | 5 | Yes |
| 3 | Training | Use NHS Pathways easements to increase training / coaching capacity & explore shortened exit messaging | 14 days | | Yes |
| 4 | Call handling capacity | Mobilise NHS Pathways CDSS clinicians to front end calls based on status of CAS clinical queue | Real time | 4 | Yes |
| 5 | External capacity | Mobilise add'l capacity to answer 111 calls and assess NEL/ SEL inbound contacts (phone & online) and London Dental & Pharmacy | 3 days | 3 | Yes |
| 6 | GP capacity | Increase GP Workforce & incorporate capacity offered through third party organisations | 24h | 2 | Yes |
| 7 | Contingency call handling | Mobilise contingency call handler & clinician roles to support handling and assessment of 999/111 calls | 24h | | Yes |
| 8 | Re-allocation | Deployment of all trained staff & others to support, review non essential tasks and stand down unnecessary meetings | Real time | | Yes |
| 9 | Overtime | Expand and modify staff overtime & incentives | Real time | 1 | Yes |
| 10 | Clinical capacity | Increased senior clinical capacity converting face to face services to telephone consultation & adding capacity | 24h | | Yes |

# 999 Call Handling Resilience and Surge Capacity

## *Forecast Surge Demand and capacity*

**Meeting COVID demand**

999 call demand surpassed 10,000 calls at the peak of the Covid-19 pandemic in March, partly as a result of high London 111 call abandonment. From April, 999 call demand decreased to approximately 4,500 calls per day (lower than business plan of 6,000 calls per day).

Over 600 dispatch hours are available to backfill during surge to meet 10,000 calls per day.

**Capacity**

To provide resilience and meet demand surges, the Trust has increased capacity in key roles:

**45** Emergency Call Handlers (ECH)

**75** 999/111 Contingency Call Handlers

**25** WTE 999CAS clinicians (and additional 80 clinicians trained to support Hear & Treat activity

*In addition, plans are underway to* ***recruit & train***

- ***150*** *Emergency Call Handlers (ECH) within the next six months*
- ***Rising to 210*** *additional ECH by March 2021*
- ***Attrition rate has also fallen*** *from c. 9 FTE per month to c. 2 FTE since Covid-19 began.*

## *The Trust has a clear view of when to deploy additional resources and the lead time:*

| # | Category | Description | Lead time | Pref. order | Winter |
|---|---|---|---|---|---|
| 1 | Call handling capacity | Contingency call taking arrangements | Ongoing | 5 | Yes |
| 2 | Revise CHUB processes | Protocol 36, Re-Shape CHUB processes, Auto-transfer C3-C5 COVID Related activity into CHUB, C3-C5 case referral to 111 providers | 1 day | 4 | Yes |
| 3 | Increase contingency capacity | Re-mobilise Contingency Call Advisors | 1-2 days | | Yes |
| 4 | Call handling capacity | Increase Staffing within EOC by returning EOC trained staff to role, increase staffing in the CHUB | 24h | 3 | Yes |
| 5 | Emergency Rule | Emergency Rule / Staying on Line / PAIs/PDIs | Real time | | Yes |
| 6 | Expectation management | LAS Hold / Comfort Message Amendments | Real time | 2 | Yes |
| 7 | Exit message | Reduction in Ring Backs & Exit Message Adjustment | Real time | | Yes |
| 8 | BT Filter | BT Filtering to support identification of COVID calls and referred to 111 Online | Real time | | Yes |
| 9 | Mutual aid | Explore & consider proactively with other ASTs | Ongoing | | Yes |
| 10 | Call handling capacity | Increase staffing using overtime & more shifts across EOC & CHUB | 1-2 days | | Yes |
| 11 | Process changes | Open EOC Escalation Areas and Contingency Dispatch Groups | Real time | 1 | Yes |
| 12 | Clinical capacity | Progress through stages of CSEP | Real time | | Yes |
| 13 | BT buddy site arrangements | BT automatically find other ambulance sites to take LAS calls | Real time | | Yes |

'Surge' capacity

'Base' capacity

# Ambulance Services

## Forecast Peak Capacity

**Forecast Peak Capacity**

At maximum surge, the Trust can deploy **646 Double Crewed Ambulances**.

**Sources of Capacity**

To meet this demand, the Trust can call upon different groups to provide capacity to **meet a surge in demand** such as:

- Non Patient Facing Paramedics
- Clinical Team Managers
- Emergency Responders/ Community First Responders
- External Mutual Aid
- REAP 4 – to release training time etc.
- London Fire Brigade – *Surge to 300 FTE*
- 3rd Year University Students
- Extra Overtime – *over and above normal overtime offered*
- Bank Paramedics
- St John Ambulance (Mutual Aid)
- London Fire Brigade – *Base support (500 FTE)*

## The Trust has a clear view on when to deploy additional resources and the lead time

The Trust can surge for seasonal demand (e.g. winter) and surge further to respond to a return in Covid-19.

| # | Category | Total DCAs* at 1pm | Total DCAs* at 3pm | Lead Time (days) | Surge Duration |
|---|---|---|---|---|---|
| 1 | HPP Paramedics (CPD) | 640 | 257 | 3 | days |
| 2 | Clinical Team Mgrs | 617 | 255 | 3 | days |
| 3 | EPs/CPEs | 614 | 249 | 3 | 1 month |
| 4 | LFB (surge) | 593 | 227 | 4 | 1 month |
| 5 | Bank Paramedics | 581 | 224 | 5 | days |
| 6 | Bank E&C | 553 | 221 | 0 | Dec/Jan |
| 7 | External Mutual Aid | 506 | 202 | 4 | 2 weeks |
| 8 | REAP | 470 | 188 | 0 | 1 month |
| 9 | Extra Overtime | 407 | 187 | 3 | 2 months |
| 10 | St John (Mutual Aid) | 391 | 186 | 0 | ongoing |
| 11 | LFB (Base) | 383 | 153 | 0 | ongoing |
| 12 | PAS/VAS | 372 | 149 | 1 | ongoing |
| 13 | CRG/MRU/APP | 369 | 145 | 0 | ongoing |
| 14 | FRUs | 365 | 145 | 0 | ongoing |
| 15 | Standard DCA Roster | 365 | 145 | 0 | ongoing |

* Total DCA Fleet (ALS, BLS, HRTU) = 646

**Covid-19 Surge** *(up to 643 DCAs at 3pm)*

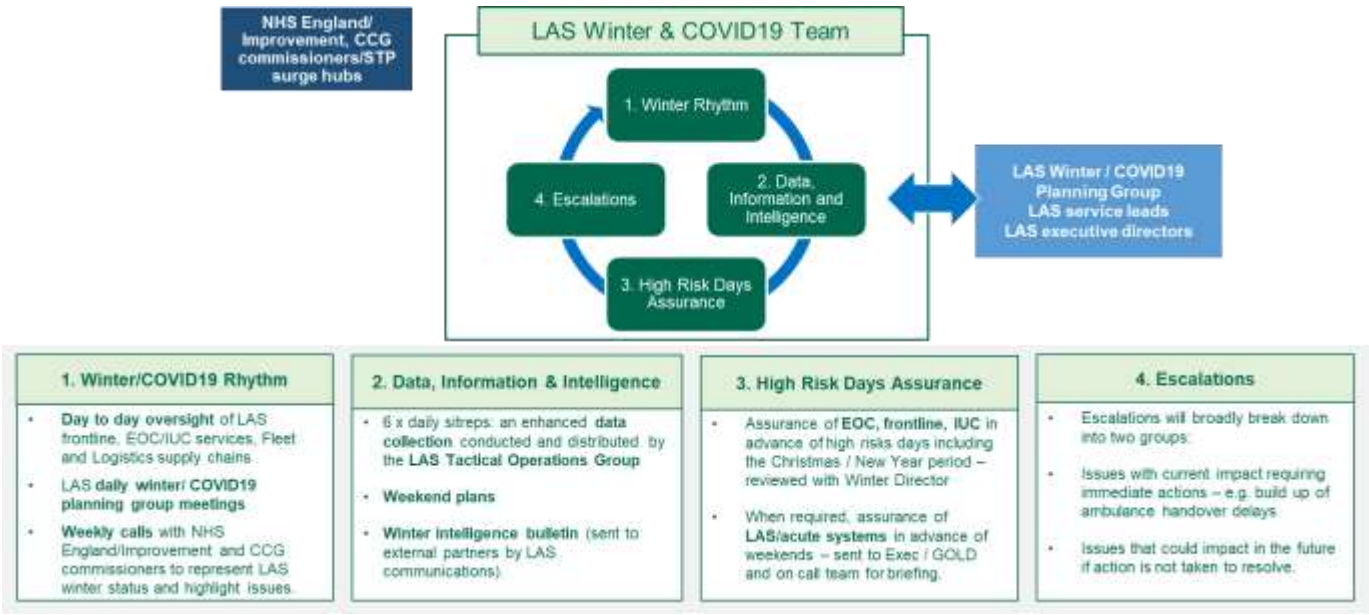
**Seasonal Surge** *(up to 467 DCAs at 3pm)*

**Baseline staffing** *(up to 383 DCAs at 3pm)*

'Surge' capacit

'Base' capacity

**LAS winter and Covid-19 Team**




**Working with Internal and External Partners**

The following set of principles informs the manner in which the LAS winter/COVID19 team will interact with internal and external partners.

1. Local service leads will be alerted by the LAS Winter / COVID19 Team in the first instance when there are concerns. They will be required to manage the escalation, bringing in wider LAS functions as required.
2. The LAS Winter / COVID19 Team will act as the core in managing internal escalations. LAS service leads and their Executive Directors will always be informed, both in and out of hours, when there are significant issues.
3. Where there are on-going external concerns, the LAS Winter/COVID19 Team will engage with the wider system including acutes, ICS surge hubs, NHSE/I and CCG commissioner winter leads. Other key internal partners will be invited to engage as appropriate. The LAS Winter/COVID19 Team will also be fully engaged with external stakeholder leads for EU Exit to ensure that all risks relating to the end of the 'transition period' on 31 December 2020 are mitigated in order to avoid any impact on LAS operational service delivery this winter.
4. The 24/7 Tactical Operations Centre (TOC) and on-call service leads will lead the escalation when there is a lack of traction with the system on weekends/bank holidays. The TOC will support the Bronze Logistics functions across all sector hubs to ensure robust flow of PPE is maintained to the frontline.
5. In terms of internal governance, performance over the winter period will be reviewed at the monthly operational performance management meetings while performance information will be included in the performance and quality reports which will be provided to the Quality Assurance Committee and the Trust Board meetings over the winter period.

**Daily Schedule**

A daily Schedule has been drafted to provide 24/7 operational control over demand and resoures. The 24/7 Tactical Operations Centre and Winter Planning Group will monitor performance and take immediate actions to respond to operational pressures.

| Timing | Activity |
|---|---|
| **04.00 – 04.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |
| **08.00 – 08.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |
| **08.30 – 09.00** | Handover to the Winter Team from Incident & Delivery Manager/on-call leads of any overnight issues |
| **09.00 – 09.30** | Winter Team preparation of brief for Winter Planning Group |
| **09.30 – 10.30** | Winter Planning Group<br>• Data/performance review<br>• Follow up actions from previous day<br>• Prioritise issues for the day |
| **10.30 – 11.30** | Winter Team will hold a weekly call (day/time TBC) with CCG commissioning winter lead and NHSE/I winter representative to report on performance and any external escalations |
| **12.00 – 12.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |
| **15.30 – 16.00** | Winter Planning Group (this meeting will only proceed if necessitated by service pressures) |
| **16.00 – 16.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |
| **17.00** | Winter Team handover any issues to the 24/7 on-duty Incident & Delivery Manager/on-call leads |
| **20.00 – 20.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |
| **23.00 – 23.30** | Winter grip teleconference – led by the 24/7 Tactical Operations Centre |

**DSLT and COLT**

During March 2020, to maintain operational grip despite demand volititaty and to oversee the wider operational changes required to respond to the Covid-19 pandemic, the Trust formed the Covid-19 Operational Leadership Group (COLT). Following an extended reduction in demand and stablisation in performance, the Trust replaced COLT with the Daily Senior Leadership Team meeting (DSLT). DSLT

allows the Trust to closely monitor demand, resources and performance but also track the actions required to preprare the Trust for further demand changes.

The Trust will reactiviate COLT if as Accountable Emergency Officer (in discussion with the Chief Executive) we judge that increased demand (or risk of) from Covid-19 means the Trust would benefit from closer monitoring of demand and capacity and that a move to on site Executive 7 day working is required. The re-establishment of COLT would include full delegated decision making of the Executive struture in line with SFIs. DSLT or COLT will provide daily oversight of the Trust performance and the delivery of the Winter Plan.

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Integrated 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.

**Since the last report:**

Since the last report we introduced some changes that allows a clear understanding of the **reporting period** for each of the 4Ps and a few step changes allowing for clear and transparent timelines located on the **contents page in slide 2**.

In terms of Directors / Chiefs Of agreeing the minimum deliverables and design of some metrics subsumed within the IPR document, work has certainly begun with Quality directorate who had already submitted their improved and revised metrics showcased in ***slides 9, 12, 13, 18, 19, 20 and 29*** during September's submission.

Similarly, the Corporate Reporting Team met with the Medical directorate and discussed clinical metrics in respect of the Trust Wide Scorecard with their focus largely around **Clinical Care Process** and **Clinical Outcomes** rather than just time targets.

**Key points, issues and risks for discussion:**

**Our Patients**

- **111 IUC Performance slides 5 & 6**
  - % of calls recommended to ED SEL & NEL ragged rating @ RED
    - This has improved and the best amongst providers in London due to the increase in ED re- validation. It should be noted that the target for %of calls recommended to ED is <=10%

**Our People**

- **Workforce Performance**
  - Information Governance training is 85% at present against annual target of 95% to meet the requirements of NHS Digital's IG Toolkit

**Horizon scan & additional information**

- Staff survey action plans was highlighted
- BLM Plan submitted to Trust Board for September's meeting which tracks progress to date and new initiatives that are now planned
- WRES and WDES national returns – expect to receive a bulletin in late September from NHSE/I with feedback on this year's submission
- Body Worn Video Cameras (BWVC)
  - The LAS is participating in the centrally funded National evaluated trial of BWVC as part of phase one of a 12 month trial. This trial was suspended during COVID-19 pressures and has now resumed
- Business Planning and Cost Improvement Programmes
  - The Trust is operating under an adjusted financial framework for April to September 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.

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

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

| **Routing of Paper – Impacts of recommendation considered and reviewed by:** | | | | | |
|---|---|---|---|---|---|
| **Directorate** | **Agreed** | | | | **Relevant reviewer [name]** |
| Quality | Yes | x | No | | |

| | | | | | |
|---|---|---|---|---|---|
| Finance | Yes | x | No | | |
| Chief Operating Officer Directorates | Yes | x | No | | |
| Medical | Yes | x | No | | |
| Communications & Engagement | Yes | x | No | | |
| Strategy | Yes | x | No | | |
| People & Culture | Yes | x | No | | |
| Corporate Governance | Yes | | No | | |

NHS
London Ambulance Service
NHS Trust

# London Ambulance Service – Integrated Performance Report


Report for discussion with Trust Board members

Analysis based on Year to **July 2020** data, unless otherwise stated **(please see page 2 for data reporting periods)**

# Contents Page

London Ambulance Service NHS Trust

# Overview

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

| | **Update on performance:** | **Achievements since the last Board** (incl. reference to Business Plan deliverable): |
|---|---|---|
| Provide outstanding care for **our patients** | 999 Performance in all national measures has been broadly very strong ever since the Covid-19 measures were implemented in the second week of April.<br><br>111 Performance on calls answered within 60 seconds SLA was strong at both North East London (NEL) and South East London (SEL) as was the abandonment rate at both sites | • *July saw the continuation of a trust wide Covid-19 response that resulted in improved performance across the board.*<br>• *NEL/SEL continued to play a big part in the national response to COVID-19 and showed strong performance in July* |
| Be a first class employer, valuing and developing the skills, diversity and quality of life of **our people** | Our in-ops vacancy rate has improved from 5.3% to 4.6%.<br><br>Our turnover has reduced from 9.8% to 9.1%. Sickness rates have remained at 4.6%. Trust compliance in Statutory and Mandatory training is outside target at 84%, PDRs have slightly improved from 64% to 67%. | • *Staff Turnover rates has further improved to 9.1% (within target).*<br>• *The 'in-ops' vacancy rate for our frontline registered and non-registered staff has improved from 5.3% to 4.6%.*<br>• *Sickness has remained at 4.6%.*<br>• *Stat and mandatory training at 84% (at target).* |
| Provide the best possible value for the tax paying **public**, who pay for what we do | In line with the revised financial framework issued by NHS England the Trust reported a YTD breakeven position on an adjusted financial performance basis in month 4 (£105k surplus before donated assets adjustments).<br><br>The amount of additional M4 retrospective top up requested to balance the Trust's position is £9.368m (YTD: £35.802m M1: £10.734m, M2: £8.110m, M3: £7.59m). This is higher than the Trust's M4 reported COVID costs of £6.617m (YTD: £33.685m M1: £12.915m, M2: £7.345m, M3: £6.807m) due to the in month recognition of costs in relation to the write off of assets connected with replacement of the Trust's dispatch system (£2.6m). Corporate spend as a proportion of income is expected to increase from 8.8% YTD to 9.5% full year due to compacted international recruitment costs in People & Culture pending confirmation of numbers.<br><br>Capital spend was £5.6m YTD (primarily on COVID-19 response requirements £5.2m) with a full year forecast of £44.2m in line with the Trust's June 2020 revised capital plan (though a further £6.1m has been identified which is likely to increase the Trust's Capital Resource Limit to £50.3m). The month end cash position was £58.3m. | • *The Trust is operating under an adjusted financial framework for April to September 2020 which has involved pausing business planning (including Cost Improvement Programmes) and contracting and commissioning processes (including CQUIN).*<br><br>• *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.* |
| **Partner** with the wider NHS and public sector to optimise healthcare and emergency services provision across London | The Trust saw strong Handover to Green performance in line with April 2020. Similarly, the ED conveyance during July was in a good position, continuing on the trend from May. Both measures are strongly influenced by the wider healthcare system. As business planning and target setting have been delayed due to Covid-19, the comparison are currently looked at in view of the trend and against the 2019/20 targets. | • *ED conveyance performance in July was within the 2019/20 targets.*<br>• *H&T performance remained within targets in July.* |

## Patients Scorecard

**July 2020**

| Indicator (KPI Name) | Basis | Data From Month | Target Status | Current Perfomance: Target & Type (Internal / Contractual / National / All) | | Current Perfomance: Latest Month | Current Perfomance: Year To Date (From April) | Current Perfomance: Rolling 12 Months | Benchmarking (Month): National Data | Benchmarking (Month): Best In Class | Benchmarking (Month): Ranking (out of 11) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Category 1 response – Mean | mm:ss | Jul-20 | G | 07:00 | A | 00:05:58 | 00:06:14 | 00:06:55 | 06:47 | 05:59 | 1 |
| Category 1 response - 90th centile | mm:ss | Jul-20 | G | 15:00 | A | 00:10:00 | 00:10:34 | 00:11:43 | 12:02 | 10:00 | 1 |
| Category 1T response – 90th centile | mm:ss | Jul-20 | G | 30:00 | N | 00:13:57 | 00:14:05 | 00:19:07 | | | |
| Category 2 response – Mean | mm:ss | Jul-20 | G | 18:00 | A | 00:11:10 | 00:13:23 | 00:22:17 | 16:39 | 11:10 | 1 |
| Category 2 response - 90th centile | mm:ss | Jul-20 | G | 40:00 | A | 00:19:46 | 00:22:15 | 00:47:07 | 00:32:33 | 00:19:46 | 1 |
| Category 3 response – Mean | h:mm:ss | Jul-20 | G | 1:00:00 | A | 00:27:55 | 00:29:14 | 00:59:15 | 00:43:19 | 00:22:47 | 2 |
| Category 3 response - 90th centile | h:mm:ss | Jul-20 | G | 2:00:00 | A | 01:01:12 | 01:00:26 | 02:22:48 | 01:38:58 | 00:45:26 | 2 |
| Category 4 response - 90th centile | h:mm:ss | Jul-20 | G | 3:00:00 | A | 02:00:01 | 01:47:17 | 03:29:52 | 02:27:08 | 01:13:25 | 2 |
| Call Answering Time - 90th centile | ss | Jul-20 | G | 24 | I | 1 | 3 | 93 | | | |
| ROSC at Hospital | % | Jan-20 | G | 33% | N | 35.2% | 30.7% | 30.8% | 30.5% | 35.8% | 3 |
| Severe Sepsis Compliance - (national AQI reported quarterly) | % | Dec-19 | G | N/A | | 94.4% | 92.1% | 91.4% | 81.1% | 94.4% | 1 |

*National average YTD

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

***Please note: 999 performance data is correct as at 09/09/20 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*

# Trust-Wide Scorecard – IUC

## Patients Scorecard (NEL IUC)

**July 2020**

| Indicator (KPI Name) | Basis | Data From Month | Target Status | Current Perfomance: Target & Type (Internal / Contractual / National / All) | | Current Perfomance: Latest Month | Current Perfomance: Year To Date (From April) | Current Perfomance: Rolling 12 Months | Benchmarking (Month): London Data | Benchmarking (Month): Best In Class | Benchmarking (Month): Ranking (Pan London) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of calls answered within 60 seconds | % | Jul-20 | G | 95.0% | A | 98.7% | 94.1% | 74.2% | 96.0% | 99.3% | 2 |
| Percentage of Total number of calls abandoned after 30 seconds | % | Jul-20 | G | 5.0% | A | 0.1% | 2.2% | 12.2% | 0.5% | 0.1% | 2 |
| % of calls closed with no onward referral (health advisor and clinician) | % | Jul-20 | R | 33.0% | A | 25.9% | 23.7% | 26.4% | | | |
| % of calls transferred to 999 | % | Jul-20 | G | 10.0% | A | 8.2% | 5.8% | 7.2% | 7.9% | 6.0% | 2 |
| % of calls recommended to ED | % | Jul-20 | R | 5.0% | A | 9.1% | 9.3% | 8.5% | 11.3% | 9.1% | 1 |

## Patients Scorecard (SEL IUC)

**July 2020**

| Indicator (KPI Name) | Basis | Data From Month | Target Status | Current Perfomance: Target & Type (Internal / Contractual / National / All) | | Current Perfomance: Latest Month | Current Perfomance: Year To Date (From April) | Current Perfomance: Rolling 12 Months | Benchmarking (Month): London Data | Benchmarking (Month): Best In Class | Benchmarking (Month): Ranking (Pan London) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of calls answered within 60 seconds | % | Jul-20 | G | 95.0% | A | 99.2% | 93.7% | 75.8% | 96.0% | 99.3% | 1 |
| Percentage of Total number of calls abandoned after 30 seconds | % | Jul-20 | G | 5.0% | A | 0.1% | 2.3% | 10.5% | 0.5% | 0.1% | 1 |
| % of calls closed with no onward referral (health advisor and clinician) | % | Jul-20 | R | 33.0% | A | 28.8% | 26.0% | 27.7% | | | |
| % of calls transferred to 999 | % | Jul-20 | G | 10.0% | A | 7.0% | 6.7% | 7.3% | 7.9% | 6.0% | 1 |
| % of calls recommended to ED | % | Jul-20 | R | 5.0% | A | 12.3% | 10.2% | 9.0% | 11.3% | 9.1% | 3 |

| 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 |

# 111 IUC Performance

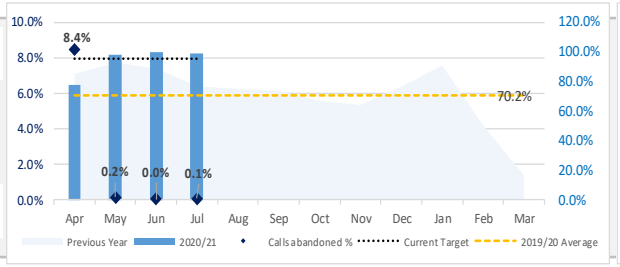
*Call answering was better than target in July for North East London (NEL) and South East London (SEL) due the strengthened capacity and response ability to Covid-19. Both sites are within target for calls transferred to 999, where we consistently perform better than the London average. The abandonment rates were also well within target for July, as well as the percentage of calls transferred to 999. We were challenged particularly in the recommendation to attend ED performance.*

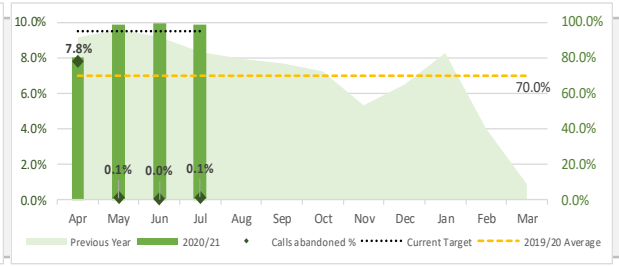
## Call Answering & Abandoned Calls

**SEL: 99.2% / 0.1%**

**Target: 95% (CA) and 5%**

**NEL: 98.7% / 0.1%**




The 111/IUC centres have been critically important in national Covid-19 response as any concerns were directed to 111 across England. The demand in July continued to be at stable levels, which can be seen in exemplary performance.

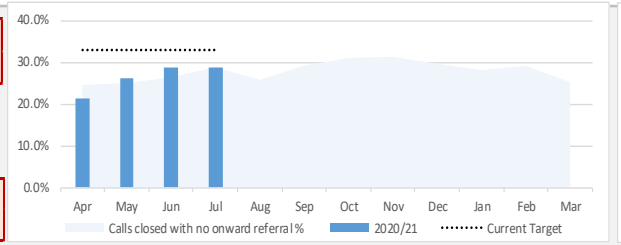
The number of calls abandoned by patients has also been well within the 5% target.

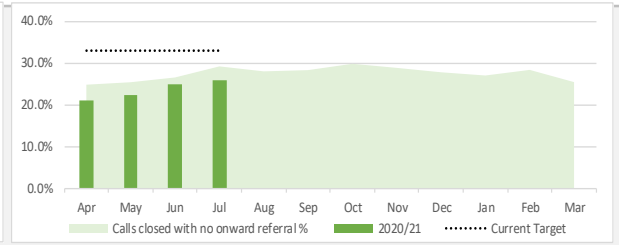
## % of calls closed with no onward referral

**SEL: 28.8%**

**Target: >33%**

**NEL: 25.9%**



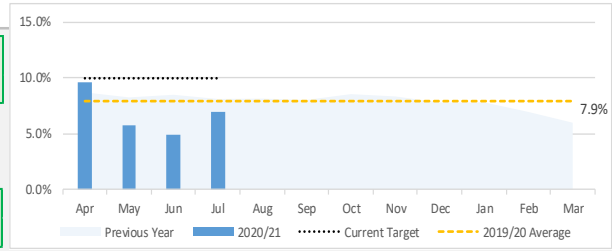

We are continuing to work to identify which patients benefit most from being managed via the CAS so that patients can have an advanced clinical assessment made and their care completed without onward referral. This significantly improves the quality of care provided over a standard 111 service and releases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

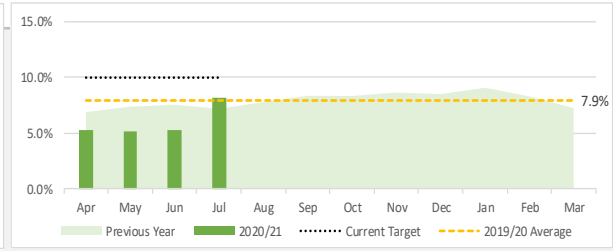
## Calls Outcome: Transferred to 999

**SEL: 7.0%**

**Target: <10%**

**NEL: 8.2%**



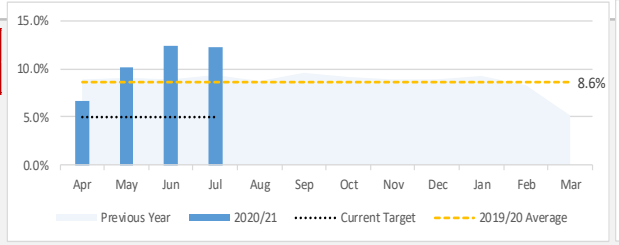

Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During July, NEL delivered 8.2%, with SEL delivering 7.0%. The SEL performance compares positively against the London average of 7.9% and remains the lowest of all providers in London, indicating the benefits of a clinical assessment service (CAS).

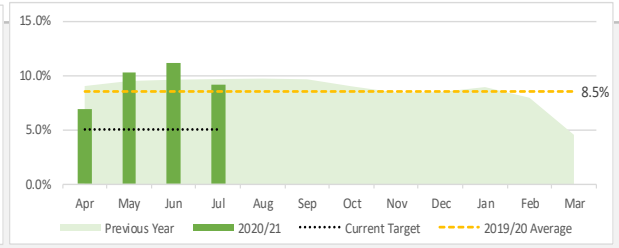
## Call Outcome: Recommended to attend ED

**SEL: 12.3%**

**Target: <5%**

**NEL: 9.1%**



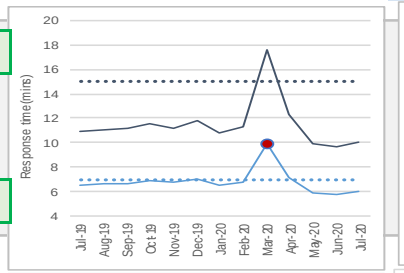
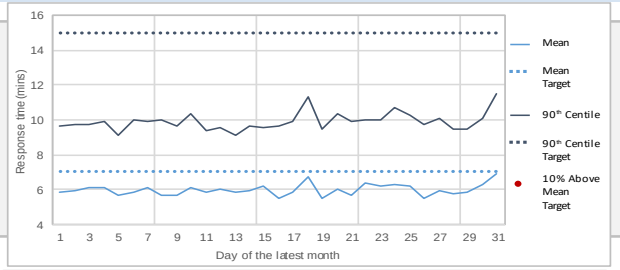
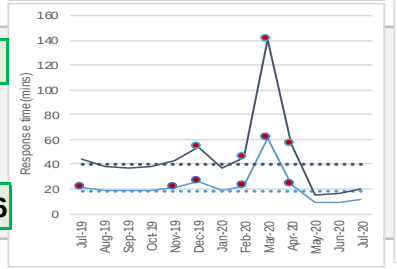
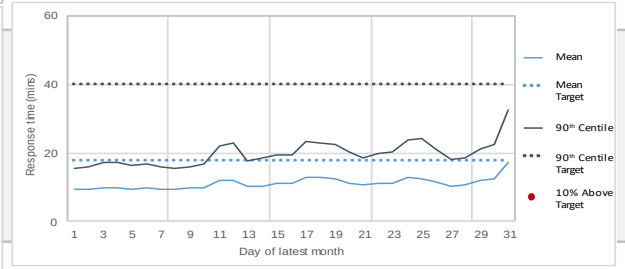
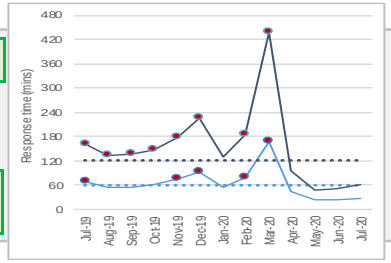
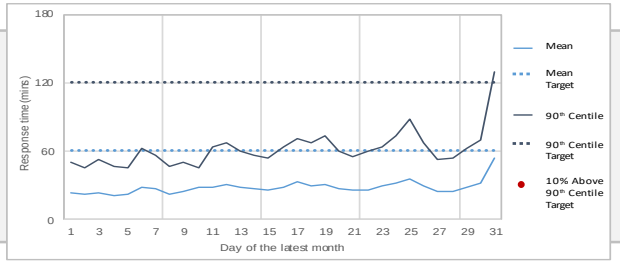
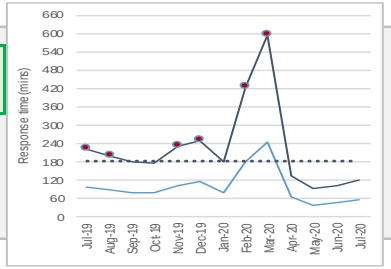
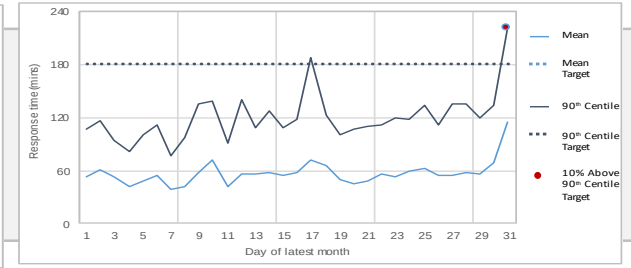

The development of our IUC services has enabled NEL and SEL to consistently outperform other providers in terms of ED avoidance, however during the Covid-19 response the performance on this metric has been challenged.

# 1. Our Patients

## 999 Response Time Performance

*The July Category 1 mean returned 5 minutes 58 seconds while the Category 1 90th centile was 10 minutes 0 seconds. The Category 1 90th centile had remained within the standard each week since the implementation of the Ambulance Response Programme (ARP), until the Covid-19 impact and shows that our most critical patients are being responded to quickly. Performance was recovered as part of the wider Covid-19 response and longer term plans are being put in place to sustain this.*

***Please note: 999 performance data is correct as at 09/09/20 and is subject to change due to data validation processes***

| | | Monthly Trend | Daily Analysis | |
|---|---|---|---|---|
| C1 | **Mean: 5:58**<br>Target: 7:00<br>**90th Centile: 10:00** |  |  | The C1 mean performance had been continuously within the national target, apart from the figures in March and April. Throughout July, there was a reduced volume of calls supported stronger performance in response to these calls.<br>The C1 90th was also within the national standard of 15 minutes. |
| C2 | **Mean: 00:11:10**<br>Target: 18:00<br>**90th Centile: 00:19:46** |  |  | During July 2020, our C2 mean and 90th centile were both within the national target, staying this way every single day of the month.<br>From the second week of April, the C2 performance improved significantly following the actions rolled out as a response to Covid-19, combined with the reduced demand on the system. |
| C3 | **Mean: 00:27:55**<br>Target: 2:00:00<br>**90th Centile: 01:01:12** |  |  | C3 90th centile was met in July, and the performance was within target due to continued reduced demand and increased response abilities by the Trust. Towards the end of the month not weather contributed to localised reduced performance. |
| C4 | **90th Centile: 02:00:01**<br>Target: 3:00:00 |  |  | C4 90th centile target was then met in July as the demand continued to be low and the response strategies continued to work to reduce the response times. Towards the end of the month not weather contributed to localised reduced performance. |

# 1. Our Patients

## 999 Response Time Performance

## Operational Demand

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.

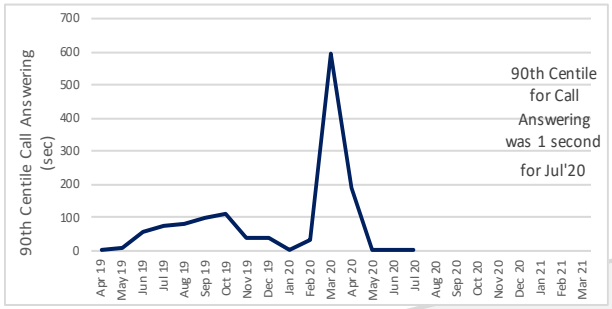
The analysis below describes: **1)** Calls Received, **2)** Incidents and Response Type (incl. Hear & Treat, See & Treat, See & Convey), **3)** Incident Category

***Please note: 999 performance data is correct as at 09/09/20 and is subject to change due to data validation processes***

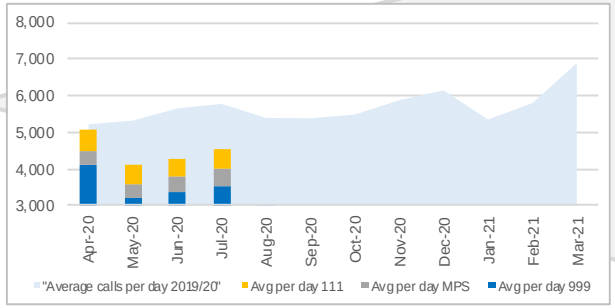
### 999 Calls Received

July 2020 saw a significantly lower number of calls compared to an equivalent period in 2019/20. As a result of the demand and increased staffing, call answering performance has been significantly better against our target on call answering 90th centile, which is less than 24 seconds

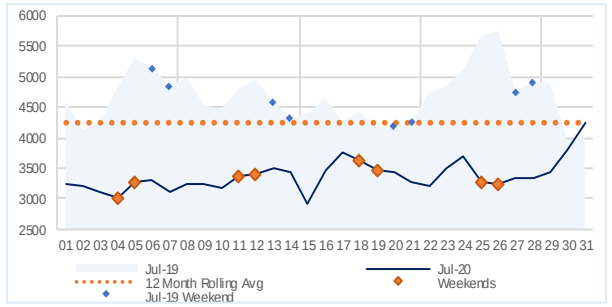
**Performance (90th Centile)**




**Average Calls Per Day**



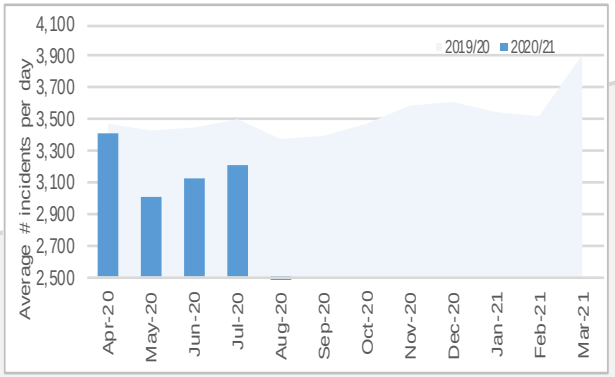

**Daily Calls Answered**



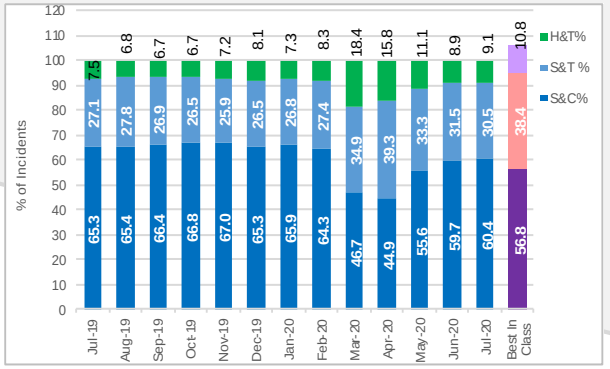

### Incidents and Response Type

July 2020 was an unprecedented month with the number of incidents per day significantly lower than in 2019/20. Performance improved for ED conveyance and Hear & Treat compared to 2019/20 due to concentrated effort on these measures and a modified response from the trust to Covid-19.

**Incidents**



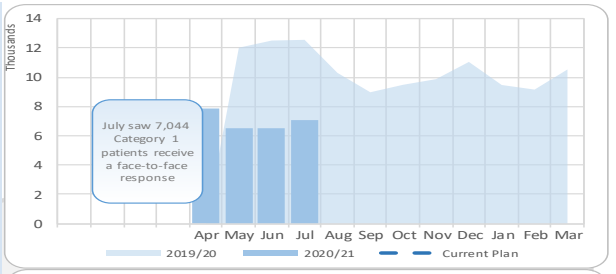

**Response Type**



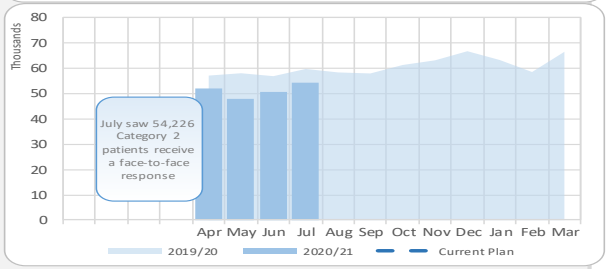

During July 2020, SWAS was best in class achieving 38.4% for See & Treat. SCAS attained 56.8% for See & Convey and NWAS achieved 10.8% for Hear & Treat categories. LAS came in at 8th, 7th and 2nd place, for S&T, S&C and H&T respectively.

### Incident Category (By Month)

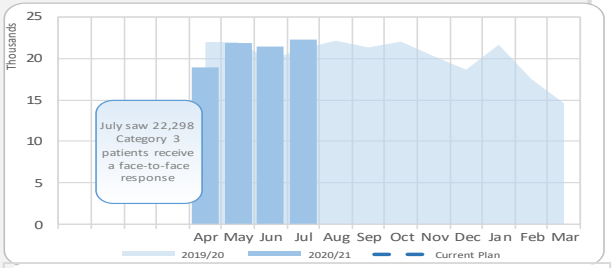
**C1**



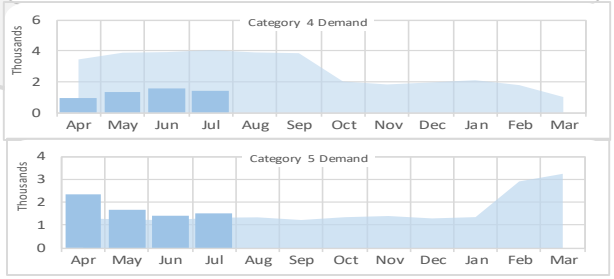

**C2**




**C3**

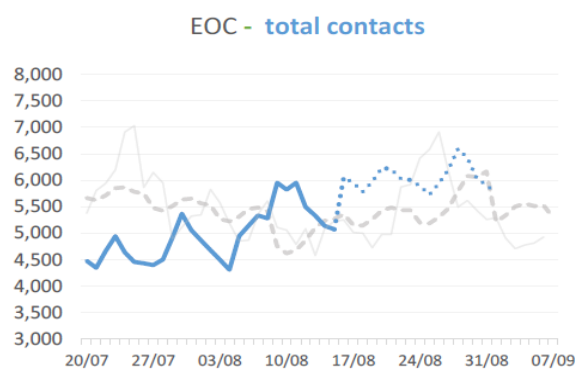


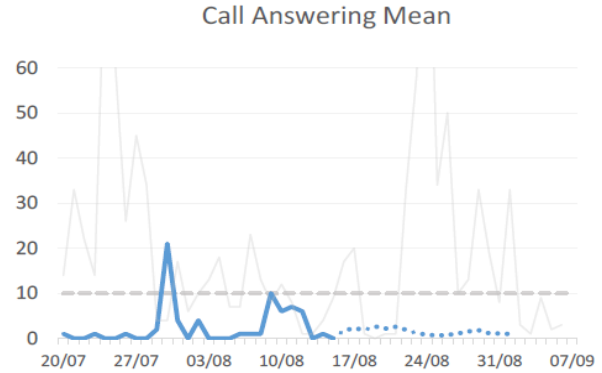

**C4/C5**

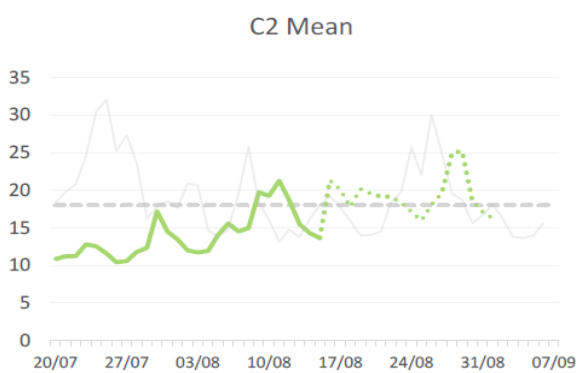


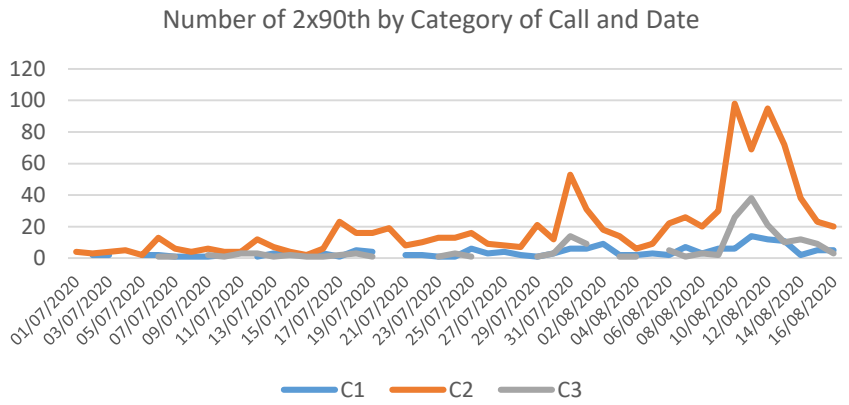
**The service is meeting operational delivery KPIs, with call answering and mean response times for Cat 1 and 2 returning to within national set timeframes. The National Ambulance Scorecard has rated the Trust as 100% against 13 weekly metrics including response times and long waits.**

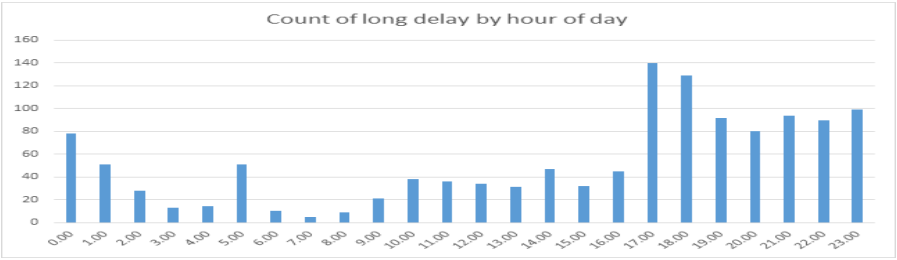
For reference only – Demand & Performance, showing 4 weeks past and 3 weeks future from today




In July there were 440 long delays and between the 1st and 16th August there were 827 long delays, which has a combined 6.4% resulted in a blue call.

| | C1 | C2 | C3 | Grand Total |
|---|---|---|---|---|
| July | 65 | 330 | 45 | 440 |
| August (1-16th) | 95 | 591 | 141 | 827 |
| Blue call | 18 | 58 | 5 | 81 |

The top three determinants where a long delay was incurred was:

- Dx012 – (15.5% n 197) – 4 required a blue call
- Calls from the MPS (9.5% n 120) – 2 required a blue call
- 17A2G – patients whom have fallen and are still on the ground (3.2%n 40) – 0 required a blue call

All delays are reviewed daily using the parameters developed during the COVID19 review. There were no cases of concerns identified as causing harm by the delay in July/August.

37.7% (n 478) patient whom experienced a long delay were not conveyed and 55.9% were conveyed. It was also found that 28.5% (361) of all long delays occurred between the hours of 17:00 and 19:00.

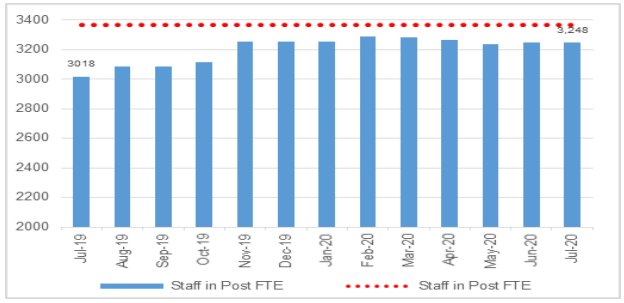
<u>Action being taken includes:</u>
Forecasting and planning with updates shared at DSLT weekly
Review of staffing for EOC and Operations
Overtime incentives to ensure cover at predicted busy periods.
Daily operational performance review
Winter planning and ambulance recruitment underway

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.

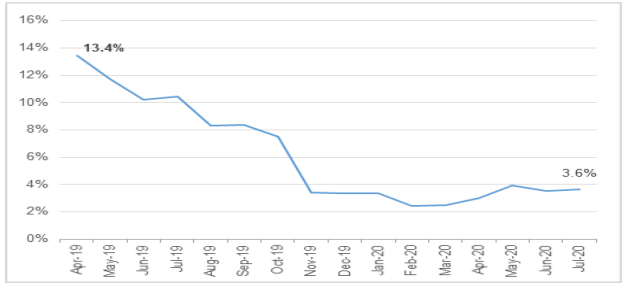
## Frontline Operational Staff

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 compared to the same period last year. (See Our People section of this report for further detail across the organisation)

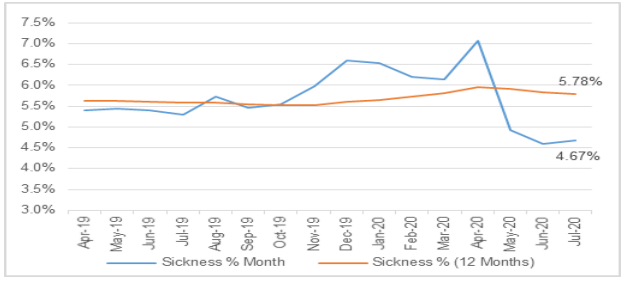
### Filled FTE




### Vacancy Rate



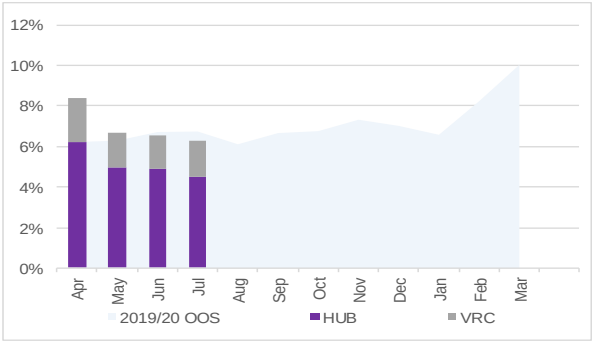

### Sickness Rate




## Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate averaged 7.34% for July 2020, a slight increase of 0.09% from the previous month.
COVID 19 vehicle decontamination continues to decrease and this task is now undertaken by Interserve providing a quick turn-around supporting DCA vehicle availability
The additional Day Vehicle Preparation staff introduced at all 14 VP Hubs is proving successful and we are currently monitoring their Vehicle Prep capture rate. The additional resource supports the night VP teams and assists with reducing the DCA shells and increasing the DCA vehicle availability.

### Out Of Service %

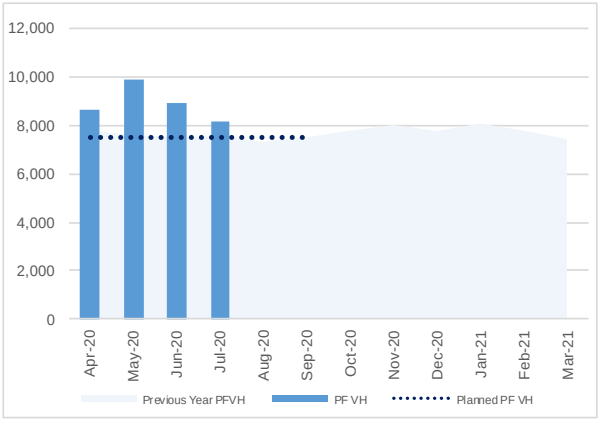



***Note:***

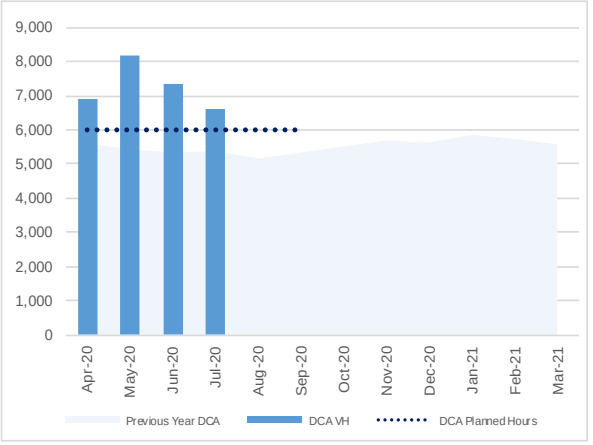
***OOS HUB*** *- This account for out of service codes related to people/crew reasons for out of service hours*

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

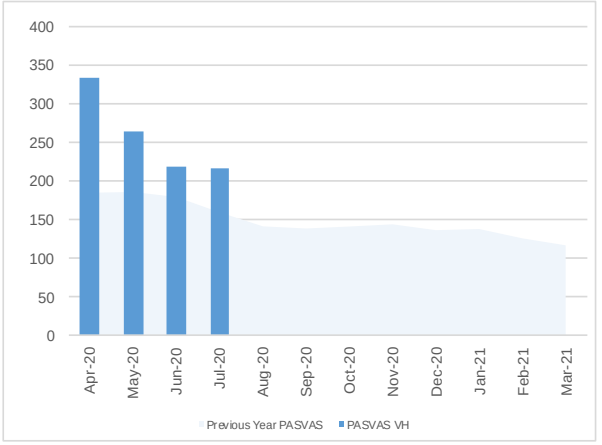
### All Vehicles (Avg per day)




### Ambulance Hours (Avg per day)




### PAS / VAS (Avg per day)



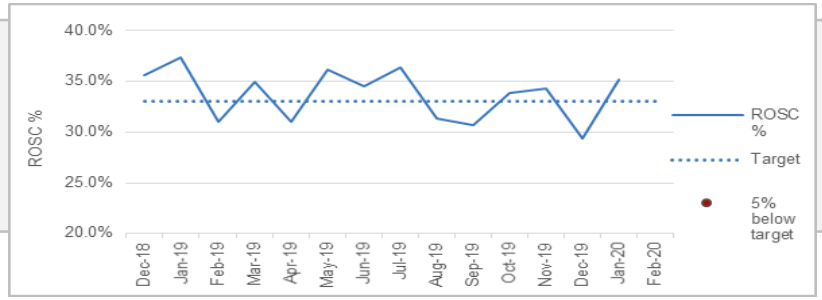
# Clinical Ambulance Quality Indicators (Latest Reported Month)

*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 January 2020, which is the most recent month published by NHS England. Due to Covid-19 there is a bigger time lag with the publication of AQI clinical outcome data. A plan is in place by NHSE to allow for reporting to catch up by January 2021.*

## ROSC at Hospital

**Month: 35.2%**

**Target: 33%**




In January 2020 the number of patients with ROSC sustained to hospital increased from 29% to 35% (overall) and from 57% to 59% (Utstein comparator) compared with December 2019. Survival to discharge increased to 8% from 7% (overall) and from 27% to 28% (Utstein). Our post-resuscitation care bundle compliance was 93% in January, down from 96% in October 2019 (reported quarterly) however the LAS continues to have the highest cardiac arrest care bundle compliance in the country. The number of defibrillator downloads completed rose to 27% (from 23% in December 2019).

## Sepsis Care Bundle

**Month: 90.3%**

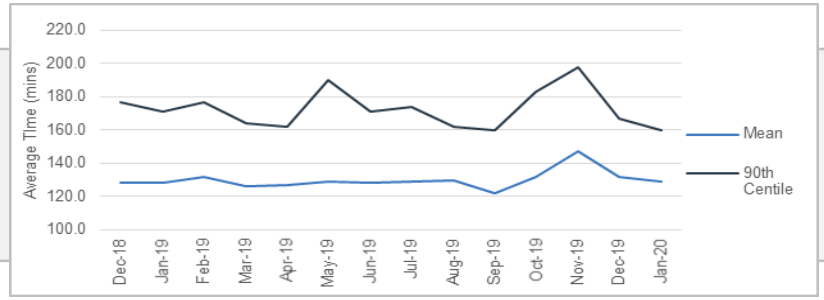
**Target: 95%**

NHS England did not publish Sepsis Care Bundle data for January, the next data due to be published will be for June 2020 (in November). The latest data available is for December 2019, which saw the data at 94.4%, ranking 1st amongst all the ambulance services.

## STEMI call to angiography

**Mean: 02:09**

**Target: TBC**

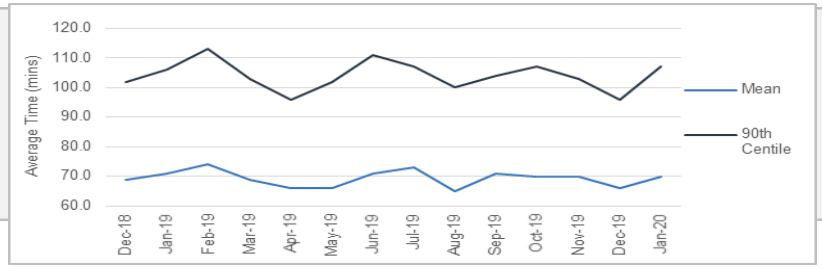



The LAS average call to angiography time for January was 02:09, this is shorter than for the past few months and places the LAS in 4th place overall. STEMI Care Bundle data was published for January – the LAS achieved compliance of 78% (equivalent to the national average), ranking in 6th place overall.

## Stroke call to door

**Mean: 01:10**

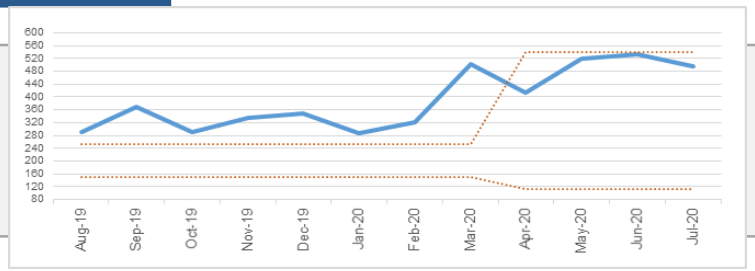
**Target: TBC**




The LAS ranked best in class again for the mean call to hospital for suspected stroke patients (01:10) in January 2020, for the 9th time this financial year. NHS England did not publish Stroke Diagnostic Bundle data for January, the next data due to be published will be for February 2020 (in October 2020).

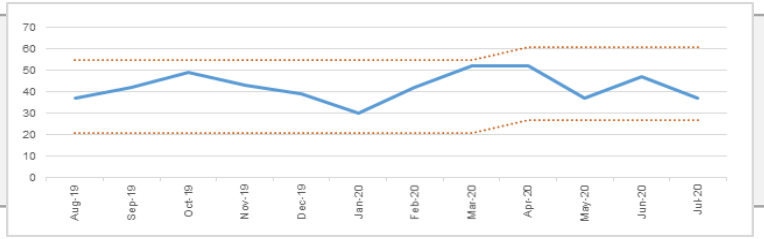
## No Harm/Near Miss

Latest Month: **459**



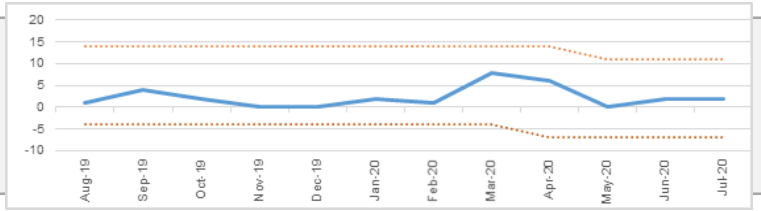

## Low Harm

Latest Month: **38**



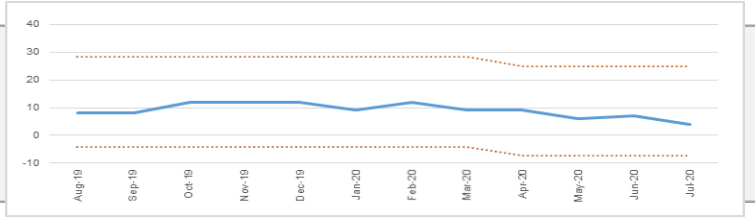

## Moderate Harm

Latest Month: **2**



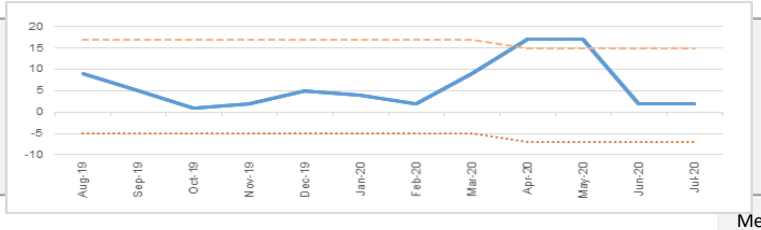

## Severe

Latest Month: **2**



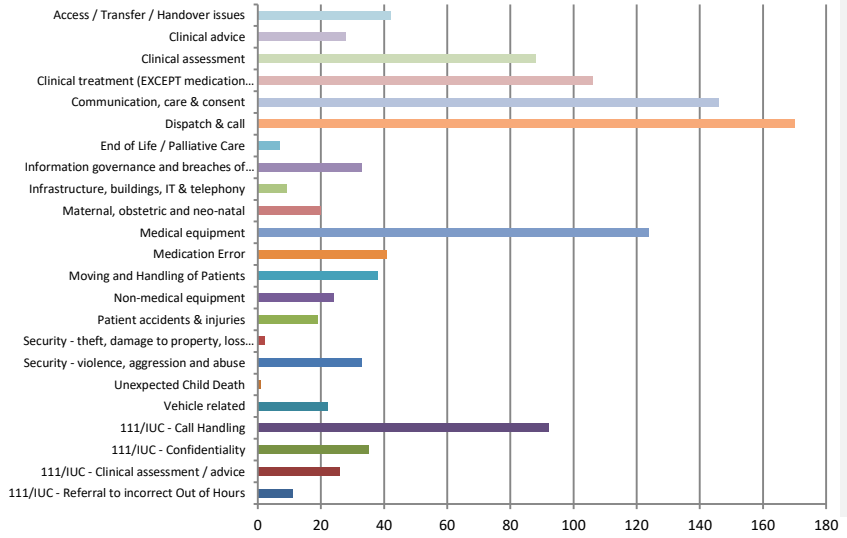

## Death

Latest Month: **2**




The number of reported incidents continues to be positive in reporting numbers particularly in regards to low/no harm incidents. This is a sign of a good reporting culture. The safety and risk hub helped ensure reporting over the peak of COVID-19. There has also been continual focus on staff training over the last year on incident reporting and staff training will account for some of the decrease in level of severity as the training provides staff with an understanding of the NPSA harm categories for incidents.

## Incident categories Jun—July 2020)

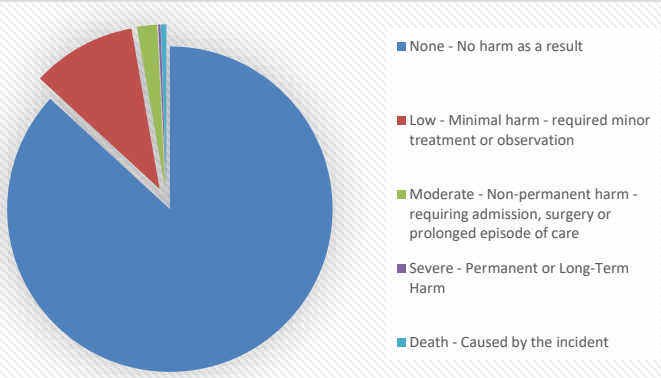


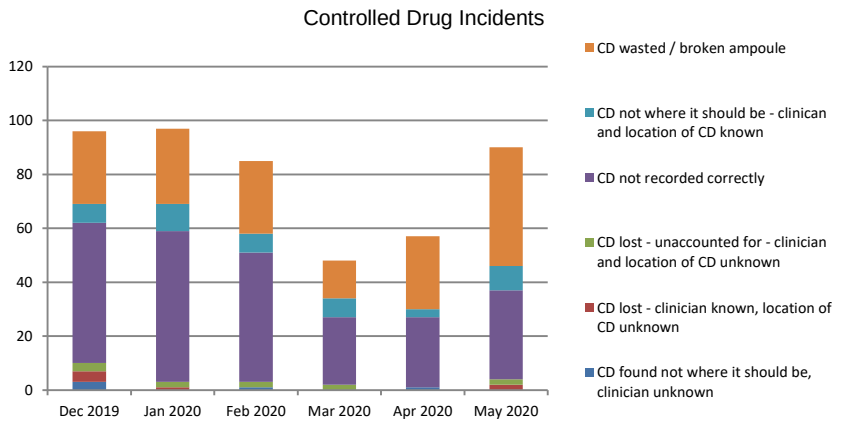

Medical Equipment, dispatch and call management and communication issues are the top three reported incidents. Actions are being taken to address these themes including:

- Review of VP hub process to strengthen to reduce to loss of medical equipment.
- Call taking staff fully made aware of updated guidelines within OP60 regarding the management of 3rd and 4th party calls.
- 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.

## Incident Management

There are 1,301 (as of 13/08/2020) which have been opened on the system longer than 35 working days (this excludes SIs and the COVID19 review incidents).
This breaks down to 679 patient incidents, 374 staff incidents, 47 visitor incidents and 316 Trust related incidents.
There is a focused piece of work being undertaken by QGAMs, Operational colleagues & the QI&L team. In particular the QI&L team have applied a methodology to incidents older than July 2019 which has seen 400 incidents finally approved. The team are now turning their attention to incidents older than 6 months old next.






- No unaccounted for loss of injectable morphine

- Total of 87 other controlled drug (CD) incidents including
- Documentation errors (n=48)
- Morphine retained off duty (n=5)
- Breakage/wastage (n=31)
- Safe/cabinet unsecured or malfunction (n=2)
- Loss of CD register (n=1)

- Non-controlled drugs (schedule 2) incidents
- Kitprep discrepancy (n=11)
- Breakages or damage (n=4)
- Documentation error (n=3)
- Missing or unsecured stock (n=7)
- Possible drug-seeking behaviour (n=1)
- Missing NAAKs (n=1)
- Errors in administration of adrenaline (n=3), calcium (n=1), dexamethasone (n=1), diazepam (n=3), glucose (n=1), insulin (non LAS) (n=1), ipratropium (n=1), lorazepam (n=1), oxygen (n=1), paracetamol (n=4), TXA (n=1).

**Actions**:
APP-UC student prescribers progressing well through course assessments.

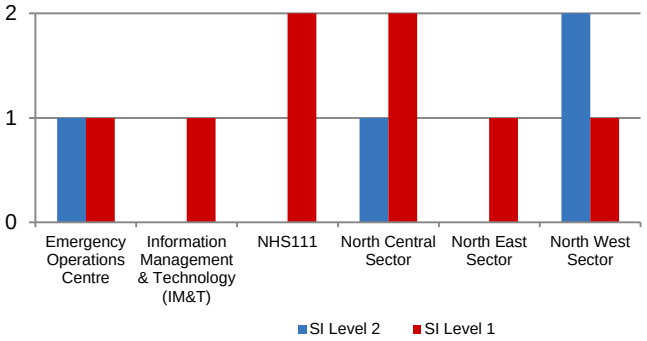
First two cases of thrombolysis delivery by APP-CC group

Antimicrobial guide developed to support antibiotic administration via PGD

Drugs administration errors followed up by local management teams with staff and resolved. New tamper evident seals being procured for oramorph.

New cytotoxic labelling for syntometrine in development

## SI Analysis




During June and July 2020, total of 12 (including NHS 111) reported incidents were declared as SIs after review at the Serious Incident Group (SIG). Fig. 1 shows the monthly distribution of declared SIs across the Trust.

The Trust's Q1 SI thematic report has been produced and should be read in conjunction with this report. Q1 saw an increased number of call handling errors and an increased number of SIs declared where patients have been not conveyed to hospital.
This is largely expected considering the demand that was placed upon the call handlers, the increase in call volume, and the desire to reduce the pressure in hospitals during the height of the COVID-19 pandemic.

## SI Actions

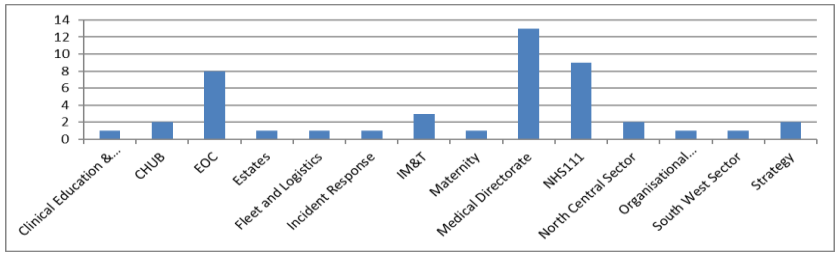
There continues to be a focus on SI actions, at the end of July there were 190 open actions, of these 45 were overdue. There are certain processes in place to monitor and encourage prompt completion of actions including:

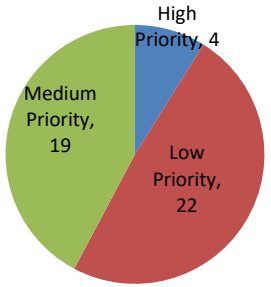
- Action owners are made aware of the overdue action by the Datix system which send a reminder every 2 days.
- The team makes contact with the owners by various correspondence to get updates on the action, provide support where possible and ensure that actions are being addressed.
- Overdue actions are also monitored at the Safety Investigation Assurance and learning group where escalations to departments are communication, if required.

There are 4 incidents which are oldest and highest in priority:
There are two actions that relate to a CADlink failure between IUC and EOC which required an IM&T fix. The second actions relates to training of NEL IUC staff on this failure.
**Update:** There is no current IM&T fix for this national issue, a risk has been drafted on to the Corporate risk register and a work around is in place. The NEL staff are receiving training and the Quality Governance and Assurance Manager for IUC keeps SIALG up to date with how this action is progressing.

There are two further IUC actions regarding a review of compliance with completion of induction for agency and contractors in IUC and a monthly audits of 5% of all agency clinicians supplied by the managed service, in order to ensure all competencies are achieved.
**Update**: Theses are progressing as part of the IUC improvement plan and are being tested to provide assurance before closing.

Overdue actions by Department



## People Scorecard

**July 2020**

| Indicator (KPI Name) | Frequency | Basis | Data From Month | Target Status | Current Perfomance: Target and Type (Internal / Contractual / National / All) | | Current Perfomance: Latest Month | Current Perfomance: Year To Date (From April) | Current Perfomance: Rolling 12 Months | Trajectory: FY20/21 Trajectory | Benchmarking: National Data | Benchmarking: Best In Class | Benchmarking: Ranking (out of 11) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Engagement Theme Score | Yearly | (n) | Jul-20 | | 6.5 | Internal | 6.1 | | 6.2 | Data Not Available | 6.3 | 6.6 | |
| Staff Survey Response Rate | Yearly | % | Jul-20 | | ≥65% | Internal | 72% | | | | | 72% | 1 |
| In-Ops Vacancy Rate (% of establishment) | Monthly | % | Jul-20 | | 5% | Internal | 4.6% | 5.3% | 5.3% | | | | |
| Staff Turnover (% of leavers) | Monthly | % | Jul-20 | | 10% | Internal | 9.1% | 9.8% | 10.4% | | | | |
| Equality, Diversity & Inclusion Theme Score | Yearly | (n) | Jul-20 | | 8.3 | Internal | 8.1 | | 8.0 | | 8.5 | 9.5 | |
| BME Staff Engagement Theme Score | Yearly | (n) | Jul-20 | | 6.4 | Internal | 6.2 | | 6.1 | | | | |
| % of BME Staff | Quarterly | % | Jul-20 | | 17.5% | Internal | 16.7% | 16.6% | 15.8% | | | | |
| Staff Sickness levels (12 month rolling) (%) | Monthly | % | Jul-20 | | 5% | Internal | 5.5% | 5.6% | 5.4% | | | | |
| Bullying & Harassment (Safe Environment Theme) | Yearly | (n) | Jul-20 | | 7.3 | Internal | 7.0 | | 6.1 | | 7.4 | 7.5 | |
| Flu Vaccination Rate (Trust Total) | Monthly | % | Jul-20 | | 75% | Internal | 55.0% | 55.0% | 55.0% | | | | |
| Statutory & Mandatory Training (85% or above) | Monthly | % | Jul-20 | | 85% | Internal | 84.0% | 85.0% | 84.0% | | | | |
| Staff PDR Compliance (85% or above) | Monthly | % | Jul-20 | | 85% | Internal | 67.0% | 65.0% | 74.0% | | | | |
| Improve leadership and management across the Trust (Visible and Engaging Leader Programmes - target of 36% of Trust Managers in 2019/20) - *currently on hold* | Monthly | (n/%) | Jul-20 | | 36% | Internal | 14.0% | 14.0% | 14.0% | | | | |
| Level 3 Safeguarding Training Completed (90% target over 3yr period) | Monthly | % | Jul-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

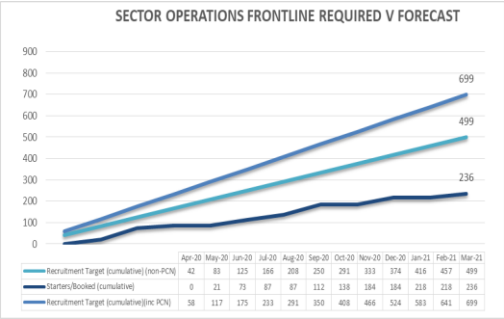
# Vacancy Rates, Staff Turnover and Sickness

## Recruitment

**Month:**

**19 FTE**

**Target: 20 FTE**




**Required Frontline: 699FTE**

**Supply: 256FTE**

**Gap: 220FTE**

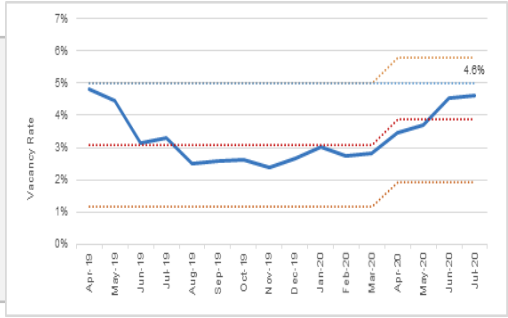
**Gap: 420FTE (PCN)**

Planning for our 2020/2021 frontline requirements is continuing as planned for UK Grads and Qualified Paramedics. 85% of the partner students have now applied and we expect 98 to start in August. There are a further 66 UK Paramedics who have passed interview and the background checks are in progress. They cannot currently be issued a start date as there are no estate available for training. Our international recruitment is continuing with 38 starting/booked year to date but this has been reduced due to the current restrictions in place for Covid-19. The impact of our reduced international and domestic recruitment is an end of year forecasted supply gap of 220fte (3,370fte)/420fte (inc PCN). To help close this gap, we have launched on 27th July our campaign for the Band 4 Assistant Ambulance Practitioner targeted at C1 Licence holders, current NETS staff for 'fast-tracking' and more widely through our normal recruitment channels .

## Vacancy Rate

**Month: 4.6%**

**Target: 5%**




**All Frontline (in-ops): 4.6%**

**Paramedics (in-ops): 2.9%**

**EOC: 0%**

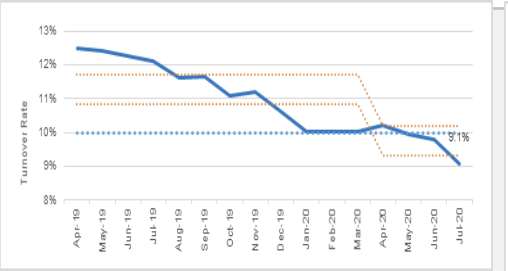
**111: 0%**

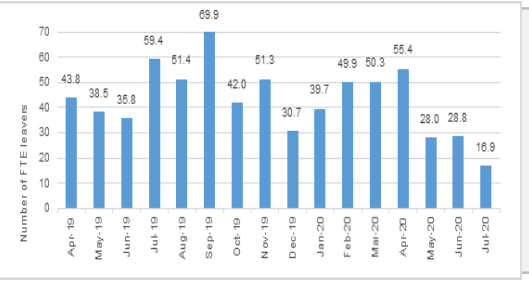
Our overall vacancy rate remains below target at 4.6%. EOC Recruitment – all posts are now filled and this includes 13 staff in training. For the fourth successive month we have seen a reduction in the expected number of leavers in EOC. NETS recruitment has progressed well and we are currently over-established. We had 24 starters across our 111 Services in July and this has reduced our vacancy rate from 13% to being fully established. We have also seen a significant reduction in the number of 111 leavers during the same period.

## Staff Turnover

**12 Month Rolling: 9.1%**

**Target: 10%**



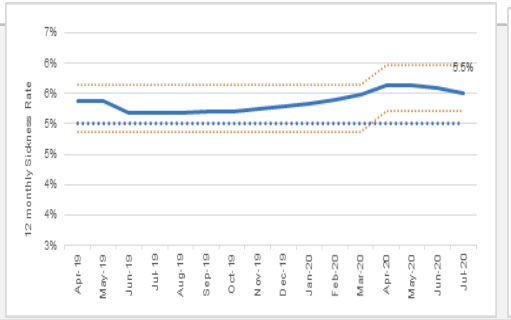

Staff turnover rates have remained on target at 10%. We have seen a further reduction from 9.8% to 9.1%. We continue to see a lower number of EOC and 111 leavers than forecasted. The telephone exit interview pilot with NHS Shared Business Services was launched in July. The one to one retention interviews with the 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

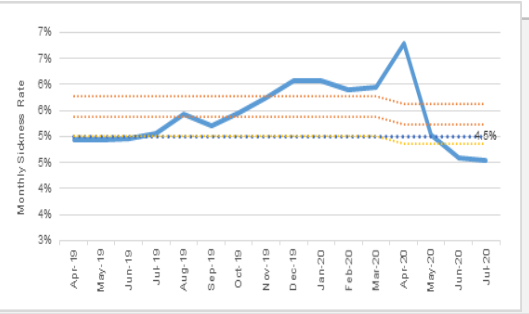
## Sickness

**12 Month Rolling: 5.5%**

**Monthly: 4.6%**

**Target: 5%**




The monthly Trust wide sickness has remained at 4.6% and our non-Covid sickness is tracking below the same period 12 months ago. We have seen improvements in a number of teams as follows - Corporate (3.6% to 3%), Emergency Care Services (4.7% to 4.5%), Estates and Facilities (2.5%). EOC has increased from 5.4% to 7.8%. Our 111 Services have maintained their sickness levels (South East 5% and 5.6%). The 111 P&C Manager has launched a sickness action plan which has been shared with the management teams. The plan incorporates health and well-being, sickness management and sickness prevention.

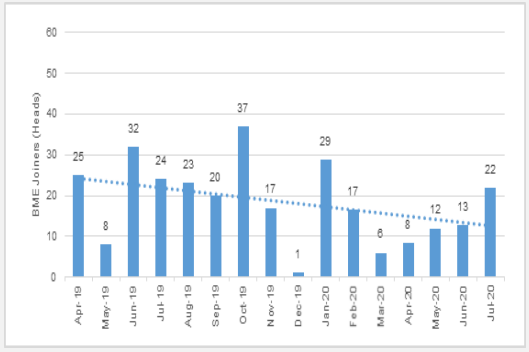
# Additional Workforce Analysis

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

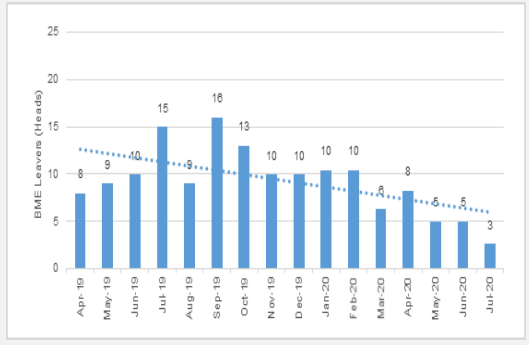
## Equality, Diversity and Inclusion Standards

The LAS WRES action plan reports starters and leavers monthly and disciplinary and recruitment data quarterly. These graphs show the numbers of BME starters and leavers from April 2019 to July 2020. During this period we have had 293fte BME starters and 148fte BME leavers, a net increase of 145fte. 26% of our total starters during this period were BME. Overall numbers of BME staff continue to increase (currently 1,030) although this representation varies at different levels in the organisation.

**BME Starters**




**BME Leavers**




We have so far completed 96% of BAME risk assessments. We are now undertaking risk assessment for staff in other vulnerable groups and for all other staff.

We have developed a 'Black Lives Matter Delivery Plan' which has three key areas covering education, response and enabling. We have delivered a number of workshop sessions with the key leaders across the organisation in July and have further planned for August and September.

We have prioritised fit testing for BME staff and have named fit testers for BME staff to contact in each sector.

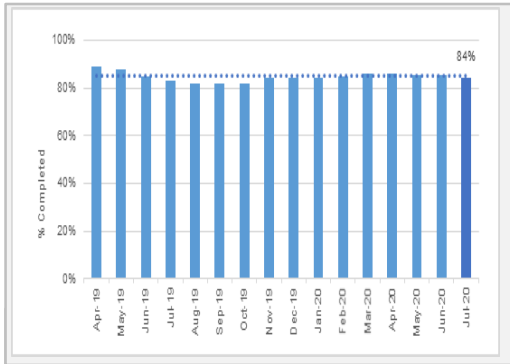
Further to last month, we have now had confirmation that the WRES and WDES national submissions have been reinstated this year and we are in the process of completing the on-line returns. There was no requirement to publish our Gender Pay details this year.

## Statutory and Mandatory Training and Appraisals

Trust compliance in Statutory and Mandatory training is **84%.**

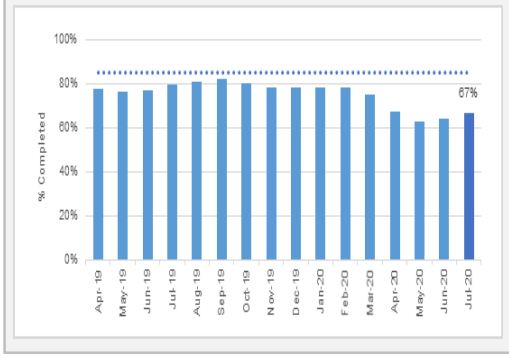
Appraisal completions at 67% at the end of July.

**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 89%. Information Governance is at 91% for July. A plan has been developed to achieve 95% by September 2020.

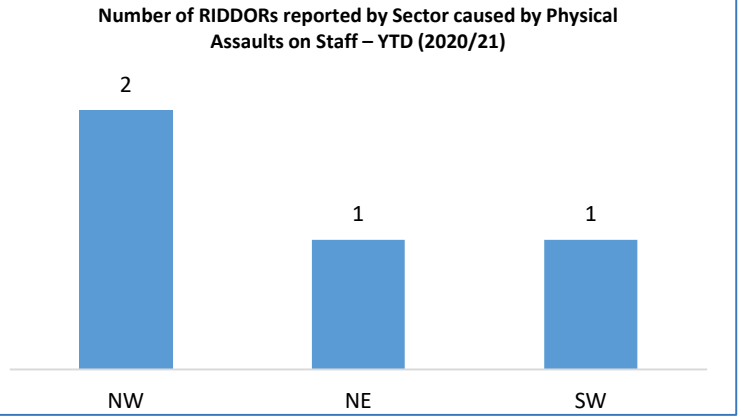
**Appraisal Compliance**

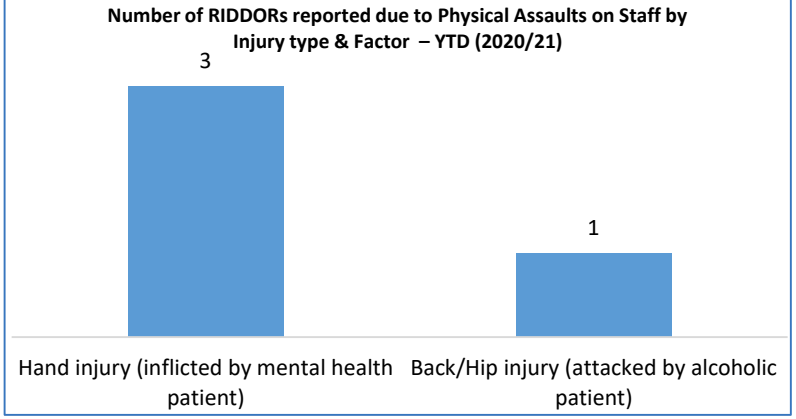



PDR Appraisals were at 67% at the end of July 2020.

Due to the change in REAP Levels during March and April 2020 - PDRs were suspended.

## RIDDOR Reportable Physical Assaults on Staff Report




| Sector | Number of Riddors | HSE Queries |
|---|---|---|
| NW | 2 | 0 |
| NE | 1 | 0 |
| SW | 1 | 0 |

NHS definitions of assault:
Physical assault – *"the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort"* (NHS Protect / NHS Employers).

Non-physical assault – *"the use of inappropriate words or behaviour causing distress and/or constituting harassment*" (NHS Protect / NHS Employers).

*NB: Clinical assault occurs when the assailant is not aware of their actions / lacks capacity. This may result from such things including the effects of prescribed medication, mental health issues, and post-ictal state.

## Physical Assaults on Staff Report by Month

| Month | No of Physical Assault on Staff by Patient | Rate of Physical Assault on Staff by Patient |
|---|---|---|
| Aug-19 | 63 | 0.65 |
| Sep-19 | 47 | 0.49 |
| Oct-19 | 67 | 0.67 |
| Nov-19 | 49 | 0.49 |
| Dec-19 | 44 | 0.43 |
| Jan-20 | 65 | 0.64 |
| Feb-20 | 37 | 0.40 |
| Mar-20 | 22 | 0.22 |
| Apr-20 | 27 | 0.31 |
| May-20 | 43 | 0.52 |
| June-20 | 47 | 0.55 |
| July-20 | 60 | 0.66 |

Notes:

- The dash board (left) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (August'2019 to July'2020).

The LAS is participating in the centrally funded National evaluated trial of BWVC as part of phase one of a 12 month trial. This trial was suspended during COVID-19 pressures and has now resumed.

- Body Worn Video Cameras (BWVC): small cameras worn on the body by frontline staff, to record visual (and often audio) interaction between public and wearer. Saved footage is encrypted securely on the device can be downloaded and stored securely and may then be used as evidence in criminal prosecutions. BWVC are primarily seen as a form of 'personal protective equipment'. These devices are believed to help reduce the impact of violence against staff. The trial is intended to evaluate their effectiveness in doing so.
- Central funding of £190K has now been received for the trial to take place. The funding from NHSE/I should cover the costs of procuring cameras, docking stations, cloud storage and electronic issuing system. Part of the funding may be used to contribute to the cost of dedicated project support, including IT support.
- All Trusts in the first phase are required to use a commercial framework agreement to procure BWVC units. The framework being used is from the East Midlands Strategic Commercial Unit, which incorporates nine suppliers who all meet prescribed standardisation.
- A specification for the tender is currently being finalised.
- A successful trial of body worn cameras at the LAS will be evidenced by a reduction in the levels of violence and aggression and harm experienced by staff, together with an increased level of successful prosecution, enabling risk 678 to be reduced from 9; significant, to its target rating of 6; moderate.
- Funding has been agreed to roll-out the BWC across the trust and currently work is underway with the projects and programme team to develop a delivery plan based on initial trial results

North East Ambulance Service (NEAS) undertook a small scale trial funded by a provider October 2018 – January 2019. They are now part of the first phase of the centrally funded 12 month National Trial with North West Ambulance Service (NWAS) and LAS. NEAS have provided feedback on their trial which is being used to inform the LAS trial.

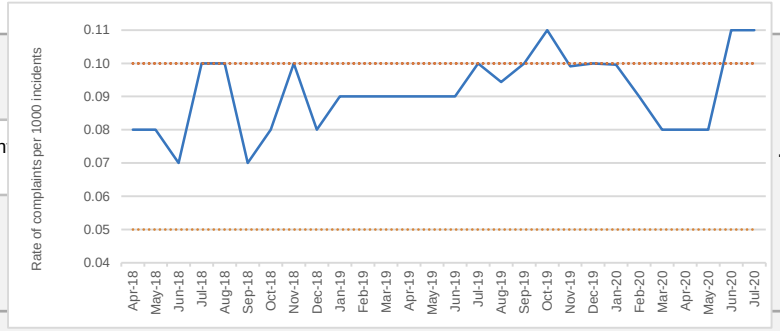
The LAS is working with NHSE/I, NEAS and NWAS, as part of the first phase of the National trial. Work towards the trial was suspended during COVID-19 but is now restarting and the tender documents are currently being finalized.

A body worn video trial group will now meet regularly to manage the LAS trial. Terms of reference have been drawn up for agreement. There will be a wide representation of stakeholders on the group. NHSE/I will be invited to sit on this group. The group will report into the Violence Reduction and Staff Safety Programme Board.

Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

## Rate of Complaints

Latest Mon
**0.11**

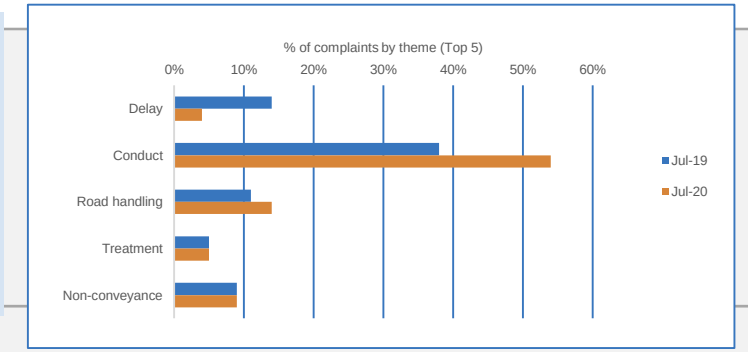



July has seen complaints rise since the dip in numbers during the Covid-19 months.

We managed 770 PALS enquiries during July and will maintain the use of the spreadsheet introduced during Covid-19 months as this has proven successful for recording more straightforward enquiries.

We managed 45 Quality Alerts in this period. We have seen a rise in internal referrals in this category.

## Categorisation

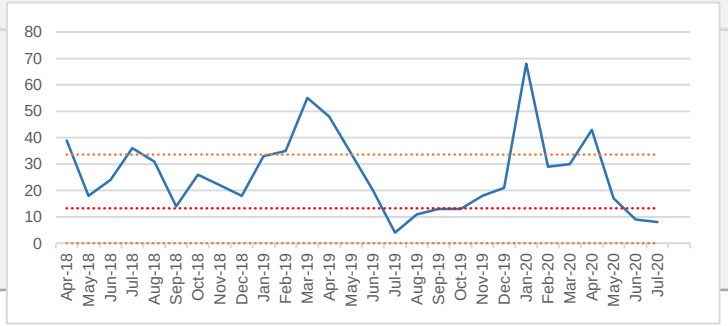



Conduct and behaviour complaints currently account for 54% of total complaints received in July. Where the key head of complaint is delayed response, the percentage has dropped to an all time low of 4%

There were 14 complaints attributed to NHS111 in in July, 8 related to NELIUC and 6 from SELIUC. A number of these were reported directly to the Patient Experiences Department by the complainant but in the main are generated by the 111 provider

## Responding to complaints

Latest
Month 8




There were 8 complaints that breached the 35 day response target but expect this to increase with reduced staffing over the summer and increased complaint numbers.

Operational pressures has resulted in delays in obtaining information from internal stakeholders and we are working with the QGAM's to monitor this

## Case examples

***Case Example***

The patient complained that the ambulance staff did not use PPE and gloves when they attended her.

The complainant was advised that our guidelines at the time indicated that where it was identified that the patient did not have symptoms suggestive of Coronavirus, ambulance staff
Should don double gloves, an apron, a surgical mask and eye protection on each patient encounter as a minimum so as to keep staff and patients safe during the coronavirus outbreak.

We alerted the local management team of this incident so that the staff are reminded that appropriate PPE should be worn at all times when carrying out their duties.

The complainant called our duty phone after receiving her response to thank our team and the Service for everything they had been doing during the pandemic and that paramount to her complaint was the safety of the staff involved.

## Actions and Learning

We are assisting the Trust as an Early Adopter with the implementation of the Patient Safety Incident Response Framework
We are also participating in the pilot for the strengthening of the business partner role within sectors
A number of changes are planned for the website to improve signposting and readily available information. We aim to start on this project in September 2020.
We have trailed a new system on the Duty desk with more than one officer being available to improve throughput in that area. We will evaluate the trial and make any identified improvements.
Since the cessation of the 'pause' arrangements during Covid-19, the Ombudsman has completed a number of investigations and requested other files on a considerate basis.
NHS Digital will recommence the collection of KO41 benchmarking data. The retrospective data for Q4 2019/20 is aimed to be collected as soon as possible but we are awaiting their instructions for that
We are aiming to develop a case weighting mechanism in Datix to monitor performance and the complexity of some complaints
The Driving Standards Team are assisting with complaints related to driving and sirens. Early indication is that is a successful venture.

## Public Value Scorecard

**July 2020**

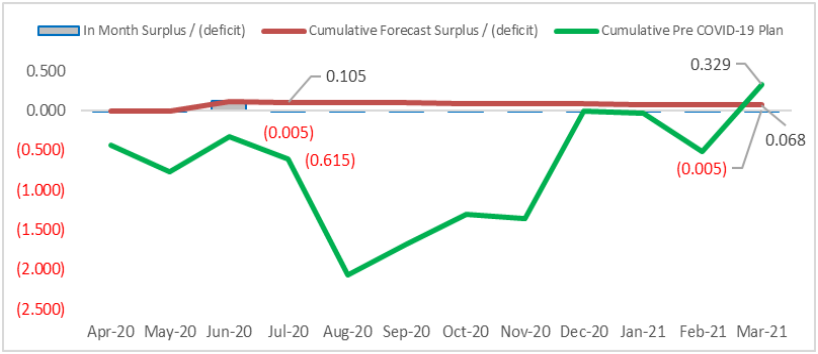
| Indicator (KPI Name) | Basis | Data From Month | Target Status | Current Perfomance: Target and Type (Internal / Contractual / National / All) | | Latest Month Actual | Latest Month Plan | YTD Actual | YTD Plan | Rolling 12 Months | Outturn: FY20/21 Forecast | FY20/21 Plan | Benchmarking: National Data | Best In Class | Ranking (out of 11) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total (Deficit)/Surplus | £m | Jul-20 | | 0.000 | A | 0.000 | (0.001) | 0.000 | (0.004) | | N/A | N/A | | | |
| Performance Against Control Total | £m | Jul-20 | | 100% | A | | | | | | 100% | 100% | | | |
| Use of resources index/indicator (Yearly) | Rating | Jul-20 | | 1 | A | | | N/A | N/A | | N/A | N/A | | | |
| % of Capital Programme delivered | % | Jul-20 | | 100% | A | -4% | 3% | 13% | 20% | | 100% | 100% | | | |
| Capital plan | £m | Jul-20 | | 44.211 | A | -1.959 | 1.145 | 5.562 | 8.648 | | 44.211 | 44.211 | | | |
| Cash position | £m | Jul-20 | | 15.1 | A | 58.3 | N/A | | | 40.9 | N/A | N/A | | | |
| % spend against Agency Ceiling | % | Jul-20 | | N/A | A | 10% | 8% | 26% | 33% | | 42% | 100% | | | |
| CIP Savings YTD | £m | Jul-20 | | N/A | A | N/A | N/A | N/A | N/A | | N/A | N/A | | | |
| | % | Jul-20 | | N/A | A | N/A | | N/A | | | N/A | N/A | | | |
| CIP Savings achieved - % Recurrent | £m | Jul-20 | | N/A | A | N/A | N/A | N/A | N/A | | N/A | N/A | | | |
| | % | Jul-20 | | N/A | A | N/A | | N/A | | | N/A | | | | |
| Commercial income generation | £m | Jul-20 | | N/A | I | N/A | N/A | N/A | N/A | | N/A | N/A | | | |
| Corporate spend as a % of turnover | % | Jul-20 | | <7.0% | I | 8.0% | N/A | 8.8% | N/A | | 9.5% | N/A | | | |
| Cost per incident (measures to be confirmed in light of COVID) | £ | Jul-20 | | N/A | I | | | | | | N/A | N/A | | | |
| Average Jobs per shift | % | Jul-20 | | 5.3 | I | 4.2 | | 3.8 | | 4.6 | | | | | |

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

# Trust Financial Position and Contract Position

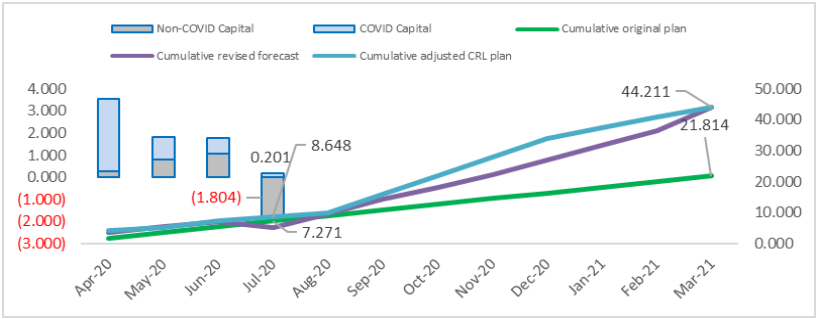
The Trust's month 4 position was on plan – breakeven on an adjusted financial performance basis (unadjusted surplus of £105k YTD). The month ended with a strong cash position of 58m.

## YTD outturn vs budget



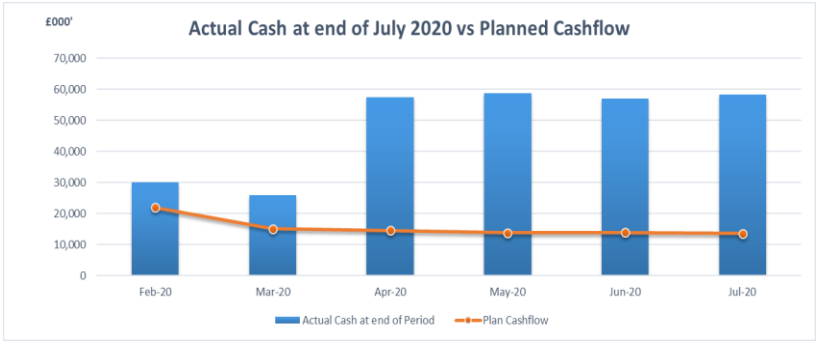

- **YTD Position:** The month 4 position was breakeven position on an adjusted financial performance basis (£105k surplus before measurement adjustments) as required under the current financial framework. The YTD position incorporated £33.7m of costs in relation to the Trust's response to COVID-19, and a retrospective income top up to balance the Trust's financial position of £35.8m.
- **Full year forecast:** The full year forecast position at month 4 is a £68k surplus (breakeven on an adjusted financial performance basis) in line with NHSI requirements. This forecast position assumes a continuation of the current financial arrangements (or a close substitute) and incorporates £78.7m 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 £81.1m.

## Financial Position Metrics




- **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). No use of resources scores are currently available under the interim financial framework arrangements.
- **Capital**: YTD capital expenditure was £5.6m YTD compared to planned capital expenditure of £8.6m (£3m behind plan). Full year forecast capital expenditure is £44.2m in line with the Trust's latest capital plan. The majority of the Trust's YTD capital spend relates to its response to the COVID-19 pandemic with £5.2m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment. The Trust's YTD capital spend position has been impacted in month by the reversal of £2.3m of capital work in progress costs in connection with the Trust Board approved CAD replacement project.

## Cash position




- **Cash:** Cash was £58.3m as at 31 July 2020, £44.8m above pre-COVID plan. The main reason for the favourable position was the payment in advance of one month's block contract income. Cash balances are expected to reduce from September onwards as this arrangement ceases in the present form at that point.
- **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 July 2020 was 94.3% and 94.9% 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 4 – July 2020)

| | Month 4 2020-21 £000 | | | YTD Month 4 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 | 37,188 | 34,608 | (2,579) | 148,337 | 135,180 | (13,156) | 445,785 | 411,276 | (34,509) |
| Other Operating Income | 172 | 11,837 | 11,664 | 1,804 | 48,117 | 46,313 | 5,933 | 115,978 | 110,045 |
| **Total Income** | **37,360** | **46,445** | **9,085** | **150,141** | **183,298** | **33,157** | **451,717** | **527,254** | **75,537** |
| **Operating Expense** | | | | | | | | | |
| Pay | (26,809) | (30,179) | (3,370) | (106,906) | (120,474) | (13,568) | (320,747) | (355,992) | (35,245) |
| Non Pay | (9,159) | (14,006) | (4,847) | (37,050) | (56,417) | (19,367) | (109,546) | (149,599) | (40,053) |
| **Total Operating Expenditure** | **(35,968)** | **(44,185)** | **(8,217)** | **(143,956)** | **(176,891)** | **(32,935)** | **(430,293)** | **(505,592)** | **(75,298)** |
| **EBITDA** | **1,392** | **2,260** | **868** | **6,185** | **6,407** | **222** | **21,424** | **21,662** | **238** |
| **EBITDA margin** | 3.7% | 4.9% | 1.1% | 4.1% | 3.5% | (0.6%) | 4.7% | 4.1% | (0.6%) |
| **Depreciation & Financing** | | | | | | | | | |
| Depreciation & Amortisation | (1,288) | (1,291) | (3) | (5,220) | (4,145) | 1,075 | (16,356) | (15,863) | 493 |
| PDC Dividend | (388) | (616) | (228) | (1,552) | (1,780) | (228) | (4,656) | (5,340) | (684) |
| Finance Income | 8 | 0 | (8) | 32 | (4) | (36) | 100 | (4) | (103) |
| Finance Costs | (15) | (2) | 13 | (60) | (17) | 43 | (182) | (34) | 148 |
| Gains & Losses on Disposals | 0 | (355) | (355) | 0 | (355) | (355) | 0 | (354) | (354) |
| **Total Depreciation & Finance Costs** | **(1,683)** | **(2,265)** | **(582)** | **(6,800)** | **(6,301)** | **499** | **(21,095)** | **(21,595)** | **(500)** |
| **Net Surplus/(Deficit)** | **(291)** | **(5)** | **286** | **(615)** | **105** | **721** | **329** | **68** | **(262)** |
| **NHSI Adjustments to Fin Perf** | | | | | | | | | |
| Remove Donations I&E Impact | 3 | 5 | 2 | 13 | (105) | (118) | 38 | (68) | (106) |
| **Adjusted Financial Performance** | **(288)** | **(0)** | **288** | **(603)** | **(0)** | **603** | **368** | **(0)** | **(368)** |
| **Net margin** | (0.8%) | (0.0%) | 0.8% | (0.4%) | 0.1% | 0.5% | 0.1% | 0.0% | (0.3%) |

### Year to Date Position

The YTD position is a £105k 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.

### Key Drivers of Position

**Income:**

- 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 £13.2m YTD and £34.8m FY forecast.
- Other operating income is favourable to pre-COVID plan by £46.3m YTD (£110m full year forecast) due to the inclusion of monthly top up and retrospective top up income under the current interim financial arrangements (£46.4m YTD and £113m full year forecast) which covers the Trust's COVID response related expenditure and ensures a breakeven position.

**Pay Expenditure:**

- Pay expenditure is currently £13.6m adverse to pre-COVID plan YTD, and forecast to end the year £35.2m adverse to pre-COVID plan primarily due to COVID-19 response costs (£10.7m YTD and £35.7m FY forecast).

**Non-Pay Expenditure:**

- Non pay expenditure is £19.4m adverse to pre-COVID plan YTD, and forecast to end the year £40.1m adverse to pre-COVID plan primarily due to COVID-19 response costs (£23m YTD and £43m FY forecast).
- Depreciation and finance costs are £0.5m favourable YTD (£0.5m 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 (£0.7m) and OneLondon project depreciation (£0.4m).

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 4 – July 2020)

| | Apr-20 Actual | May-20 Actual | Jun-20 Actual | Jul-20 Actual | Jul-20 YTD Move | Jul-20 YTD Plan | Jul-20 Var |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Opening Balance** | **25,964** | **57,387** | **58,796** | **57,028** | **25,964** | **25,964** | **0** |
| Operating Surplus | 1,360 | 1,319 | 1,465 | 2,259 | 6,403 | 6,403 | 0 |
| (Increase)/decrease in current assets | (8,741) | (2,906) | 2,709 | 2,168 | (6,770) | (6,770) | 0 |
| Increase/(decrease) in current liabilities | 46,479 | 4,778 | (3,108) | (4,349) | 43,800 | 43,800 | 0 |
| Increase/(decrease) in provisions | 93 | 88 | 213 | (198) | 196 | 196 | 0 |
| Net cash inflow/(outflow) from operating activities | 39,191 | 3,279 | 1,279 | (120) | 43,629 | 43,629 | 0 |
| **Cashflow inflow/(outflow) from operating activities** | **39,191** | **3,279** | **1,279** | **(120)** | **43,629** | **43,629** | **0** |
| Returns on investments and servicing finance | (4) | 0 | (8) | 0 | (12) | (12) | 0 |
| Capital Expenditure | (7,764) | (1,870) | (3,039) | 1,430 | (11,243) | (11,243) | 0 |
| Dividend paid | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing obtained | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing repaid | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cashflow inflow/(outflow) from financing** | **(7,768)** | **(1,870)** | **(3,047)** | **1,430** | **(11,255)** | **(11,255)** | **0** |
| Movement | 31,423 | 1,409 | (1,768) | 1,310 | 32,374 | 32,374 | 0 |
| **Closing Cash Balance** | **57,387** | **58,796** | **57,028** | **58,338** | **58,338** | **58,338** | **0** |

### Operating Position

**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 £32.4m, this is due to NHSI paying one months block income in advance each month.

Cash funds at 30 July stand at £58.3m and the operating surplus is on target.

### Current Assets

- The movement on current assets is (£6.8m).
- The movement is due to a decrease in trade receivables £0.5m, increase in accrued income (£5.4m) and prepayments (£1.9m).

### Current Liabilities

- The movement on current liabilities is £43.8m.
- The movement is due to an increase in deferred income £36.7m (block contract payments in advance), accruals £12.5 and payables (£5.4m).

### Provisions

- The movement on provisions was £0.2m which relates to legal and international student payments.

### Capital Expenditure

- Capital cash movement was an outflow of £11.3m.

# 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 operating under an adjusted financial framework for April to September 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.

CIP Savings

**FY Forecast: N/A**

**FY Target: N/A**

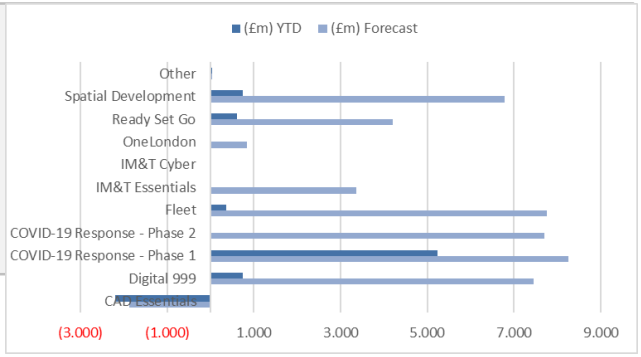
## Capital Plan

- YTD capital expenditure is £5.6m compared to planned capital expenditure of £8.6m primarily due to the in month reversal of £2.3m of capital work in progress in conjunction with the CAD upgrade project.
- Full year forecast capital expenditure is £44.2m in line with the Trust's latest capital plan which was revised upwards from £21.8m in mid-late June to reflect additional capital investment required in relation to its COVID-19 response.
- A further £6.1m has been identified which is likely to increase the Trust's 2020-21 CRL limit to £50.3m.

Capital Plan Breakdown

**YTD: £5.6m**

**FY Plan: £44.2m**

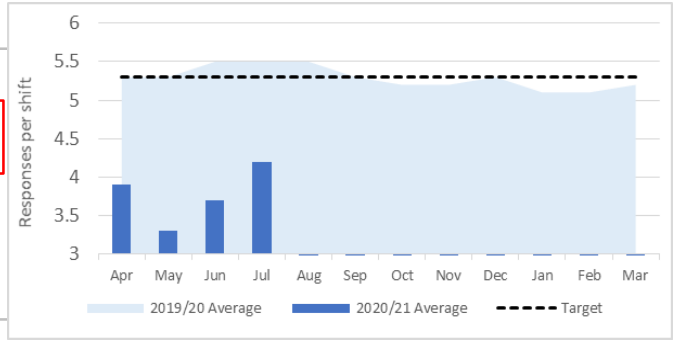



## Jobs per shift (DCA)

Average jobs per 12 hour shift

**Actual: 4.2**

**Target: 5.3**




Operations are tracking the performance of jobs per shift on a monthly basis. 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

## Partners Scorecard

**July 2020**

| Indicator (KPI Name) | Basis | Data From Month | Target Status | Target and Type (Internal / Contractual / National / All) | | Current Perfomance: Latest Month | Current Perfomance: Year To Date (From April) | Current Perfomance: Rolling 12 Months | Trajectory: FY19/20 Trajectory | Benchmarking (Month): National Data | Benchmarking (Month): Best In Class | Benchmarking (Month): Ranking (out of 11) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital handover | minutes | Jul-20 | G | 18.5 | I | 17.8 | 18.2 | 20.8 | | | | |
| Post-handover (Handover 2 Green) | minutes | Jul-20 | G | 16.0 | I | 14.4 | 14.6 | 14.0 | | | | |
| See and Convey – to ED (Contractual Position) ** | % | Jul-20 | G | 58.4% | I | 53.6% | 49.5% | 53.7% | | 54.2% | 50.5% | 6 |
| Hear and Treat % ** | % | Jul-20 | G | 7.9%* | I | 9.1% | 11.3% | 9.6% | | 7.3% | 10.8% | 2 |
| Hear and Treat (n) ** | % | Jul-20 | Grey | 90,307* | I | 9,091 | **43,920** | 120,719 | | | | |
| 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 | Grey | 100 | | | | TBC | | | | |

**Benchmarking Key**

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

***Please note: 999 performance data is correct as at 09/09/20 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
- Grey — KPI not reported / measurement not started

* This target is based on the 2019/20 actual figure

# 4. Our Partners

## 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 09/09/20 and is subject to change due to data validation processes***

### Arrival at Hospital to Patient Handover

We saw a slightly higher number of delays in July, compared to June, However the overall number of hours was still low with only 429 hours lost from our arrival to patient handover over 30 mins. Queens Romford, North Middlesex and Whipps Cross had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the had the highest number of lost hours over 30 minutes, at 100.6 hours for the month.

| STP | Hospital | Total Conveyances | Handovers | Handovers Exceeding 30 mins | % of Handovers over 30 mins | Total Time Lost Over 30 Mins | Average Arr at Hosp to Patient Handover Time |
|---|---|---|---|---|---|---|---|
| North Central | Barnet | 1,392 | 1,376 | 167 | 12% | 18.9 | 20.9 |
| | North Middlesex | 2,566 | 2,511 | 449 | 18% | 58.1 | 21.6 |
| | Royal Free | 1,618 | 1,569 | 135 | 9% | 11.4 | 19.1 |
| | University College | 1,225 | 1,202 | 22 | 2% | 2.3 | 14.7 |
| | Whittington | 1,379 | 1,345 | 78 | 6% | 10.3 | 16.4 |
| North East | Homerton | 1,227 | 1,167 | 25 | 2% | 2.3 | 14.5 |
| | King Georges | 1,115 | 1,083 | 116 | 11% | 10.9 | 20.9 |
| | New ham | 1,722 | 1,654 | 199 | 12% | 15.0 | 20.5 |
| | Queens Romford | 2,893 | 2,829 | 803 | 28% | 102.5 | 25.6 |
| | Royal London | 1,605 | 1,526 | 78 | 5% | 8.3 | 18.0 |
| | Whipps Cross | 1,660 | 1,609 | 262 | 16% | 45.8 | 21.7 |
| North West | Charing Cross | 1,207 | 1,172 | 16 | 1% | 1.6 | 15.3 |
| | Chelsea & West | 1,309 | 1,273 | 16 | 1% | 2.7 | 15.8 |
| | Ealing | 1,374 | 1,347 | 59 | 4% | 9.9 | 14.2 |
| | Hillingdon | 1,242 | 1,223 | 18 | 1% | 2.8 | 12.2 |
| | Northw ick Park | 3,058 | 3,018 | 89 | 3% | 30.2 | 13.3 |
| | St Marys | 1,551 | 1,517 | 92 | 6% | 12.7 | 17.5 |
| | West Middlesex | 2,019 | 1,988 | 28 | 1% | 3.2 | 15.2 |
| South East | Kings college | 1,895 | 1,844 | 142 | 8% | 14.1 | 20.3 |
| | Lew isham | 1,385 | 1,316 | 73 | 6% | 9.1 | 17.7 |
| | Princess Royal | 1,856 | 1,780 | 72 | 4% | 12.2 | 15.3 |
| | Queen Elizabeth II | 2,357 | 2,312 | 44 | 2% | 4.4 | 12.7 |
| | St Thomas' | 2,131 | 2,085 | 53 | 3% | 3.2 | 16.5 |
| South West | Croydon | 2,272 | 2,202 | 112 | 5% | 13.6 | 18.9 |
| | Kingston | 1,561 | 1,534 | 31 | 2% | 2.3 | 17.2 |
| | St Georges | 1,816 | 1,750 | 174 | 10% | 14.4 | 19.3 |
| | St Helier | 1,266 | 1,245 | 103 | 8% | 21.3 | 19.2 |
| | **TOTAL** | 46,701 | 45,477 | 3,456 | 8% | **444** | 17.8 |

Max average breach value

Value >10 mins per breach

### Patient Handover to Green

In July handover to green performance was Similar to June, with a 14.4 minute average. However, over 2,500 hours were lost due to patient handover to green exceeding the 14 minute threshold. There is organisational focus to continue improving on the metric with action plans focusing on clarification of targets, improving the process and sharing good practice across sector.

| 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 | 2,137 | 953 | 45% | 123.1 | 13.8 | 25.6 | 7.8 |
| | Edmonton | 2,945 | 1,511 | 51% | 192.1 | 15.0 | 26.6 | 7.6 |
| | Friern Barnet | 1,823 | 936 | 51% | 110.0 | 14.8 | 24.9 | 7.1 |
| North East | Homerton | 2,431 | 1,117 | 46% | 134.9 | 13.5 | 24.9 | 7.2 |
| | New ham | 3,264 | 1,719 | 53% | 227.7 | 15.1 | 27.3 | 7.9 |
| | Romford | 3,556 | 1,814 | 51% | 173.7 | 14.2 | 23.6 | 5.7 |
| North West | Brent | 3,568 | 1,719 | 48% | 201.5 | 14.3 | 24.4 | 7.0 |
| | Fulham | 2,159 | 1,103 | 51% | 119.9 | 14.6 | 24.0 | 6.5 |
| | Hanw ell | 2,800 | 1,349 | 48% | 117.6 | 13.7 | 21.7 | 5.2 |
| | Hillingdon | 1,473 | 693 | 47% | 60.9 | 13.8 | 21.8 | 5.3 |
| | Westminster | 1,671 | 746 | 45% | 85.6 | 13.7 | 23.2 | 6.9 |
| South East | Bromley | 2,756 | 1,535 | 56% | 160.9 | 14.9 | 25.1 | 6.3 |
| | Deptford | 3,859 | 1,791 | 46% | 168.3 | 13.4 | 22.6 | 5.6 |
| | Greenw ich | 2,079 | 1,229 | 59% | 108.2 | 15.2 | 23.2 | 5.3 |
| South West | Croydon | 2,114 | 1,255 | 59% | 131.0 | 15.2 | 24.9 | 6.3 |
| | New Malden | 1,250 | 689 | 55% | 67.0 | 14.8 | 24.0 | 5.8 |
| | St Helier | 1,427 | 743 | 52% | 65.1 | 14.3 | 22.6 | 5.3 |
| | Wimbledon | 1,477 | 800 | 54% | 80.1 | 14.6 | 23.5 | 6.0 |
| Other | NULL | 1,033 | 682 | 66% | 68.1 | 14.7 | 23.6 | 6.0 |
| | IRO | 2 | 1 | 50% | 0.1 | 8.1 | 16.4 | 6.0 |
| | Other | 786 | 426 | 54% | 65.2 | 14.5 | 26.5 | **9.2** |
| | Training | 867 | 492 | 57% | 53.8 | 15.6 | 25.0 | 6.6 |
| | Bromley | 2,756 | 1,535 | 56% | 160.9 | 14.9 | 25.1 | 6.3 |
| | **TOTAL** | 45,477 | 23,303 | 51% | 2514.8 | **14.4** | **24.3** | **6.5** |

Max average breach value

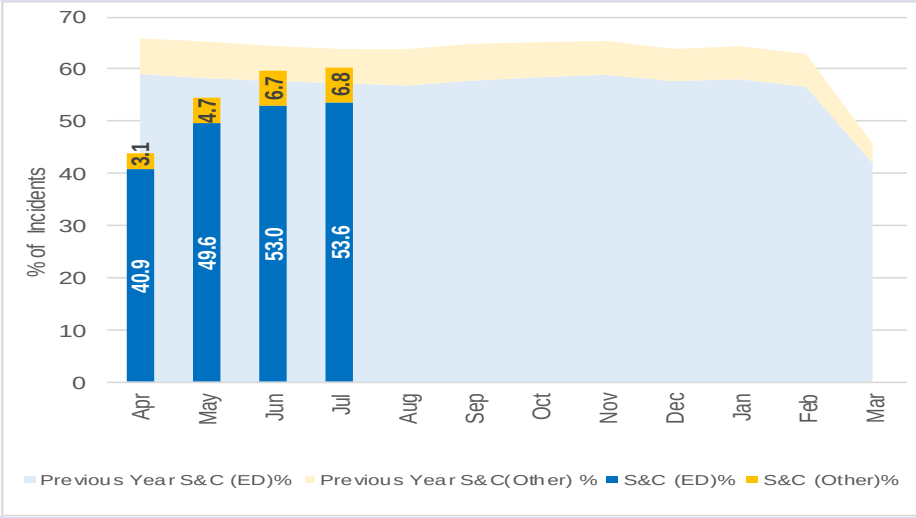
Value >7 mins per breach

# Maximising safe non-conveyance to ED

## See and Convey to Emergency Department

| | | Jul-20 | Year To Date | Year-end Target |
|---|---|---|---|---|
| See & Convey ED % | LAS | 53.6% | 49.5% | |
| | Target | | | TBC |

The conveyance to emergency departments target (58.25%) was delivered in June (53.3%), with the figure very similar to the June performance. There has been some weakening in performance for this metric following the reduction in the proportion in Covid patients, however the performance has stabilised in June and July due to a similar profile of demand.

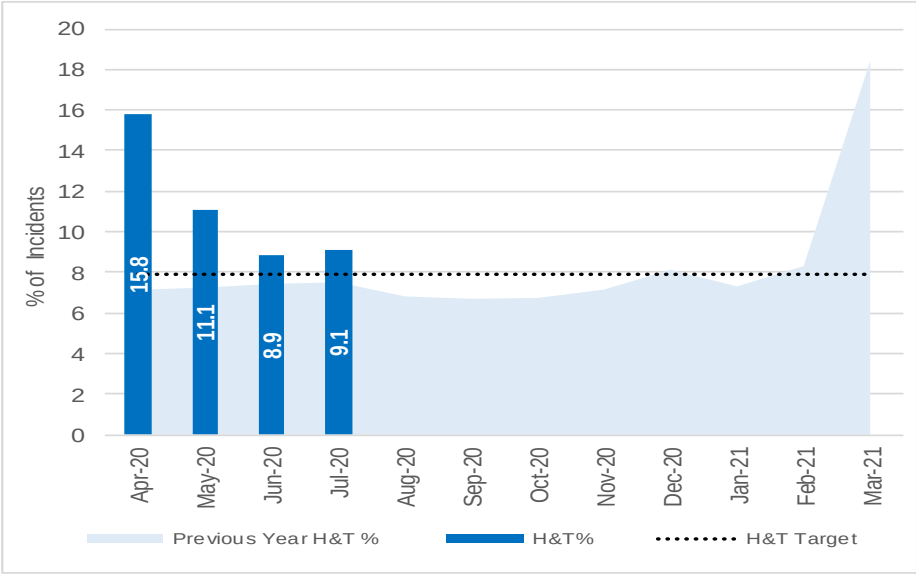



## Hear and Treat %

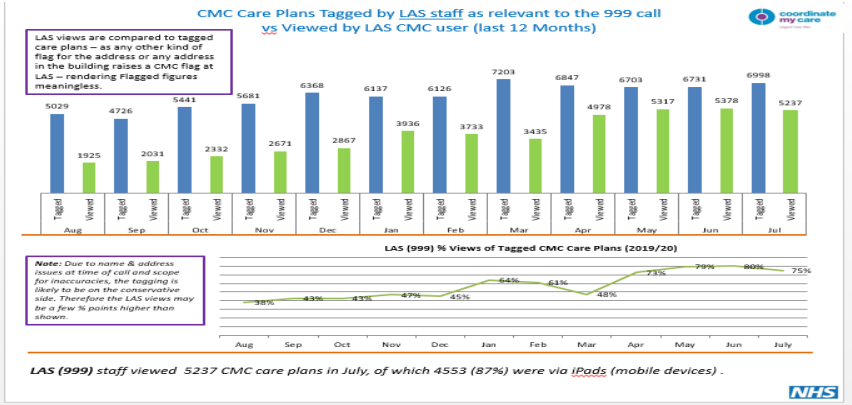
| | | Jul-20 | Year To Date | Year-end Target |
|---|---|---|---|---|
| Hear & Treat % | % | 9.1% | 11.3% | |
| | (n) | 9,091 | 43,920 | TBC |

Hear and treat delivered 9.1% in July against the Trust target of 7.9%. These results are an improvement on 2018/19 rates, however there has been a reduction in H&T rates following a reduction in proportion of Covid patients. The rate remained stable when comparing June and July.

***Please note: 999 performance data is correct as at 09/09/20 and is subject to change due to data validation processes***



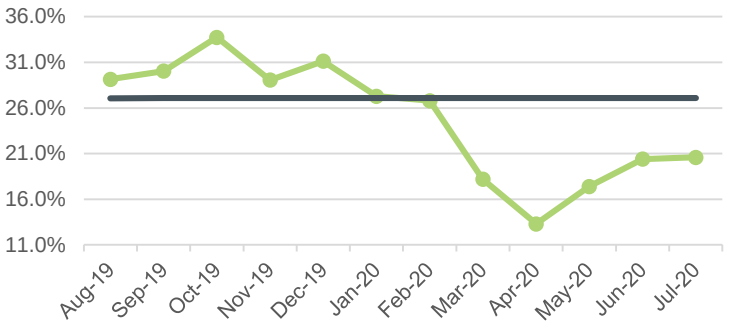
# End of Life Care & Mental Health




The CMC viewing figures continue to improve. Action: Pilot role of CMC coordinator in EOC begun

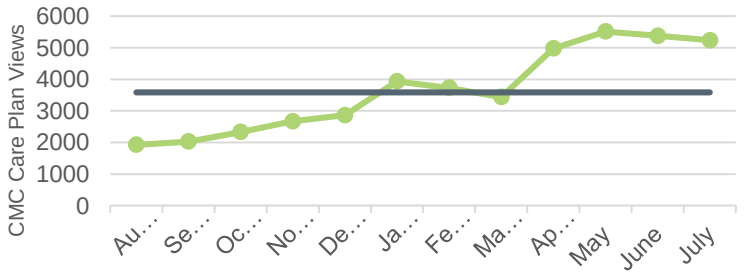
## ED Conveyance

Latest Month (Jul): 20.62%




ED conveyance continues to be lower than earlier in the year. **Action** : Collaboration with nursing/care homes re: advance care planning and its influence on ED conveyance and staff interaction with LAS.

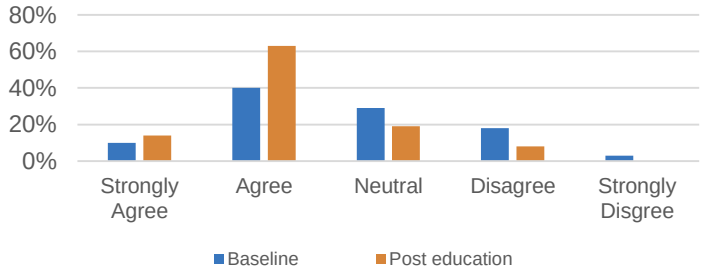
## CMC Views



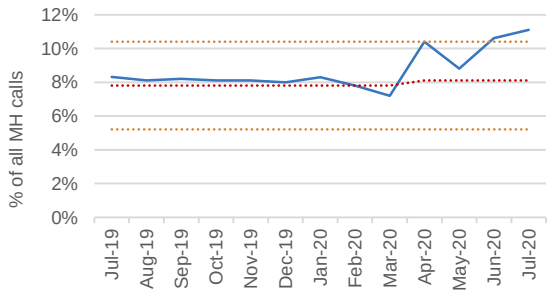

## Staff Confidence

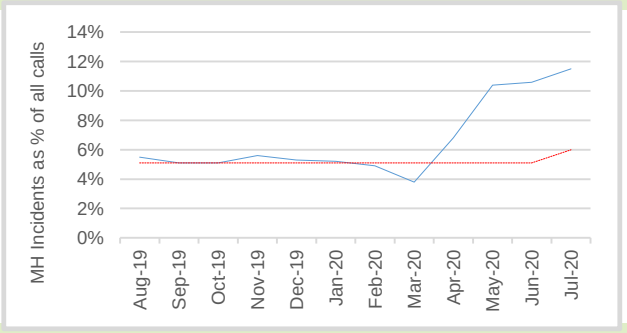
77% staff post education felt confident

*27% increase from baseline*

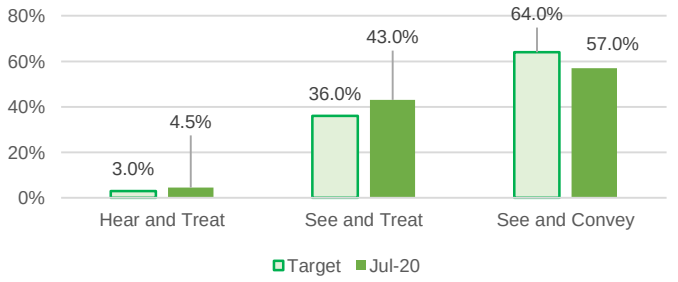



The EOL Team have supported the development of the 87% App as part of the Wellbeing hub




Creation of more appropriate care pathways for advice and support.




During the peak of Covid-19 pandemic many of the London Mental Health Providers offered an alternative provision to patients experiencing a mental health crisis. Instead of attending the Emergency Department, Mental Health Assessment Units were set up away from the ED space and the majority of them set up Appropriate Care Pathways (ACP's) with the LAS. Camden and Islington Mental Health Trust requested a divert for all Mental Health Patients who otherwise would have been conveyed to either the Royal Free, Whittington or UCLH ED to be taken to their Mental Health Assessment Unit at St Pancras Hospital. This was signed off by the London CAG and LAS staff were briefed via the Covid-19 Patient Facing Staff Guidance. Since then we have received at least 6 datix reports from staff as well as informal staff feedback that patients are being refused access to the unit; we have liaised with clinical team about specific cases and it became apparent that there is clear exclusion and inclusion criteria and staff need to call ahead to make a referral. **Action**: The local group station management team and LAS mental health team in conjunction with the mental health provider are in the process of signing off an ACP and arranging local comms.

**Organisational Improvement**

Over the past two months the Trust has developed and signed off our post Covid-19 Strategic Recovery Plan and a new Model of Care. The Model of Care outlines the principles that we will adhere to in developing our service provision to improve the care that we provide for our patients. Focus has now moved onto the development and implementation of a wide ranging organisational improvement programme.

The Covid-19 pandemic exposed significant risks to the way that the London Ambulance Service operates – and the wider healthcare system it supports – in continuing to operate in a highly inefficient and expensive way. This transformation programme will build on the changes that were made through the Covid-19 pandemic to achieve higher quality of care and equity of access for patients, improving care outside hospital settings and ensuring conveyances to the most clinically appropriate location when necessary.

We are proposing that within this programme we bring together a number of strands that will enable London Ambulance Service to provide a modern out of hospital health care service:

- Building on pre-Covid 19 progress with 999 and NHS 111 integration
- Consolidating, embedding and enhancing changes to the London Ambulance Service operating model driven by the response to the challenges presented by Covid-19
- Much needed changes to the London Ambulance Service estate, providing far better facilities for staff and enhancing operational response and training
- Opportunities presented to improve the efficiency and effectiveness of our corporate processes
- Working with system partners to find the best approach to funding services.

This programme will see a fundamental change in our operational estate. However it is much more than an estates programme. It is the catalyst to improving so much about the way in which we deliver care for our patients and the satisfaction and enjoyment that our staff have working for LAS,

| | | | | |
|---|---|---|---|---|
| **For our patients** we will provide the right care in the right place at the right time, consistently no matter the time of the day or month of the year | **For our staff** we will provide a high quality working environment, better support from managers and colleagues and greater access to high quality learning & education | We will **improve operational performance** by reducing complex processes and ensuring we deliver performance all day, every day | We will become a **greener and more environmentally sustainable** organisation by designing out waste and reducing emissions | We will reduce inefficiencies and unwarranted variation, providing **best value for money** |

**Enabling Strategies**

Simultaneously to developing our organisation-wide recovery plan, model of care and improvement programme, we are still working with Directors and subject matter experts to progress our suite of enabling strategies. Ensuring that we learn the lessons of Covid-19 and other major events such as Black Lives Matters, we are developing our strategies to meet the needs of our organisation today and for the future. The main enabling strategies that we are currently developing are:

- Diversity & Inclusion strategy
- Wellbeing strategy
- Environment & sustainability strategy

As with all of our enabling strategies we will engage with our staff and work closely with Trust Board in their development.

London Ambulance Service NHS
NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

# Executive Director Report: Quality and Assurance Directorate (Q2)

## 1. Patient Safety

Patient Safety Incident Response Framework:

The inaugural meeting of the system wide the Patient Safety Incident Reponses Framework (PSIRF) programme was held on September 2nd September. Representatives fro pan-London healthcare organisations, national safety teams and commissioners were present. The main aim of the first meeting was to identify, based on a 3 year analysis of safety data ( claims, complaints, Serious Incidents, safety incidents) , the top safety and quality themes that the organisation should focus on as part of the required annual plan.

The main themes identified from the group related to patient safety culture, patients waiting over the required response times, particularly those patient who are deemed following triage, less acutely ill, call handling triage, handover points across the healthcare system that require handover to different providers and specifically escalation policies and management of patient during high demand in both integrated urgent care, emergency services and acute hospitals and human factor related topics. An area already agreed as requiring important focus at other London Ambulance Service governance groups was also included, response and management of care home incidents.

The programmes will be discussed at the next Quality Oversight Group and ratified by the membership. For each theme further analysis will be undertaken , learning form this will be developed into clear improvement plans. The quality improvement and assurance models, currently being implemented as sector and service level will be utilised to take the learning forward. Staff who have been trained in quality improvement and service development will support operational teams in development and implementation of plans. Monitoring and reporting of progress will be via the sector based quality reviews and through the sector and corporate quality reporting mechanisms.

Current themes from Serious incidents and data analysis

During the last quarter the main themes from incident analysis relate to :

- During quarter one of this year a number of incidents related to patients not being conveyed to hospital, when on review they should have been referred following the first assessment. Demand was high during this time (Covid related) and the need to try and ensure where appropriate patients were managed at home. Increased understanding of the disease process and

changes in guidance to reflect this have been included in training and communication programmes.

- unavailability of medical equipment on ambulances – a task and finish group are currently investigating this further and looking at ways to re-design the process prior to the introduction of asset tracking systems
- dispatch and call handling of calls from other health care professionals and metropolitan police – new guidance has been issued and awareness raised with call handling staff
- handover of communication has been highlighted by other providers and is being included as a theme to address within the PSIRF programme
- Within the integrate urgent care setting, referrals not being received due to staff not ensuring that the referral had been successfully received by healthcare providers – specific communications have been disseminated to staff to ensure that they always check a referral has been completed successfully and this will continue to be audited regularly.

## 2. Patient Experience/Caring

### Mental Health

Positive feedback continues to be received in relation to the mental health response car and system wide providers are working with the LAS to ensure that the service is provided until agreement on the long term model and funding streams.

During Covid a different provision for mental health patients was agreed via an alternative pathway in two boroughs. The patients were re-directed via a clinical pathway to mental health assessment units rather that emergency departments. A number of incidents have been reported that suggest patients have been refused access due to access criteria not being met. The mental health team at LAS, local management teams have worked with providers to ensure clear inclusion and exclusion criteria going forward for these patients

### End of Life

Including patients care request on the Co-ordinate My Care (CMC) database has seen improvements both in the numbers being placed in to the system and the numbers viewed by LAS staff when attending patients ( from 4,000 per month in May to 5000 per month currently). We have also seen a reduction in conveying patients who are at the end of their life to emergency departments when compared to last year (64% to 57%) and an increase in see and treat (36% to 43%), which suggests patient's wishes to remain at home are being acted upon. However it is recognised that there is a need to work more closely with care homes to ensure all patients have an advanced care plan and better communication with staff. The end of life team are

working closely with LAS staff and also system healthcare partners to improve the position further.

**Maternity**

The maternity team with the support of the quality directorate, are working closely with NHS Resolution, who deal with all patient claims for the NHS, to develop the first maternity standards for ambulance services. The standards will be shared with the Care Quality Commission, to ensure that all regulators are using the same standards to assess ambulance trusts. The standards will agreed by relevant national ambulance groups and ratified at the Ambulance Association Chief Executive group.

A number of maternity management cases have been identified at the Serious Incident and Learning group – an agreed thematic review has been started, the main issue appear to be escalating to either clinical advice or to maternity units in a timely manner. Staff support and training is being provided across the trust from the maternity team to improve knowledge and skills in this area.

**Frequent Callers**

As with end of life patients, there has been an increase in the number of care plans for patients classed as frequent callers to the service uploaded onto the CMC database. Work carried out in North Central London using targeted multi-disciplinary approach and the use of CMC records with a reduction of 31% of numbers of frequent callers, 9% reduction in calls and a 47% reduction in calls requiring conveyance when compared to the same time period last year. This model is being developed pan-London.

**Complaints.** From a reduction during Covid-19 demand in May (0.08 per 1000 incidents) we are now seeing complaints increasing to 0.11 per 1000 incidents. Conduct and behaviour complaints account for 54% of those received. Delayed response has dropped significantly to 4% which reflects the current resource in the organisation to support Covid demand. The behavioural aspects of complaints has been agreed to be included as one of the thematic reviews by the pan-London Patient safety incident panel as this is a theme across most ambulance trusts.

## 3. Health, Safety and Security

### Status of Covid-19 RIDDOR Investigations:

A programme of investigations is underway into cases where members of LAS staff have tested positive for Covid-19. The objectives of this programme are to:

- Identify any cases where the evidence suggests there is a reasonable probability that the case is due to occupational exposure and hence reportable under RIDDOR.
- Identify opportunities to improve the risk control systems in place moving forward

The programme is looking at 296 cases recorded on GRS as confirmed Covid-19 positive, and 3 covid-19 related fatalities.

Of the 296 cases confirmed covid-19 positive, 230 of these are identified as patient facing staff, 57 do not undertake patient facing activities. The remaining are excluded from investigations as they are not employed by LAS.

**Investigations into fatalities**

Sadly there are 3 members of staff who have died as a result of becoming infected with Covid-19. None of these were in patient facing roles and all had underlying health conditions. Investigations were undertaken following the principles of the process agreed at QGARD.

These investigations have been completed and reviewed by a panel consisting of management and union representatives. This panel last met on 7 August 2020 where it was agreed that 2 of the 3 cases were reportable to the HSE under RIDDOR as the evidence available could not exclude the reasonable possibility that this was due to an occupational exposure.

**Investigations into patient facing staff**

The process for investigating cases where patient facing staff have tested positive for Covid-19 is based on a 2-stage approach developed by NWAS and agreed at QGARD.

- 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.
- Any investigation that is rated as medium or high likelihood of being RIDDOR reportable is subject to a Stage 2 investigation.
- Stage 2 involves a deep dive into the case to look at controls and circumstances surrounding possible infection.

Reports completed at Stage 2 will be reviewed by the RIDDOR panel to determine the appropriateness of reporting to the HSE.

All cases associated with each station group will be forwarded to the H&S Adviser who will review with the LGM to determine any local actions.

The current position:

- 194 stage 1 investigations complete (84%)
- Of these 50 (26%) are rated moderate requiring further investigation
- Investigations complete for 5 (pending final report structure) and initiated for 5.
- The next panel meeting is due in September 2020

**Investigations into non-patient facing staff**

There are currently 57 members of staff who are not patient facing on GRS who are recorded as Covid-19 positive. The investigations are following the same principles as the patient facing staff, but the assessment is more qualitative as it does not relate to specific patient incidents.

These are just starting, with the priority initially on staff working in the logistics office at Bow. The second priority will be staff at the call centres.

**Opportunities to improve and lessons learned**

Learning gained through the investigations are being logged, reviewed by the panel and progress against these tracked. Key lessons to date include:

- Improving the return to work process to consider potential for staff to return whilst still contagious
- Improvements to the risk assessment process for staff who may be at higher risk from Covid-19

## 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 .

There a small number(4) of smaller stations that have been identified as being used for rest breaks to support social distancing , these will all be assessed and compliance met by 18th September target.

## Violence Reduction Standards:

A Violence Reduction Standards Task and Finish Group (VRSTFG) has been formed to ensure relevant work streams are undertaken to comply with Violence Reduction Standards set by NHS England/Improvement, currently in draft form and due to be launched. The VRSTFG, will monitor progress, identify compliance and areas for improvement are implemented and will meet regularly to manage the LAS trial.

Terms of reference have been drawn up and agreed at the inaugural meeting. There is a wide representation of stakeholders on the group, including Staff-Side and NHSE/I, who are funding the pilot into body warn cameras. The group will report into the Violence Reduction and Staff Safety Programme Board.

**Criminal Justice:**

A Criminal Justice Group (CJG) is being formed and will meet regularly to ensure oversight of staff violence related incidents and support for victims in both prosecutions and welfare. Terms of Reference have been drawn up for agreement. This Group includes representation from a member of the Metropolitan Police Service Operation Hampshire Team. The group will report into the Violence Reduction and Staff Safety Programme Board and through the monthly quality report.

**Musculo-skeletal (MSK) Injuries and manual handling update**

Health, Safety & Security Department have developed an MSK Action Plan, an MSK Programme board has been setup to manage and assure that projects that sits underneath the programme meets its objectives. Due to COVID the programme board will now meet in the 3rd week of Sept'20. The main aim of the first meeting will be to develop and agree the framework for the programme, the communication strategy and the programme launch in November.

- The peak of MSK incidents reporting in 2020/21 (up to end of July'20) varies by month from sector to sector with the highest MSK incidents reporting during June 2020.
- There is an average of 1 reported moving and handling incident for every 2000 face to face attendances.

As part of the on-going work in relation to lifting equipment failures , a task/finish group has been set up to identify root causes and remedial actions, we have also met with the manufacturer to improve the servicing and turnaround times going forward. Short video clips and stickers along with bulletins are to be produced around the use of the Mangar Elk to try and address some of the root causes of failure.

**Personal Protective Equipment (PPE)**

A corporate level group to monitor PPE equipment, fit testing and supply has had its inaugural meeting. A sub-group was immediately agreed to ensure that the fit-testing programme of staff both current, new , bank and volunteers is robust and provides on-going monitoring following the reduction in demand due to Covid-19. An issue with stock supplies was highlighted and also the need to identify on-going costs to supply appropriate kit. The organisation now has a better understanding of all of the relevant equipment and numbers required i.e. optic kits for staff who wear glasses .The group will report into the Health and Safety and Wellbeing committee.

## 4. Safeguarding

The annual safeguarding report has been approved at the Quality Assurance Committee in July and reviewed by the commissioners in August. The commissioners commended the work of the team in taking forward significant programmes of work. All regulatory standard were met alongside the Level 3 Safeguarding training trajectory.

However due to social distancing guideline the way in which training and education will need to be delivered is being considered. The trajectory has been re-set and the delivery mode arranges with support from clinical education and training and operational teams. The training will start in the next month and will ensure that the 1603 members of staff have met their required competency and the trajectory by the end of 2020/21.

## 5. Quality Account Priorities

The quality priorities have now been set and included as part of the monthly reporting via the quality report. Eighteen quality priorities were identified and of these 17 are on track and making good progress. The only exception relate to the roll out of tempus monitors for the motorcycle and community first responders. During Covid-19 high demand these services were taken off the road to support ambulance related calls. Currently there is no date set for these services resuming, the Chief Operating Officer has therefore requested that this priority is removed from reporting.

## Quality Improvement and Assurance : Operational Models

The new operational model for quality assurance and improvement hubs is being trialled and started on September 1st. Quality and Assurance teams will reside in sectors and services on a day to day basis and take forward the quality directorates key objectives, improvement and business plans working within 'Quality Hubs'. The model is also aligned to the Trusts quality and estates strategic objectives of Ambulance Modernisation. Both incorporate Trust functions relating to operational services within Ambulance Hubs. Supporting the model will be staff trained in quality improvement, corporate staff and senior managers. The implementation plan sets out a number of key deliverables, measures outcomes, resource implications and staff feedback.

The benefits of the model will be:

- Embed quality improvement and accelerate the development of a safety and compliance culture by utilising technology and robust and standardised quality assurance and improvement frameworks across all areas.

- Increases the profile and influence of the Quality Directorate, its constituent departments, and their agendas in the sectors and services.
- Improved embedding and focus/delivery of quality priorities in the sectors
- Ability to tailor approaches to individual sectors' requirements and objectives
- Improved communication between sectors and 'parent' departments (both lines and speed), this allows for more timely 'course corrections' to be made in response to themes and priorities
- Supports cross sector improvement and delivery, and aligns closer to other enabling strategies
- Furthers development of operational ownership for the quality agenda

The trial will be completed by the end of October 2020 with a full report and business case to agree requirements for full roll out during 2021.

## 6. Looking forward

Further development of the 'Hub' models to ensure that we have robust quality assurance and improvement frameworks for any new service ie. PTS, IUC expansion, is critical and work is underway to develop these with key stakeholders.

Key improvement programmes agreed utilising patient safety and investigation framework and increased analytical skills capacity within the team will be agreed and developed. These programmes will cut across all quality directorate functions e.g. violence and aggression, patient care pathways, compliance culture.

Ensuring that the 2021/22 quality priorities reflect the expansion of the s services and assurance framework reflect the changing nature of Care Quality Commission inspection regimes (consultation on this is expected by the end of 2020, Health Service Journal September 2020)

London Ambulance Service NHS
NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

# Executive Director Report: Chief Medical Officer

## Hot Topic Updates

- A revised London Ambulance Service Major Trauma Decision tool has been disseminated internally and externally with partner healthcare providers.
- Collaborative working is continuing with the regional and local stakeholders to embed many of the local pathways which were set up during the first peak of COVID-19 in order to ensure patients can be treated closer to home where clinically appropriate, reducing Emergency Department crowding and minimising the risk of nosocomial infection
- The business case for a dedicated Medicines Packing Unit has been approved which will see a dedicated site for the packing and distribution of medicines across the Trust.
- Following assessment centres 22 Urgent Care Advanced Paramedic Practitioners and 8 Critical Care Advanced Paramedic Practitioners have been appointed.

## 1. Medicines Management

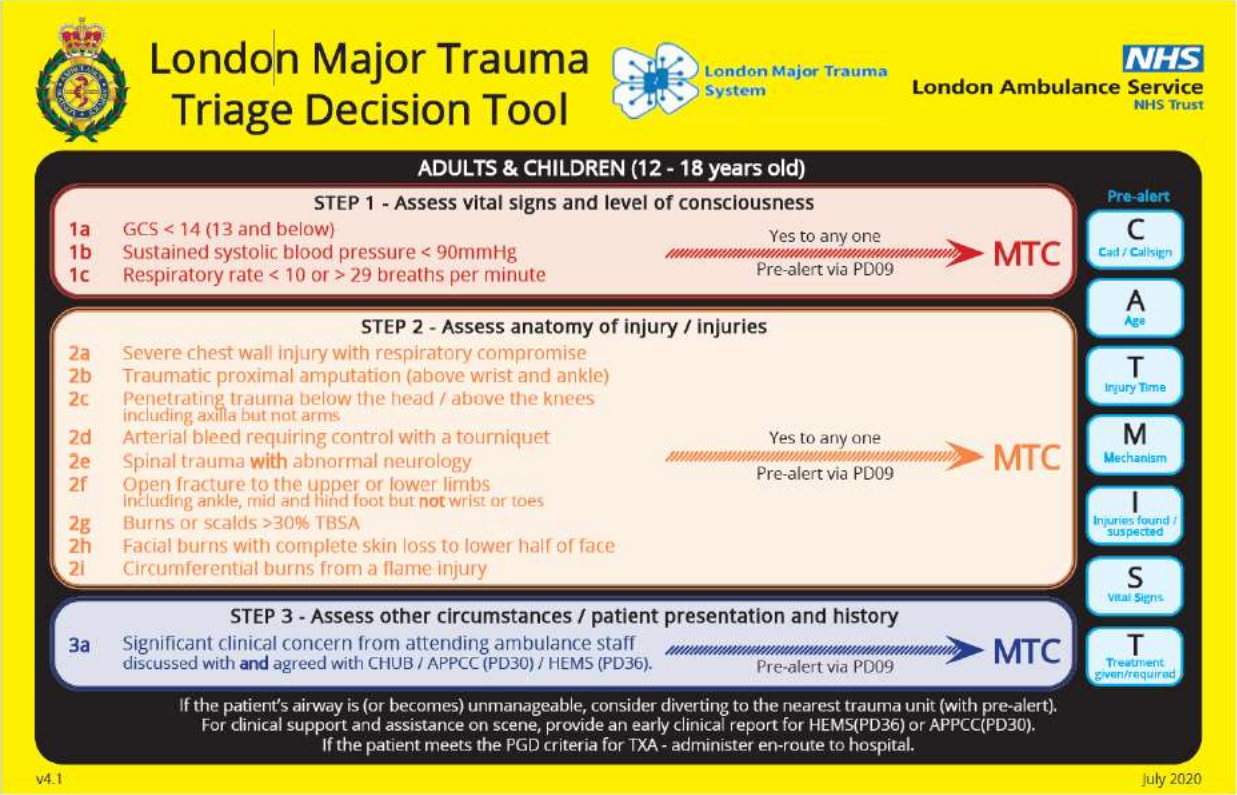
Medicines form an integral part of most patients' treatment or management, and the majority of services within the Trust are involved in managing medicines at some level and hence medicines command a significant part of the Trust's resources, either directly or indirectly. It is critical that the principles of medicines management are integrated into the Trust's systems, work practices and culture at all levels. Medicines management incidents continue to be monitored and lessons learnt used to continuously improve processes.

Currently medicines, which include controlled drugs for the Trust, are distributed across all the LAS sites in Greater London via the Logistics Support Unit (LSU). The medicines related functions conducted at the LSU comprise of: purchasing, receipt of medicinal goods, dispensing, packing, storage, delivery, distribution and disposal. Medical Gases are supplied by BOC, who deliver directly to ambulance stations.

Following a review of medicines packing a decision was made that, in order to ensure on-going best practice in all aspects of the handling and use of medicines, which consequently maintains the quality, and the integrity of medicinal products a dedicated medicines packing unit should be set up based on the Good Distribution Practice (MHRA). A business case has been approved and floor plans are being prepared for the identified site.

## 2. Patient Care – clinical development and governance

An updated Major Trauma Decision tool has been shared internally and externally. The changes have been made as a result of three years empirical work looking at the outcome and interventions required for patients conveyed direct to a Major Trauma Centre, along with very considerable expert review and has been signed off by the Pan London Trauma Steering Group and the NHS E (London) Clinical Advisory Group.




**Advanced Practice Practitioners (APP)**

Following recent assessment centres 22 Urgent Care Advanced Paramedic Practitioners (APP) and 8 Critical Care Advanced Paramedic Practitioners have been appointed – two successful candidates had been on the rotational paramedic programme supporting the on-going work for career progression within LAS. Additional senior clinical roles are now being recruited to in order to provide clinical oversight and governance to the increased numbers of clinicians undertaking advanced practice.

From 5 October 2020 the operational delivery of the APPs will move to the Ambulance Services Directorate – this aligns with the decision that all Trust clinical face-to-face resources will be in one directorate. The Clinical Directorate will maintain the responsibility for all the clinical governance, leadership and effectiveness aspects of the APP programme and will continue to drive clinical innovation and new aspects of care to improve patient outcomes. The Advanced Practice Governance Policy has been approved and implemented.

**Pathway development**

The Clinical Directorate continues to lead on the development of the Trusts future clinical model including Same Day Emergency Care (SDEC) pathways. An internal Clinical Advisory Group has been set up to provide the appropriate clinical governance for pathway changes.

## 3. Infection Prevention and Control (IPC)

On the 4 May 2020, NHS England/Improvement published the new guidance on Infection Prevention and Control (IPC) and alongside this, they published the IPC Board Assurance framework.

The framework was designed to help providers assess themselves against the new IPC guidance, as a source of internal assurance that quality standards are being met. The framework was underpinned by the legislative framework including the Health and Safety at work 1974, IPC code of practice and the CQC key lines of enquiry (KLOES).
The framework covered 10 domains. In May LAS rag-rated themselves as compliant (green) for 5 domains and partially compliant (amber) for 3 domains. 2 domains were not relevant to ambulance services. This assessment was submitted to the Care Quality Commission.
On 31 July CQC provided additional questions in preparation for a telephone interview with the Director of Infection Control (for LAS this is the CMO) and Chief Quality Officer on 11 August after which their written assessment was shared. This found that the Trust Board can be assured that LAS has effective infection prevention and control measures in place.

As we remain in a Pandemic and are entering the Winter virus period there is a continued focus on Hand Hygiene across the operational workforce – the August Operational Workplace Review Hand Hygiene audit submissions have improved slightly since August and the Head of Infection Prevention and Control is working closely with the Operational and Quality managers to further improve it. Bromley Group Station is performing very well and is to be congratulated.

## 4. Clinical Audit and Research

Several research trials which were necessarily suspended in March 2020 due to COVID-19 have now restarted.

**MATTS - Major Trauma Triage Study – University of Sheffield**

The MATTS project is a comprehensive programme of research investigating pre-hospital triage tools for use in NHS major trauma networks. Its aim is to develop an accurate, acceptable and usable pre-hospital triage tool to identify patients with major trauma benefiting from Major Trauma Centre care.

The project consists of 3 phases:

- **Phase one**: Identification and review of existing triage tools, and development of a new tool by expert consensus, for evaluation in subsequent phases.
- **Phase two**: A prospective cohort study to validate triage tools from Phase One and identify an optimally performing candidate triage tool.
- **Phase three**: Operational implementation and service evaluation of the candidate triage tool.

**STRETCHED: STRategies to manage Emergency ambulance Telephone Callers with sustained High needs – an Evaluation using linked Data**

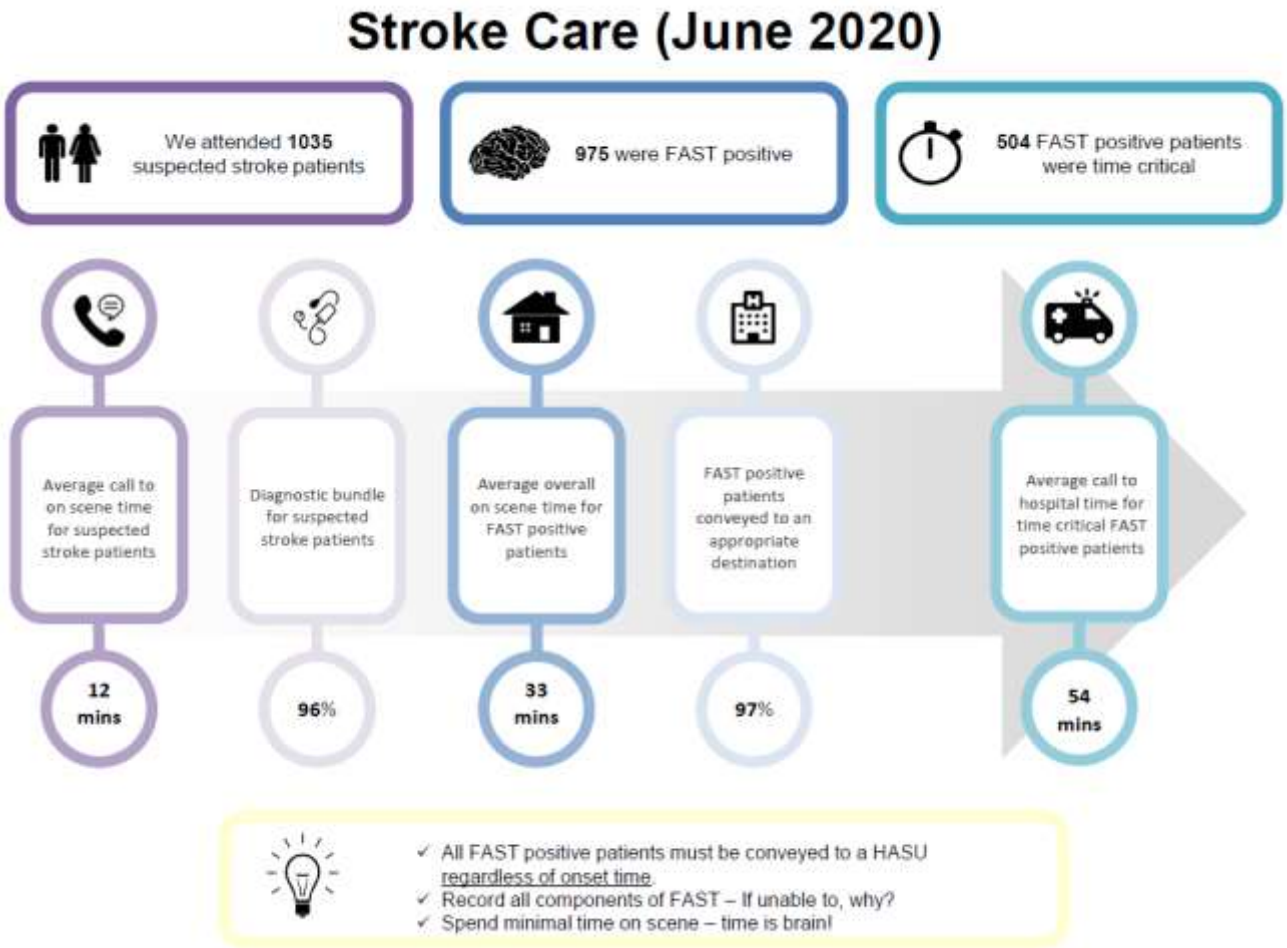
A small number of people phone 999 frequently; more than five times a month or 12 times in three months. However, they don't always have a medical problem that could cause death or disability that requires immediate treatment. One method of getting people the right help is called "case management". People are referred to a multi-disciplinary team including social services, GPs, community mental health and Emergency Departments. These services work

with the ambulance service to identify what the caller might need, and a treatment plan is created. Four UK ambulance services are involved.
This study, led by Swansea University, aims to evaluate the effectiveness, safety and efficiency of the current case management approaches to the care of people who frequently call the emergency ambulance service, and gain understanding of barriers and facilitators to implementation.

**Clinical Audit**

Reporting by NHS England of the Ambulance Quality Indicators (AQI) was suspended due to the COVID-19 pandemic but re-opened in July 2020 for submissions starting with December 2019 data. This means there will be an even larger time lag than usual as things return to normal, and this is evidenced in the IPR where the AQI data is from December 2019 and January 2020.

Internally the care provision has continued to be reviewed and the Clinical Audit team have circulated the Stroke Care Pack for June 2020 and the ST- Elevation Myocardial Infarction Care Pack for May 2020. There is always a time lag in receiving end-to-end patient data. These Care Packs are shared with Clinical Team Managers to facilitate clinical feedback and learning within their teams.

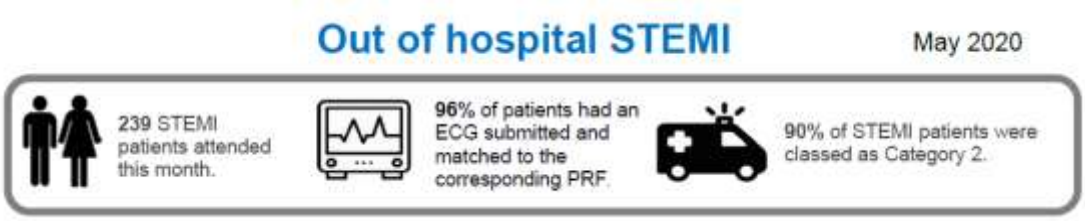


**ST- Elevation Myocardial Infarction Report (STEMI) – May 2020**

LAS attended 239 patients with a suspected ST-Elevation Myocardial Infarction (STEMI) following a 12-Lead electrocardiogram (ECG).where an ST- Elevation Myocardial Infarction was diagnosed.
When treating suspected STEMI patients, our clinicians undertake a range of assessments and interventions as necessary for the patient's condition. Of these, four key elements form a

specific pre-hospital STEMI care bundle: use of aspirin, the administration of glyceryl tri-nitrate (GTN); two pain assessments (pre- and post-treatment), and the appropriate provision of analgesia. STEMI patients are conveyed rapidly to an appropriate destination hospital for further treatment. Patients should be transported to a specialist Heart Attack Centre (HAC), where they will be taken directly to the catheter laboratory for angiography to assess whether they would benefit from a reperfusion procedure to unblock the artery.

90% of the patients were categorised as a Category 2 at 999 call handling (mean response time 18 minutes; 90% in 40 minutes) and the average 999 call to on scene time was 10 minutes compared to 23 minutes in April 2020 which was during the Peak of COVID-19 in London.
99.6% of the patients were conveyed to the appropriate destination for on-going treatment.




The **LAS 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 is reviewed. These recontacts remain very low indicating LAS clinicians are making safe decisions about non conveyance of patients.

| Sector | June 2020 | | July 2020 | |
|---|---|---|---|---|
| | Re-contacts per 1000 Face to Face patient incidents | Re-contacts per 1000 patient Non-Conveyances | Re-contacts per 1000 Face to Face patient incidents | Re-contacts per 1000 patient Non-Conveyances |
| NC | 1.4 | 3.8 | 1.3 | 3.9 |
| NE | 0.9 | 2.6 | 1.3 | 3.9 |
| NW | 1 | 3.1 | 0.8 | 2.5 |
| SE | 1 | 3.1 | 0.9 | 2.8 |
| SW | 1.1 | 3.5 | 1.1 | 3.6 |

## 5. Digital Clinical innovation

In a project led by the LAS Chief Clinical Information Officer, on 26 August 2020 LAS, input the first patient through electronic patient care record (ePCR), updating their details throughout the patient journey. Over the past few months, clinicians from across the Trust representing various grades, sectors and different types of responders have worked really hard to develop the new ePCR, to ensure it meets the appropriate needs for the Trust and for patients.

Replacing the paper-based patient report form with an electronic ePCR minimises the need for long text, enabling users to work through an intuitive system using tick boxes, prepared data lists and free text sections to enter patient details. ePCR will:

- provide a collaborative platform to simplify the entry of our patients' personal and clinical data.
- improve the user experience for our staff and volunteers.
- reduce duplication of questions our patients are asked.
- allow photos to be taken at scene for hospitals to view i.e. wounds pre dressing.
- supports a better patient journey and end user experience

## 6. Caldicott Guardian Annual Report

The Caldicott Guardian Annual Report has been discussed at the Information Governance Group and is presented to the Trust Board at this meeting for assurance.

## 7. Clinical Education and Standards

Work is ongoing, in collaboration with estates, to identify a suitable locations for two new, purpose designed dedicated learning centres.

Our Clinical Education Team helped to deliver a three week Newly Qualified Paramedic Induction course to 96 UK partner students. The home for our NQP training was Wembley Stadium, which allowed us to train a larger group of student. COVID-19 has brought challenges to traditional classroom learning, but thanks to the help of our education team, tutors and the Wembley Stadium team, we were able to accommodate our students to remain in smaller 'bubbles', which enabled the course to run smoothly and created a better learning experience. To maintain the 'bubble' concept, the venue was used to accommodate four mess rooms, toilet facilities, and also office facilities for tutors, which were big enough to maintain social distancing safely.

## Looking forward

- To support the development of the Same Day Emergency Care (SDEC) pathways being developed collaboratively with NHSE London ahead of Winter
- Working closely with NHS England Intensive Care Cell to ensure plans are in place to ensure there is sufficient capacity for the sickest patients in London over Winter.

- To support the preparation for the LAS Influenza Vaccination programme to provide assurance around the training of the peer vaccinators and governance of the vaccine supply chain.
- To prepare for the first cohort of 72 Assistant Ambulance Practitioners in October which is an exciting new role. The role, which is a band 4 position, fits within our career structure and means that colleagues can start in NETS and transition right the way through to Advanced Paramedic Practitioner (APP). New AAPs will undertake a 12-week programme provided by our Clinical Education and Standards team, which will result in a level 3 diploma in Ambulance Emergency and Urgent Care Support. This also includes the blue light driving course. After successful completion of the 12-week induction, the AAP will work under the direct supervision of a mentor/Practice Placement Educator (PPEd) in clinical practice for 26 weeks.
- To identify the new sites for the dedicated Clinical Learning Centres

London Ambulance Service NHS Trust

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| **Assurance report:** | **Quality Assurance Committee** | **Date:** | **08/09/2020** |

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| **Summary report to:** | **Trust Board** | **Date of meeting:** | **29/09/2020** |
| **Presented by:** | **Mark Spencer, Non-Executive Director and Chair of Quality Assurance Committee** | **Prepared by:** | **Mark Spencer, Non-Executive Director and Chair of Quality Assurance Committee** |

**Matters for escalation:**

- Terms of Reference (ToR) for committee requires that Non-Executive Directors are in the majority. Members agreed this was not necessary and recommends Trust Board agrees that the ToR are amended to remove this.
- BAF 54 (see below) re-articulation to emphasise the need to understand and demonstrate the full costs of a sustainable integrated urgent care (IUC) service.

**Key decisions made / actions identified:**

- QI/QA New Operating Model was presented and embeds a QI approach delivered in a hub and spoke model in each sector. A pilot was agreed, but the committee cautioned against seeking too much impact in the 2 months proposed. If confirmed effective this could be extended to other areas of Trust business.
- The developing plans for Winter were presented. Brexit and a probable C-19 second wave are likely to add to normal pressures. Ambulance handovers could be a major problem if Trusts lack capacity and have Covid-19 streaming. The plans will continue to be reviewed.
- The clinical governance and other activities arrangements for Advanced Paramedic Practitioner was reviewed. Clinical oversight of the LAS APP programme is provided by a Consultant Paramedic reporting to the Medical Director. Clinical Practice Development Managers provide support and leadership in urgent and clinical care. Clinical Operations Manager and Chief Pharmacy roles are clear and defined. The Quality Assurance Committee (QAC) approved the implementation of the policy.

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| **Risks:** | • Whilst there is good progress being made the associated risks of the Medicine Management implementation have been revised and included on the corporate Risk Register.<br>• BAF 54 – the risks of failing to meet key KPIs in 111/IUC was reviewed. As the contract payments have been modified because of C-19 the immediate financial risk is negated. However Quality Assurance Committee decided that, because of the need highlighted in the Internal Audit, to have a greater understanding of the costs in delivering a sustainable IUC model that this should continue on the Board Assurance Framework (BAF) with modification to reflect this challenge. Chief Pharmacist and Chief Operating Officer were asked to rearticulate the risk for the Boards consideration. |
| **Assurance:** | • Staff Immunisation delivery programme was reviewed and will ensure our staff safely receive immunisations and clear the back log. This is now being delivered by Vaccination UK (a CQC registered and established provider.<br>• The actions in staffing, training and delivery of Medicines Management were reviewed and QAC commended the work being done.<br>• Covid-19 RIDDOR investigations were reviewed and noted that the death of two staff members from Covid-19 could not exclude occupational exposure and so had been reported to the Health and Safety Executive. |

London Ambulance Service NHS
NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

# Executive Director Report: People and Culture September 2020

## 1. Hot Topic Updates

- The Trust continues to focus on the experience of our BAME staff by delivering the actions outlined in the "Black Lives Matter" plan which was approved in July 2020. An updated plan has been submitted to the Trust Board for September's meeting which tracks progress to date and new initiatives that are now planned.

- The Chair has written to all staff on behalf of the Trust Board to apologise for not always addressing issues that were raised by BAME staff in the past and expressing her ongoing support to ensuring there is a significant positive change in the future.

- Over 630 of the Trust's line managers have participated in 8 virtual workshops of approximately 100 people entitled "Why Silence is not the Answer". The workshops are designed to provide a safe space for all participants to learn about the lived experience of BAME staff and to talk and listen to each other's experiences of racism. The workshops will be rolled out to everyone in the Trust by the end of the financial year.

## 2. Regional Updates

- The "We are the NHS: People Plan 2020/21 action for us all" was published in July. A Trust response is being prepared for submission to our North West London STP later in September. A gap analysis has been conducted across a range of people factors and feedback has been requested from the Extended Leadership Group (the 70 most senior leaders in the Trust) for ideas and initiatives to address the gaps identified.

- The first draft of the London Workforce Race Equality Strategy has been published by Yvonne Coghill. There is a dedicated section relating to the Trust's progress in addressing racial inequality issues.

- The Trust returns for the Workforce Race Equality Strategy (WRES) and Workforce Disability Equality Strategy (WDES) have been submitted. Reporting was originally placed on hold owing to COVID but ha snow re-started.

## 3. Wellbeing

- The Trusts Wellbeing Hub has been successfully launched. Our recent "How are you Doing" wellbeing survey recorded that 79% of the staff who responded had heard about the hub. The hub is a central point of entry for all managers, employees and volunteers for information and support relating to their health and wellbeing.

- The Trust has launched its 2020 flu campaign which aims to see all staff receive a vaccination. Internal communications has created a holistic communication plan which includes interviews and videos from clinical staff, survivors of flu and several of the 200 peer vaccinators who have been trained to deliver the vaccines across the Trust.

- A new CQC regulated supplier has been identified to provide immunisations against diseases such as Hepatitis, Measles Mumps and Rubella and Pertussis to staff that require them. A detailed immunisation plan has been created by the Business Support Managers in Ambulance Operations and members of the People & Culture Wellbeing Hub to ensure that all staff immunisations are up to date. The number of staff immunised is reported and monitored each week through the Daily Senior Leadership Team (DSLT) meeting.

- 98% of BAME staff, 96% of vulnerable staff and 97% of all staff have had a risk assessment completed.

- The Trust repeated it's "How are Doing Survey" for the second time in August. The anonymous survey runs every two months to capture staff's view of their morale and the wellbeing, and the effectiveness of the welfare, mental health and emotional support they receive from the Trust. 400 staff responded on this occasion and an infographic has been produced to summarise the results of the first survey and the actions taken as a result.

## 4. Highlights

- The Trust introduced a new Weekly Payroll Scheme on 1 May following feedback from staff that they wanted to gain faster access to payments for the overtime that they work. The programme was delivered in just 3 months during COVID by the Scheduling and Payroll teams.

- Staff who have opted into the scheme now receive their overtime payments within 2 weeks, an improvement from 5-9 weeks before go-live.
    - Just under 3,000 staff are opted into the weekly payroll scheme;
    - Over 20,000 payments have been made to staff;
    - Staff are receiving payments 36 days quicker on average than previously.

## 5. Resourcing Risks and Issues

- People & Culture's recruitment team have worked with Ambulance Operations to create and recruit a new Assistant Ambulance Practitioner (AAP) Band 4 role. As at 31 August 358 external and 57 internal applications had been received for the 240 roles

- The Trust welcomed 15 new international Paramedics from Namibia in August. International recruitment has been negatively impacted by COVID as the Trust was unable to conduct its usual recruitment exercise in Australia and Australian Paramedics have not been able to travel to the UK for work. Over 50 potential international Paramedics have contacted us to say they wish to join us as travel restrictions are lifted and dates for training courses and HCPC registration are confirmed.

- The Trust is preparing for a pilot Paramedic 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

- People & Culture have been working with the Internal Communications team to prepare the engagement and communication plans for the 2020 NHS Staff Survey which will run from October. In 2019 the Trust achieved a 71% response rate but there was little positive movement in scores on the previous year.

**Ali Layne-Smith**

**Director of People & Culture**

**September 2020**

London Ambulance Service NHS
NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

# Executive Director Report: Finance M4

- **Hot Topic Updates**

  - Interim national financial arrangements continue until the end of September which ensure the Trust will meet its financial target through a retrospective top-up mechanism for the first half year.

  - The Trust has been working in partnership with our host ICS, NW London Health Care Partners (HCP), to agree planning assumptions which will feed into a system financial envelope for the remainder of the year. At the time of writing, system finance envelopes have just been issued and I am working with NW London HCP and other NWL provider CFOs to agree the financial principles for allocation of the system level growth and covid funding to inform our organisation level income envelope which will form part of the NWL ICS final submission. This is expected to be confirmed after the end of September. Trust finances will need to be managed within this envelope. The Trust has retained its covid resilience capacity since the beginning of the year in line with the national team directions and the ICS draft system plan submission assumes full funding based on our M4 forecast for workforce, activity and finance.

  - In a separate paper, the Trust Board is asked to approve our business plan for the remainder of the year assuming funding is in line with the M4 forecast. This equates to an income envelope of £527m inclusive of Covid funding of £75m and a total Trust capital plan of £50.3m. The capital funding is still subject to formal notification but if confirmed will be the one of the largest capital settlements in our history.

- **M4 Finance Position**

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

  - £33.7m of Covid-19 revenue expenditure has been incurred cumulatively to Month 4 and retrospective claims to M3 have all been funded in full. The Month 4 retrospective top of £9.4m was higher than reported Covid costs due to in month recognition of £2.6m costs in relation to the write off of assets connected to the replacement of the Trust's dispatch system.

- The Trust has a cash balance of £58.3m at the end of July.

- The Trust capital resource limit for the remainder of the year is agreed by the STP at £44.2m, however this requires formal notification. A further £6.1 m of CRL has been identified for brokerage within NWL HCP which will increase the Trust's 20/21 CRL limit to £50.3m. A total of £5.6m has been spent to M4, with significant ramp up projected in the forecast.

- **Looking forward**

  - Looking forward the team's focus is in four main areas:

    a. Embedding a culture of compliance and control through the new Supply Chain Management Board and Procurement Transformation Plan progress to improve contract management compliance and category plan oversight.
    b. Standing up the governance infrastructure and delivery model for the Trust's ambitious investment-led efficiency and modernisation programme.
    c. Supporting the pipeline of business cases to deliver the £50m capital programme and readiness for mobilising the ambulance operations modernisation case.
    d. Readiness for sustainable commissioning. This involves both the immediate preparations for the move away from current block payment arrangements to introduce incentives to deliver the phase 3 performance as well as development of a sustainable commissioning model to deliver LAS services once for London where desirable with London system partners.

Lorraine Bewes OBE
Chief Finance Officer
21st September 2020

London Ambulance Service NHS Trust

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| **Assurance report:** | **Finance and Investment Committee (FIC)** | **Date:** | **22/09/2020** |

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| **Summary report to:** | **Trust Board** | **Date of meeting:** | **29/09/2020** |
| **Presented by:** | **Fergus Cass, Non-Executive Director, Chair of Finance and Investment Committee** | **Prepared by:** | **Fergus Cass, Non-Executive Director, Chair of Finance and Investment Committee** |

**Matters for escalation:**

## Financial Plan 2020/21

The financial plan for 2020/21 is being presented to the Board; forecast expenditure comes to £527m, of which £81m relates to COVID-19. The Committee supports approval of this plan, subject to a caveat. Income of £495m is believed secure but £32m of projected COVID and growth funding is still under discussion. Under the financial regime that applies from 1st October, breakeven is no longer assured. The Committee therefore recommends formal communication with commissioners about two issues: (1) the risk that demand will exceed the activity level used in the forecast (2) the implications of any shortfall in the COVID funding.

## Capital Expenditure Budget 2020/21

An updated version of the capital budget is being presented to the Board. The Committee recommends approval. Compared with the £44.2m budget agreed in July, the latest iteration takes account of additional funding of £6.1m and includes a prioritised plan to manage projects in such a way that the full capital allocation of £50.3m is spent. It should be noted, however, that this allocation has yet to be confirmed.

## Business Cases

The Committee supports approval of two business cases that were also reviewed by the Logistics and Infrastructure Committee (LIC). These are: (1) consolidation of training facilities into two new leased locations following the reconfiguration of ambulance stations, at a cost of £14.7m of which £4m is capital and (2) leasing and equipping a warehouse to replace the five sites that support the Logistics Support Unit; the cost is £10.9m of which £0.9m is capital. The Committee requested that the final versions of these business cases clarify certain costs and benefits.

## Efficiency Programme

The Committee was briefed on the new Cost Improvement Programme (CIP) governance framework. This included the listing of efficiency opportunities amounting to £55m per annum of internal savings and £35m of savings to the wider healthcare system. Work is in hand to validate these opportunities, agree them with Directors, and plan their delivery. CIP activities were suspended during the COVID emergency; the Committee strongly supports the plan to quickly recommence them.

**Other matters considered:**

### Financial Performance, Month 4

The Trust reported a breakeven position to the end of July. Total expenditure amounted to £183.2m, which was £32.4m above budget. COVID expenditure was £33.7m in the period. The system of "top-up" payments, which will end in September, enabled a breakeven position.

### Cash Position

Cash was £58.3m at the end of July, up £32.4m since March. This reflects: receipt of block contract funding a month in advance; low levels of outstanding debts, and a high level of outstanding supplier invoices. Cash flow is projected to remain above the target level for the next 12 months but this depends on remaining in breakeven after September and matching capital expenditure with the related funding.

### Commercial Update

The Committee received an update on the workstreams being progressed by Commercial Services. This mainly focused on issues associated with the involvement of paramedics in Primary Care Networks (PCNs). Work is in hand to find the best way forward.

**Key decisions made / actions identified:**

### Financial Planning

In discussing the Annual Plan for 2020/21, the Capital Budget, business cases, and the Cost Improvement Programme the Committee noted that planned investments are likely to increase the Trust's cost base in the short term, especially because of rental payments and higher depreciation. It was agreed that, at its next meeting, the Committee would review a 3–5 year financial plan that will reflect expected cost developments. This would provide a baseline against which to assess the impact and adequacy of the efficiency programme, the content of which is expected to be finalised within the next month.

### Estate Planning

27 locations are no longer being used as ambulance stations following reconfiguration in response to COVID. The Committee will be updated at its next meeting on the financial impact of the plans for these sites.

### Procurement

The Committee was briefed on progress in building the capacity and capability of the Procurement function. It stressed the importance of the supplier relationship role, where procurement and operational leads will be jointly responsible. It noted the development of category plans and recommended that these should include savings targets.

### Financial Transformation Plan

The Committee discussed the Financial Transformation Plan and the plan to upgrade the costing system. It requested a full progress report at its next meeting. It noted that work is also in hand relating to the structure and resourcing of the Finance function, including a strengthening of business partnering arrangements.

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| **Risks:** | The Committee agreed that there continues to be a BAF risk of failing to achieve breakeven in 2020/21, arising from uncertainty about the level of activity and from the fact that the Trust's allocation of COVID funding after September is not yet resolved.<br><br>As noted, capital allocations have yet to be confirmed, creating a risk around the Trust's ability to fund the agreed capital programme. |
| **Assurance:** | The Committee received reports on financial performance, including cash flow, to the end of July (Month 4). Key figures are noted above. The reports included explanations of variances from budget.<br><br>It also reviewed the forecast for the full year and was briefed on demand scenarios, resource assumptions, the latest financial framework, and the status of discussions with commissioners. This enabled it to reach a consensus view of the uncertainties, risks and possible mitigations. |

London Ambulance Service NHS Trust

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| **Assurance report:** | **Audit Committee** | **Date:** | **03/09/2020** |

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| **Summary report to:** | **Trust Board** | **Date of meeting:** | **29/09/2020** |
| **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:**

**Immunisation OOH – Procurement & Contract Management**

Following a root cause review, a "No Purchase Order, No Contract, No Pay" process has been introduced for contracts over £50k and Single Tender Waivers have been strengthened with further controls to embed cultural change. FIC will monitor this and other actions from the root cause review as part of accelerating the Procurement Transformation programme.

**Counter Fraud**

AC welcomed a comprehensive report but noted a higher volume of cases under investigation and questioned whether this was indicative of wider process and cultural issues. The COO and CFO are to consider and revert with an assurance plan.

**Other matters considered:**

**Scope of CIP audit**

CIP audit in Q4 is being reframed to consider benefit realisation and capital expenditure controls, given the Trust is investing in transformation with a capital programme that has almost doubled.

**Key decisions made / actions identified:**

**Managing our strategic risks**

AC agreed to recommend a new format of the BAF to the Board, incorporating risk appetite gap trend reporting, and to maintain the current reporting frequency.

AC asked the executive to develop a broader assurance reporting framework, review the LAS Risk Management model and how it maintains oversight of the interplay and delineation between strategic and operational risks and consider embedding risk management through process ownership. Director attestations would be introduced as part of the latter to enhance the 20/21 year-end assurance process.

AC asked that Audit & Risk "clinics" be introduced with the CEO present to stay on top of key risks and audit recommendations.

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| **Risks:** | **Single Tender Waivers**<br>AC expressed its ongoing concern with the organisation's over-reliance on STW's and the need to see these coming down and being effectively controlled. This will become an AC agenda point with Finance providing an assurance report including trends and progress. |
| **Assurance:** | **Absence & Sickness Management**<br>Internal audit's findings - Significant assurance with some improvements required. AC observed that more work is required to address staff perceptions in applying the policy empathetically.<br><br>**Data Security and Protection Toolkit**<br>Internal audit's findings – Partial assurance with improvement required. AC acknowledged good progress in this area, with 73% compliance and NHSD recognising our SIRO training arrangements. |

London Ambulance Service NHS Trust

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| **Assurance report:** | **Logistics and Infrastructure Committee** | **Date:** | **15/09/2020** |

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| **Summary report to:** | **Trust Board** | **Date of meeting:** | **29/09/2020** |
| **Presented by:** | **Sheila Doyle, Non-Executive Director, Chair of Logistics and Infrastructure Committee** | **Prepared by:** | **Sheila Doyle** |

**Matters for escalation:**

The business case for Training Consolidation and Logistic Support Unit were discussed in detail. Members requested further assurance on the wider strategic benefits of each case and recommended a number of amendments prior to review by the FIC and submission to the Board for approval.

The Committee agreed that due to the volume of business cases currently being developed it is essential to ensure that an integrated report is produced, linking business cases to the Trust Strategy and clearly outlining delivery of efficiencies and performance improvements.

**Other matters considered:**

Members received a paper outlining the next stage of the Bow Modernisation Programme including drivers for the case, scope, options appraisal, and timelines to delivery of the outline business case (OBC).

A discussion paper was presented in support of the Trust's 999/111 integration strategy as well as in response to COVID-19. The focus of the paper was in respect of estate and infrastructure investment at Maritime House (Barking) and Southern House (Croydon).

Members requested that both papers are updated to provide assurance on investment requirements, expected benefits and alignment to the Estates Strategy and wider system changes.

Members reviewed the integrated performance report for IM&T, Fleet and Estates. Further work is required to ensure that fire risk assessments and fire drills are up to date. Members discussed the challenges of retrieving call recordings from the current outdated system. This matter will be escalated to the Audit committee if current resolution proposals are unsuccessful.

The CAD replatform project is on track to go live on Sept 15th. This project will provide much needed resilience for the CAD system over the winter period and in advance of the CAD modernisation project that is expected to conclude in mid-2021.

The committee welcomed the Project and Programmes (P&P) report and were pleased to note the level of integration between P&P, Finance

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| | and Procurement. P&P and Finance will be working together to develop the 5 year plan including integrated benefits tracking. |
| **Key decisions made / actions identified:** | Members welcomed plans to invest in culture and leadership development within IM&T and requested a more detailed update at the November LIC.<br><br>The Fleet Strategy is being developed and members agreed to review the proposal offline and to provide any feedback to the team in advance of a formal review at the November LIC.<br><br>A short paper explaining the various Power, cooling and UPS repair and maintenance work will be presented to the Nov meeting. |
| **Risks:** | Members were informed that the score for BAF risk 58 has been reviewed as requested. It is 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 residual risk rating from 12 to 16 to reflect the increased dependency on critical IT systems. |
| **Assurance:** | Training Consolidation and LSU business cases were not approved due to gaps in assurance. The papers will be updated prior to submission for approval.<br><br>There is evidence of good progress on IM&T infrastructure & cyber remediation.<br><br>Members discussed the quality and detail of the papers received and agreed that more work is required to address gaps in business cases. That said, the focused and proactive discussion allowed the Non-Executive Directors to provide a good level of challenge as well as identify key issues that needed further clarification. |

London Ambulance Service NHS
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| **Assurance report:** | **Digital 999 Programme Assurance Board** | **Date:** | **10/09/2020** |

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| **Summary report to:** | **Trust Board** | **Date of meeting:** | **29/09/2020** |
| **Presented by:** | **Sheila Doyle, Non-Executive Director, Chair of Digital 999 Programme Assurance Board** | **Prepared by:** | **Sheila Doyle** |

**Matters for escalation:**

Both projects remain at Amber status due to a combination of technical challenges and resource constraints.

Initial feedback on ePCR pre-live trial has been very positive with 93 active users on the system.

CAD project is running 3-4 weeks behind schedule due to delays in server build and resource constraints in IM&T. Some delays can be absorbed by existing contingency within the plan. Despite this slippage, timescales remain in line with FBC 'most likely' scenario.

The program is tracking a key risk regarding the impact of a second wave of Covid-19 which in the near-term could impact CSR ePCR training and CAD EOC design workshops, should guidance on social distancing / local lockdowns change.

In addition, there is a key CAD development risk relating to expected timeframe for CAD Cleric development and whether current planning assumptions are correct. EOC design workshops taking place over September and early October will provide a clearer view of the scale of Cleric development and timelines.

**Other matters considered:**

Members received feedback from 2 paramedics who are actively using the ePCR system. The feedback was very positive and reflects initial feedback received on social media. The Chief Clinical Information Officer will continue to survey users through structured and unstructured channels.

Members considered the feedback on hospital handover challenges and iPad battery life and were informed that both matters are being addressed.

Members received a report on the program financial performance and noted that both projects are tracking slightly under plan. The report also set out the cash and non-cash releasing benefits, which will be considered in detail at the November PAG.

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| **Key decisions made / actions identified:** | Deep dive into benefits realisation planning will take place in November.<br><br>Scope of the next PWC review was agreed. In addition, PWC are invited to attend all future PAG meetings. |
| **Risks:** | The team is actively managing a technical risk relating to dual site resilience for ePCR in order to mitigate any delay to the full-live ePCR deployment timeline. This is a pre-requisite for Go-live and the team are confident this will be resolved before full-live. |
| **Assurance:** | The PAG received a report on the first audit review conducted by PWC. The review focused on program governance and project controls and concluded that the program is progressing well with new governance arrangements reflecting good practice.<br><br>The report highlighted areas of attention including stronger articulation of the strategic benefits, greater focus on benefits realisation, ensuring CAD operational processes meet LAS needs and further attention to change management and adoption.<br><br>Members received a report on operational readiness which has been signed off by IM&T, Clinical & Communications Directors. In addition, clinical input at QAC has been confirmed by the Chair of the Quality Assurance Group.<br><br>Members received a report on the ePCR testing exit criteria. The User Acceptance testing completed 100 clinical scenario tests, 20 defects were discovered which were resolved and approved during the re-testing phase. The report confirmed that of the 249 additional functional and non-functional tests outlined in the Cleric tender submission, 149 passed, 59 were not applicable and 41 part/fail tests have no impact on the pre-live or go-live. |

London Ambulance Service NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report to:** | **Trust Board** | | | |
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | M4 Finance Report | | | |
| **Agenda item:** | 9.1 | | | |
| **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 purpose of this paper is to set out the financial position for the Trust as at 31 July 2020.

Key points to note are that the Trust:

- Has a breakeven position as at the end of July 2020 in line with the interim financial framework established by NHS England
- Has a cash balance of £58.3m at the end of July
- £33.7m of revenue COVID 19 expenditure has been incurred to the 31 July 2020
- The Trust Capital Resource Limit for the remainder of the year is agreed by the STP at £44.2m, however requires formal notification. A further £6.1m of CRL has been identified for brokerage from within NWL HCP which will increase the Trust's 2020-21 CRL limit to £50.3m.

The Trust has received confirmation from NHS England that the current interim arrangements of base allocations and monthly retrospective top up will continue to the end of September.

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

The Board is asked to review and note the financial position of the Trust at the end of July, 2020/21.

**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 | | |

London Ambulance Service NHS Trust

# Finance Report

## Month 4: July 2020

# Key Headlines

This paper updates on the financial position as at the end of July 2020 (month 4, financial year 2020-21).

The Trust is operating under an adjusted financial framework (which has now been extended to September 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 4 (£105k surplus YTD before measurement adjustments in relation to donated assets).

The amount of additional M4 retrospective top up requested to balance the Trust's position was £9.368m (YTD: £35.802m M1: £10.734m, M2: £8.110m, M3: £7.59m). This is higher than the Trust's M4 reported COVID costs of £6.617m (YTD: £33.685m M1: £12.915m, M2: £7.345m, M3: £6.807m) due to the in month recognition of costs in relation to the write off of assets connected with the Trust's dispatch system (£2.6m) which is being replaced but was only approved in late March 2020 after the submission of the Trust's pre-COVID plan. The write-off was intended to be covered from general contingency budgets and was therefore not expected to be a pressure for the full year, however as the retrospective top-up mechanism requires break-even in month, the in month charge has formed part of the retrospective top up claim. Recognition of the cost has only now crystallised following review of the assets by internal Programme boards.

Month 4 YTD expenditure incorporates the below:

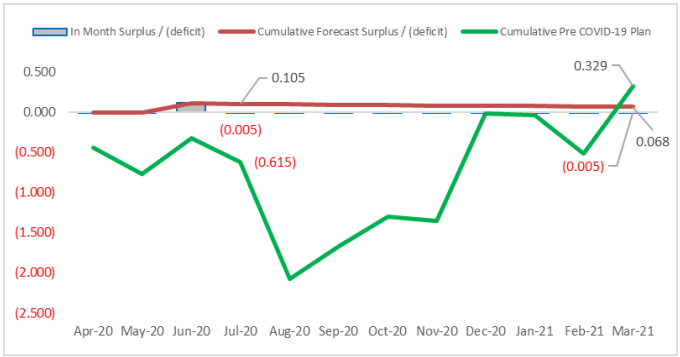
1. Pay expenditure of £120.5m YTD, £13.6m higher than the pre-COVID business plan. It is also £13.6m higher than expected in NHSI planning primarily due to COVID-19 costs (£10.7m YTD), with the remainder due to higher than expected increases in AfC costs (£1.4m) and increased use of higher cost resourcing (agency and incentives £1.7m).
2. Non pay operating expenditure (including depreciation but excluding finance costs) is £60.6m YTD, £18.3m higher than the pre-COVID business plan. Compared to central NHSI planning expectations this is £23.1m higher than expected due primarily to COVID-19 costs (£23m YTD). Higher depreciation than expected in NHSI planning (£1.5m) and the write back of CAD assets (£2.6m) was offset by underspends in non-pay spend for non COVID-19 activity due to reduced focus on non-COVID areas.

The Trust finished the month with a cash position of £58.3m.

Capital spend was £5.6m YTD which includes the reversal of £2.3m of capital in connection with CAD upgrade work in progress costs as part of the approved CAD replacement project and COVID-19 response requirements capital spend which amounted to £5.2m YTD. The Trust is currently still forecasting to spend £44.2m in line with its June 2020 revised capital plan.

# Key Financial Indicators

## Surplus / (Deficit)




| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |

- The month 4 in-month position was a £5k deficit (breakeven on an adjusted financial performance basis) in line with NHSI requirements
- The month 4 YTD position was a £105k surplus (breakeven on an adjusted financial performance basis) in line with NHSI requirements
- The full year forecast position at month 4 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 September 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 £33.7m 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 £35.8m.

## Use of Resources Rating

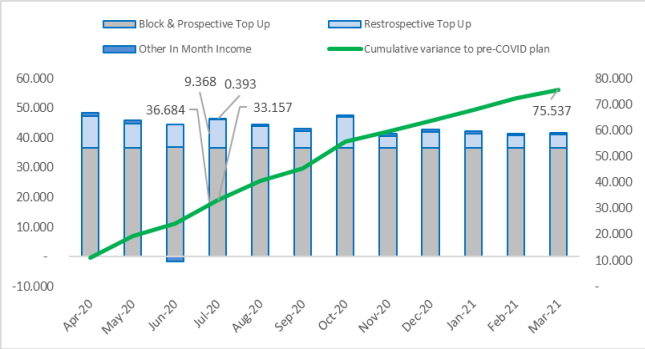
| | YTD | | Full year | |
|---|---|---|---|---|
| | Plan | Actual | Plan | Actual |
| Capital service cover rating | | | | |
| Liquidity rating | | | | |
| I&E margin rating | | | | |
| Variance from control total | | | | |
| Agency rating | | | | |
| **Overall rating** | | | | |

| M4 | 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

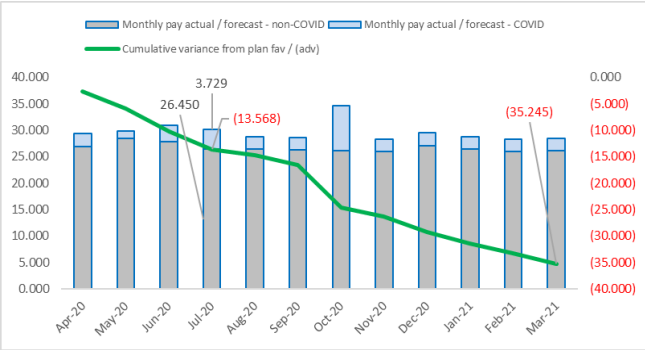
## Income




| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |

- YTD and forecast income assumptions are in line with the current financial framework for April to September 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 (£35.8m YTD, FY forecast £81.1m).
- Other Operating Income is £48.1 YTD (FY forecast £116m) which is comprised mainly of top up and retrospective top up income £46.4m YTD (FY forecast £113m) and Education & Training Income £1.3m YTD (FY forecast £2.4m).
- The total income position is £33.2m higher than pre-COVID plan YTD (FY forecast £75.5m higher than pre-COVID plan).

## Pay Expenditure

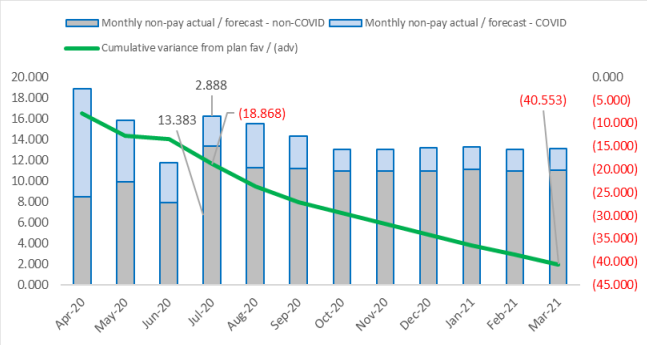



| M4 | YTD | Forecast |
|---|---|---|
| AMBER | AMBER | AMBER |

- Pay expenditure is £120.5m YTD, £13.6m higher than expected in NHSI planning due primarily to COVID-19 costs (£10.7m YTD), with the remainder due to higher than anticipated increases in AfC costs (£1.4m) and increased use of higher cost resourcing (agency and incentives).
- £0.3m of previously capitalised pay costs related to the CAD replacement project were written back in the in month position.
- Pay Expenditure is currently forecast to be £35.2m higher than pre-COVID plan across the financial year primarily due to COVID-19 costs (forecast to be £35.7m YTD).

# Key Financial Indicators

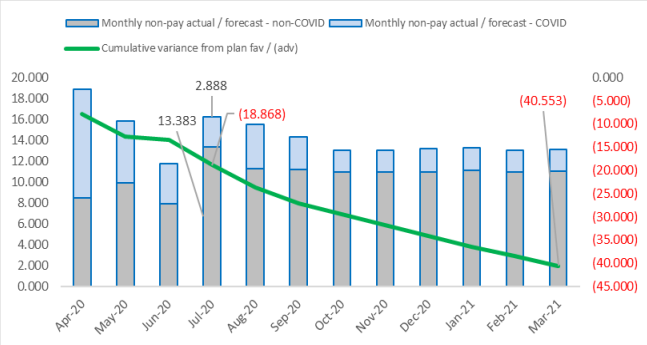
## Non-Pay Expenditure




| M4 | YTD | Forecast |
|---|---|---|
| AMBER | AMBER | AMBER |

- Non pay expenditure including depreciation and finance costs was £62.7m YTD, £18.9m higher than the pre-COVID business plan (forecast FY overspend £40.6m).
- Non pay COVID-19 costs are £23m YTD (FY forecast £43m) 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.
- £1.9m of previously capitalised non pay costs (hardware, software and professional fees) related to the CAD replacement project were written back as expenditure in the in month position.
- This was offset by underspends in non-pay spend for non COVID-19 activity (£6.1m YTD) due to reduced focus on non-COVID areas and lower than pre-COVID budgeted depreciation.

## Agency Ceiling




| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |

- YTD agency spend is £2.3m compared to the cumulative YTD agency ceiling of £3m.
- Full year agency spend is currently forecast to be £3.8m, which is £5.1m 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

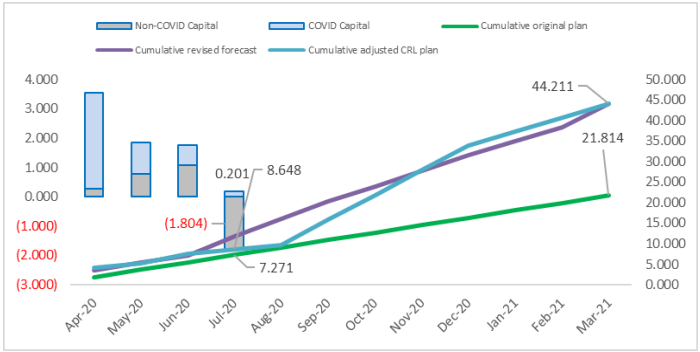
## Cost Improvement Programme

| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |

- **The Trust is operating under an adjusted financial framework for April to September 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.**

## Capital Expenditure

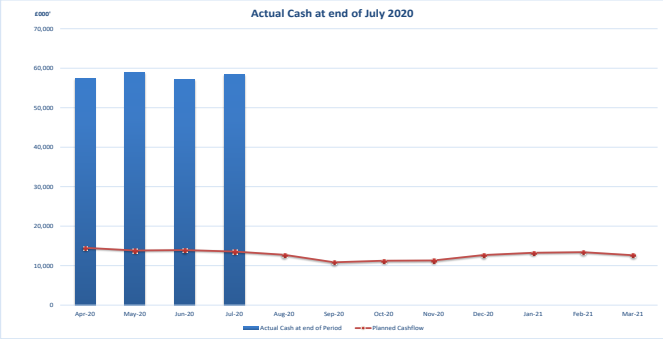
| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |




- YTD capital expenditure is £5.6m YTD compared to planned capital expenditure of £8.6m (£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 £5.2m spent YTD primarily on expanding IT and telephony systems, additional IT equipment and additional clinical equipment.
- The Trust's YTD capital spend position has been impacted in month by the reversal of £2.3m of capital work in progress costs in connection with the Trust Board approved CAD replacement project.

# Key Financial Indicators

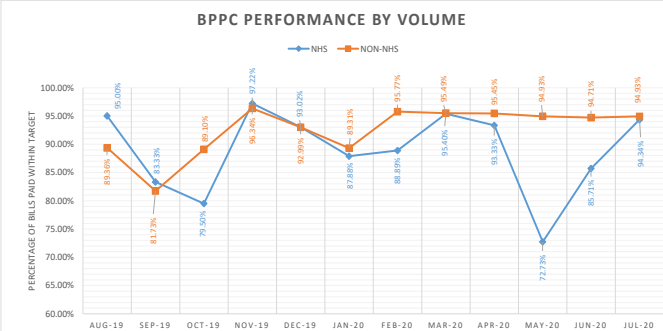
## Cash




| M4 | YTD | Forecast |
|---|---|---|
| GREEN | GREEN | GREEN |

- Cash was £58.3m as at 31 July 2020, £44.8m 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 July. Cash balances are expected to reduce from September onwards as this arrangement ceases in the present form at that point.

## Better Payment Practice Code




| M4 | YTD | Forecast |
|---|---|---|
| AMBER | AMBER | AMBER |

- 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 July 2020 was 94.3% and 94.9% 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 wherever possible. At present whilst only 12% of invoices were paid within 7 days based on their invoice date (26% based on date received), invoices are put on the next payment run regardless of due dates as soon as they are authorised for payment. The Trust currently makes two payment runs to suppliers each week.

# COVID-19 Response Expenditure

| | Actual £000 YTD Month 4 2020-21 | Actual £000 Apr-20 | Actual £000 May-20 | Actual £000 Jun-20 | Actual £000 Jul-20 |
|---|---|---|---|---|---|
| Additional Staff Costs (EOC and Ambulance Services) | **6,718** | 1,677 | 801 | 1,894 | 2,347 |
| NHS 111 Additional Capacity - Staff | **2,953** | 297 | 527 | 890 | 1,239 |
| NHS 111 Additional Capacity - External Contracts | **4,885** | 979 | 1,849 | 1,330 | 726 |
| Decontamination Services - Premises | **541** | 116 | 206 | - 16 | 236 |
| Defibrillators, Medical and Ambulance Equipment | **799** | 1,229 | 191 | - 681 | 59 |
| IT Support | **1,212** | 370 | 496 | 43 | 303 |
| Private Ambulance Services | **1,694** | 558 | 638 | 593 | - 95 |
| Vehicle Leasing | **107** | 26 | 29 | 38 | 14 |
| Telephony, Radio and IT Systems Expansion | **2,039** | 906 | 112 | 848 | 173 |
| Accommodation | **953** | 400 | 344 | 241 | - 33 |
| Personal Protective Equipment | **3,384** | 3,639 | 905 | - 1,165 | 5 |
| Fleet Maintenance and Preparation | **4,688** | 1,531 | 621 | 1,535 | 1,001 |
| Critical Care Transfer Service | **984** | 524 | 242 | 167 | 50 |
| Property Adjustments and Expansions | **381** | 148 | 48 | 123 | 62 |
| Other | **2,347** | 516 | 336 | 965 | 530 |
| **Total COVID-19 Expenditure** | **33,685** | **12,915** | **7,346** | **6,807** | **6,617** |

The Trust has incurred £33.7m of COVID 19 incremental costs YTD (M1 12.9m, M2: £7.3m, M3: £6.807m, M4: £6.617m) 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 (£6.7m 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, protective face visors, glasses, masks and filters.
- Accommodation (£1m YTD) for accommodation for staff to support isolation requirements. This local provision has now ceased and only the national scheme will be used in future.
- NHS 111 Additional Capacity Staff (£3m YTD) for additional resourcing through internal sources.
- NHS 111 Additional Capacity External Contracts (£4.9m YTD) for additional clinician resources such as GPs, nurses and advanced practitioners (£1.7m) and additional non-clinical call handling resource support (£3m).
- Fleet Maintenance and Preparation (£4.7m YTD) additional external fleet maintenance support and preparation resources for cleaning higher numbers of vehicles more frequently.
- Defibrillators, Medical and Ambulance Equipment (£0.8m YTD) for additional defibrillators, ambulance and medical equipment for the expanded fleet.
- Private Ambulance Services (£1.7m) for additional private ambulance resources
- Telephony & IT Systems Expansions (£2m YTD) expanding the capacity of telephony and technical systems and equipment.
- IT Support (£1.2m YTD) IT support resources
- Critical Care Transfer Service (£1m YTD) which was stood up in conjunction with London Nightingale Hospital and now supports hospital transfers. Staffing (£0.6m), consumables, equipment and support services (£0.4m).
- Decontamination Services - Premises (£0.5m YTD) for increased frequency of premises cleaning.

The Trust is actively reviewing its COVID-19 response in conjunction with partners to minimise cost whilst maintaining resilience and resource capacity throughout this challenging period.

# Movement in Forecast Outturn

| Directorate / Division | Annual Budget | M3 Forecast | M4 Forecast | M3 to M4 Movement fav/(adv) | COVID-19 Total Cost in Positions |
|---|---|---|---|---|---|
| Chief Executive | (2,718) | (2,556) | (2,578) | (22) | 0 |
| Chairman & Non-Executives | (157) | (114) | (114) | (0) | 0 |
| People & Culture | (8,937) | (8,066) | (8,074) | (8) | 0 |
| Communication & Engagement | (3,175) | (2,454) | (2,444) | 10 | 0 |
| Ambulance Services | (217,858) | (253,733) | (254,465) | (732) | (28,714) |
| 999 Operations | (35,573) | (44,211) | (42,822) | 1,390 | (3,476) |
| IUC Services | 450 | (43,154) | (42,814) | 340 | (14,968) |
| Performance | (1,593) | (1,317) | (1,437) | (120) | 0 |
| Programmes & Projects | (2,685) | (3,803) | (5,854) | (2,051) | 0 |
| COO Management | (1,118) | (1,219) | (1,144) | 76 | 0 |
| Corporate Governance | (860) | (660) | (732) | (72) | 0 |
| Finance | (4,319) | (3,609) | (3,746) | (137) | 0 |
| Strategy, Tech & Development | (1,004) | (1,180) | (1,011) | 169 | 0 |
| IM&T | (14,761) | (18,330) | (18,343) | (14) | (3,789) |
| Medical | (25,157) | (22,242) | (22,807) | (565) | (984) |
| Quality & Assurance | (11,301) | (10,862) | (10,752) | 110 | 0 |
| Strategic A&P Management | (367) | (160) | (164) | (4) | 0 |
| Property | (10,590) | (13,327) | (14,216) | (890) | (1,536) |
| Fleet & Logistics | (39,317) | (59,693) | (59,593) | 100 | (21,723) |
| **Directorate Sub-Total** | **(381,041)** | **(490,690)** | **(493,111)** | **(2,421)** | **(75,189)** |
| Central Income | 415,459 | 520,414 | 520,369 | (45) | 0 |
| Central Depreciation & Fin Charges | (20,033) | (19,487) | (19,339) | 149 | 0 |
| Apprenticeship levy | (1,009) | (1,484) | (1,358) | 126 | 0 |
| Legal Provisions | (1,012) | (916) | (890) | 26 | 0 |
| Other central costs & income | (185) | 1,233 | 525 | (709) | 0 |
| Net Reserves incl Unallocated CIP | (11,849) | (5,000) | (2,357) | 2,643 | 0 |
| COVID-19 Income and Central Costs | 0 | (4,003) | (3,771) | 231 | (3,471) |
| **Central Sub-Total** | **381,371** | **490,758** | **493,179** | **2,421** | **(3,471)** |
| **Total surplus / (deficit)** | **329** | **68** | **68** | **(0)** | **(78,661)** |

**Commentary on key forecast movements**

**1. Ambulance Services**

- Increase in FY forecast cost between M3 and M4 primarily due to increased subsistence forecast (£250k), increased HART estate costs (£380k) and increased vehicle leasing costs (£110k)

**2. 999 Operations**

- Decrease in FY forecast cost between M3 and M4 due to increased attrition and subsequent decreased substantive staff forecast (0.7m) and decreased non-substantive staff forecast (bank, overtime and incentives (£0.6m).

**3. Programmes & Projects**

- Increase in full year forecast between M3 and M4 due to the inclusion of revenue costs in relation to the Digital 999 Programme (£2m) including write back of capital WIP.

**4. Medical**

- Increase in FY forecast cost between M3 and M4 due to increased forecast clinical education and training costs (£0.5m).

**5. Property**

- Increase in FY forecast between M3 and M4 primarily due to increased premises services costs (incl building maintenance) £0.8m, and increased rent, rates, service charges and utilities forecasts (£0.1m).

**6. Central Income and Costs**

- Net reserves incl unallocated CIP forecast movement between M3 and M4 due to the reduction of £5m contingency budget by £2.6m to reflect cost of CAD upgrade write back costs on the D999 programme.
- Other Central Costs and Income forecast movement between M3 and M4 due to notification from HEE of a decrease in education and training income of £0.7m.

# Supporting Information

# SOCI

| | Month 4 2020-21 £000 | | | YTD Month 4 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 | 37,188 | 34,608 | (2,579) | 148,337 | 135,180 | (13,156) | 445,785 | 411,276 | (34,509) |
| Other Operating Income | 172 | 11,837 | 11,664 | 1,804 | 48,117 | 46,313 | 5,933 | 115,978 | 110,045 |
| **Total Income** | **37,360** | **46,445** | **9,085** | **150,141** | **183,298** | **33,157** | **451,717** | **527,254** | **75,537** |
| **Operating Expense** | | | | | | | | | |
| Pay | (26,809) | (30,179) | (3,370) | (106,906) | (120,474) | (13,568) | (320,747) | (355,992) | (35,245) |
| Non Pay | (9,159) | (14,006) | (4,847) | (37,050) | (56,417) | (19,367) | (109,546) | (149,599) | (40,053) |
| **Total Operating Expenditure** | **(35,968)** | **(44,185)** | **(8,217)** | **(143,956)** | **(176,891)** | **(32,935)** | **(430,293)** | **(505,592)** | **(75,298)** |
| **EBITDA** | **1,392** | **2,260** | **868** | **6,185** | **6,407** | **222** | **21,424** | **21,662** | **238** |
| **EBITDA margin** | 3.7% | 4.9% | 1.1% | 4.1% | 3.5% | (0.6%) | 4.7% | 4.1% | (0.6%) |
| **Depreciation & Financing** | | | | | | | | | |
| Depreciation & Amortisation | (1,288) | (1,291) | (3) | (5,220) | (4,145) | 1,075 | (16,356) | (15,863) | 493 |
| PDC Dividend | (388) | (616) | (228) | (1,552) | (1,780) | (228) | (4,656) | (5,340) | (684) |
| Finance Income | 8 | 0 | (8) | 32 | (4) | (36) | 100 | (4) | (103) |
| Finance Costs | (15) | (2) | 13 | (60) | (17) | 43 | (182) | (34) | 148 |
| Gains & Losses on Disposals | 0 | (355) | (355) | 0 | (355) | (355) | 0 | (354) | (354) |
| **Total Depreciation & Finance Costs** | **(1,683)** | **(2,265)** | **(582)** | **(6,800)** | **(6,301)** | **499** | **(21,095)** | **(21,595)** | **(500)** |
| **Net Surplus/(Deficit)** | **(291)** | **(5)** | **286** | **(615)** | **105** | **721** | **329** | **68** | **(262)** |
| **NHSI Adjustments to Fin Perf** | | | | | | | | | |
| Remove Donations I&E Impact | 3 | 5 | 2 | 13 | (105) | (118) | 38 | (68) | (106) |
| **Adjusted Financial Performance** | **(288)** | **(0)** | **288** | **(603)** | **(0)** | **603** | **368** | **(0)** | **(368)** |
| **Net margin** | (0.8%) | (0.0%) | 0.8% | (0.4%) | 0.1% | 0.5% | 0.1% | 0.0% | (0.3%) |

**Year to Date Position**

The YTD position is a £105k 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 now incorporates extended COVID response requirements expected 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 £13.2m YTD and £34.8m FY forecast.
- Other operating income is favourable to pre-COVID plan by £46.3m YTD (£110m full year forecast) due to the inclusion of monthly top up and retrospective top up income under the current interim financial arrangements (£46.4m YTD and £113m full year forecast) which covers the Trust's COVID response related expenditure and ensures a breakeven position.
- Pay expenditure is currently £13.6m adverse to pre-COVID plan YTD, and forecast to end the year £35.2m adverse to pre-COVID plan primarily due to COVID-19 response costs (£10.7m YTD and £35.7m FY forecast).
- Non pay expenditure is £19.4m adverse to pre-COVID plan YTD, and forecast to end the year £40.1m adverse to pre-COVID plan primarily due to COVID-19 response costs (£23m YTD and £43m FY forecast).
- Depreciation and finance costs are £0.5m favourable YTD (£0.5m 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 (£0.7m) and OneLondon project depreciation (£0.4m).

# Financial Position by Directorate

| Directorate | Month 4 2020-21 £000 | | | | | YTD Month 4 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 | (235) | (211) | | (211) | 24 | (941) | (832) | | (832) | 109 | (2,718) | (2,578) | | (2,578) | 139 |
| Chairman & Non-Executives | (13) | (12) | | (12) | 1 | (52) | (21) | | (21) | 31 | (157) | (114) | | (114) | 43 |
| People & Culture | (749) | (499) | | (499) | 250 | (2,863) | (1,418) | | (1,418) | 1,445 | (8,937) | (8,074) | | (8,074) | 863 |
| Communication & Engagement | (264) | (203) | | (203) | 61 | (1,026) | (734) | | (734) | 292 | (3,175) | (2,444) | | (2,444) | 731 |
| Ambulance Services | (18,147) | (21,350) | (2,077) | (19,273) | (1,127) | (72,091) | (85,999) | (7,633) | (78,367) | (6,276) | (217,858) | (254,465) | (28,714) | (225,751) | (7,893) |
| 999 Operations | (2,951) | (3,458) | (199) | (3,259) | (308) | (11,740) | (15,330) | (986) | (14,343) | (2,603) | (35,573) | (42,822) | (3,476) | (39,346) | (3,772) |
| IUC Services | 60 | (4,202) | (1,989) | (2,214) | (2,273) | 160 | (17,394) | (7,998) | (9,396) | (9,555) | 450 | (42,814) | (14,968) | (27,846) | (28,296) |
| Performance | (136) | (114) | | (114) | 21 | (542) | (444) | | (444) | 98 | (1,593) | (1,437) | | (1,437) | 156 |
| Programmes & Projects | (221) | (2,844) | | (2,844) | (2,623) | (884) | (3,323) | | (3,323) | (2,439) | (2,685) | (5,854) | | (5,854) | (3,170) |
| COO Management | (89) | (106) | | (106) | (17) | (355) | (400) | | (400) | (45) | (1,118) | (1,144) | | (1,144) | (26) |
| Corporate Governance | (72) | (72) | | (72) | 0 | (285) | (264) | | (264) | 21 | (860) | (732) | | (732) | 128 |
| Finance | (363) | (309) | | (309) | 54 | (1,454) | (1,193) | | (1,193) | 261 | (4,319) | (3,746) | | (3,746) | 572 |
| Strategy, Tech & Development | (91) | (85) | | (85) | 6 | (363) | (309) | | (309) | 54 | (1,004) | (1,011) | | (1,011) | (7) |
| IM&T | (1,227) | (1,312) | (325) | (987) | 240 | (4,920) | (7,130) | (2,673) | (4,457) | 464 | (14,761) | (18,343) | (3,789) | (14,555) | 207 |
| Medical | (2,072) | (1,668) | (50) | (1,617) | 455 | (8,200) | (6,915) | (984) | (5,931) | 2,269 | (25,157) | (22,807) | (984) | (21,823) | 3,333 |
| Quality & Assurance | (940) | (878) | | (878) | 62 | (3,755) | (3,510) | | (3,510) | 245 | (11,301) | (10,752) | | (10,752) | 550 |
| Strategic A&P Management | (31) | (18) | | (18) | 13 | (122) | (62) | | (62) | 60 | (367) | (164) | | (164) | 203 |
| Property | (874) | (1,600) | (275) | (1,325) | (451) | (3,593) | (5,108) | (824) | (4,284) | (691) | (10,590) | (14,216) | (1,536) | (12,680) | (2,090) |
| Fleet & logistics | (3,337) | (4,467) | (1,178) | (3,289) | 48 | (13,359) | (21,485) | (9,926) | (11,558) | 1,801 | (39,317) | (59,593) | (21,723) | (37,870) | 1,447 |
| **Directorate Sub-Total** | **(31,750)** | **(43,406)** | **(6,094)** | **(37,312)** | **(5,562)** | **(126,386)** | **(171,869)** | **(31,025)** | **(140,845)** | **(14,459)** | **(381,041)** | **(493,111)** | **(75,189)** | **(417,922)** | **(36,880)** |
| Central Income | 34,341 | 46,182 | 6,617 | 39,565 | 5,224 | 137,886 | 180,538 | 33,986 | 146,552 | 8,667 | 415,459 | 520,369 | 78,961 | 441,408 | 25,949 |
| Central Corporate | (2,882) | (2,781) | (523) | (2,258) | 624 | (12,115) | (8,563) | (2,961) | (5,602) | 6,513 | (34,088) | (27,190) | (3,771) | (23,418) | 10,670 |
| **Total** | **(291)** | **(5)** | **0** | **(5)** | **286** | **(615)** | **105** | **0** | **105** | **721** | **329** | **68** | **0** | **68** | **(262)** |

**IUC Services**

- Overspends excl COVID of £9.6m YTD (£28.3m 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 £8m YTD (£15m FY forecast) primarily in relation to increased call handling and clinical resourcing compared to pre-COVID planning.
- YTD expenditure excl COVID is £0.1m higher than pre-COVID plan, and forecast to be £0.1m lower for the full year.

**Ambulance Services**

- Overspends excl COVID YTD (£6.3m) and FY forecast (£7.9m) are due primarily to overtime, incentives and private ambulance covering vacancies and providing specialist support (the forecast for which has been extended to cover response requirements over the remainder of the financial year).
- COVID-19 costs are £7.6m YTD (full year forecast £28.7m) primarily in relation to increased resourcing levels in preparation for higher absence rates and longer out of service.

**999 Operations**

- Overspends excl COVID YTD (£2.6m) and FY forecast (£3.8m) are due primarily to overtime and incentives (£1.9m YTD and full year forecast £2.2m adverse variances) and over-establishment in the 999 Quality & Continuous Improvement area (£0.6m YTD and full year forecast £1.2m adverse variances).
- COVID-19 costs are £1m 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**

- YTD overspend of £2.4m (full year forecast £3.2m) excl COVID driven by Digital 999 project costs £2.4m YTD (£2.8m full year forecast), and central project management overspends (£0.2m full year forecast).

**Fleet & Logistics**

- Underspend excl COVID of £1.8m YTD (£1.4m FY forecast) driven by reduced underlying transport costs primarily in relation to fuel discounting (£1.1m YTD, £0.9m FY forecast) and fleet maintenance and insurance costs (YTD underspend £0.5m, FY forecast underspend £0.8m).
- COVID-19 costs of £9.9m YTD (full year forecast £21.7m) 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 £2.7m YTD (full year forecast £3.8m) relate primarily to IT equipment and IT services to enable home working, and systems and telephony expansions.

**Medical**

- Favourable variance excl COVID of £2.3m YTD (forecast full year £3.3m favourable) driven by net vacancies (£1.9m favourable YTD, £2.7m favourable FY forecast) primarily re APPs, lower than planned trainee costs and Clinical Education & Training vacancies.
- COVID-19 costs of £1m YTD (FY forecast £1m) relating to the Critical Care Transfer Service.

**Property**

- YTD overspend of £0.7m excl COVID (full year forecast £2.1m) driven by premises services, utilities and rent, rates and service charges (£0.5m overspend YTD, FY forecast overspend £2m).
- COVID-19 costs of £0.8m YTD (FY forecast £1.5m) relate primarily to increased premises cleaning and facilities adjustments to facilitate new operating models.

# Income

| Income by Type | Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | YTD Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | Full Year 2020-21 £000 Budget | Forecast | Budget Variance fav/(adv) |
|---|---|---|---|---|---|---|---|---|---|
| **Patient Care Income** | | | | | | | | | |
| Commercial Service Income | 212 | 86 | (126) | 847 | 334 | (514) | 2,541 | 1,175 | (1,366) |
| Emergency & Urgent Care Income | 33,836 | 34,027 | 191 | 134,886 | 133,610 | (1,276) | 405,710 | 405,831 | 121 |
| Emergency Bed Service Income | 8 | 0 | (8) | 31 | 0 | (31) | 93 | 0 | (93) |
| Injury Cost Recovery Income | 119 | 85 | (34) | 505 | 341 | (164) | 1,257 | 1,022 | (235) |
| Neonatal Service Income | 38 | 12 | (26) | 163 | 32 | (131) | 491 | 130 | (361) |
| Non-Contract E&UC Income | 8 | 14 | 6 | 63 | 33 | (30) | 229 | 122 | (106) |
| Other Patient Care Income | 33 | 181 | 147 | 133 | 19 | (114) | 264 | 562 | 298 |
| Patient Transport Service Income | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Specialist Service Income | 560 | 203 | (357) | 2,241 | 812 | (1,429) | 6,720 | 2,433 | (4,287) |
| Telephone Advice Service Income | 2,372 | 0 | (2,372) | 9,467 | 0 | (9,467) | 28,481 | 0 | (28,481) |
| **Total Patient Care Income** | **37,188** | **34,608** | **(2,579)** | **148,337** | **135,180** | **(13,156)** | **445,785** | **411,276** | **(34,509)** |
| **Other Operating Income** | **172** | **11,837** | **11,664** | **1,804** | **48,117** | **46,313** | **5,933** | **115,978** | **110,045** |
| **Total Income** | **37,360** | **46,445** | **9,085** | **150,141** | **183,298** | **33,157** | **451,717** | **527,254** | **75,537** |

The Trust is currently operating under an adjusted financial framework for the period April to September 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 YTD position by the crediting of invoices issued in relation to the Flowers case (£2.5m) in M3.

*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 £0.5m and £1.4m respectively.

*Specialist Service Income*

- £1.4m 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 £35.8m YTD and full year forecast of £81.1m.

*Education & Training*

- Training and Development funding is £0.5m favourable YTD and forecast to be £0.5m favourable full year due to revised allocations from HEE.
- YTD and full year forecast apprenticeship income is on plan.

# Pay Expenditure

| Pay Expenditure by Type | Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | YTD Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | Full Year 2020-21 £000 Budget | Forecast | Budget Variance fav/(adv) |
|---|---|---|---|---|---|---|---|---|---|
| **Substantive** | | | | | | | | | |
| Corporate & Support Staff | (3,222) | (2,758) | 464 | (12,826) | (10,657) | 2,169 | (38,875) | (32,633) | 6,242 |
| Directors And Senior Managers | (1,543) | (1,299) | 245 | (6,169) | (4,846) | 1,323 | (18,234) | (14,745) | 3,489 |
| Frontline Control Staff | (2,132) | (2,104) | 27 | (8,516) | (8,277) | 240 | (26,026) | (26,185) | (159) |
| Frontline Ops Staff | (15,340) | (14,947) | 392 | (60,810) | (58,774) | 2,036 | (183,843) | (180,501) | 3,342 |
| Med, Nursing & Clin Adv Staff | (625) | (613) | 12 | (2,505) | (2,576) | (71) | (7,483) | (7,678) | (196) |
| Non-Emergency Control Staff | (35) | (12) | 23 | (140) | (56) | 84 | (424) | (153) | 271 |
| Non Emergency Ops Staff | (392) | (438) | (46) | (1,570) | (1,803) | (233) | (4,712) | (5,307) | (596) |
| Ops Management & Team Leaders | (2,655) | (2,650) | 5 | (10,597) | (10,584) | 13 | (32,128) | (31,663) | 465 |
| Other Pay Costs | (336) | (111) | 226 | (1,704) | (471) | 1,232 | (2,528) | (1,358) | 1,170 |
| Overtime & Incentives | (303) | (3,579) | (3,276) | (1,167) | (17,015) | (15,848) | (3,747) | (46,394) | (42,647) |
| **Total Substantive** | **(26,584)** | **(28,512)** | **(1,928)** | **(106,005)** | **(115,059)** | **(9,055)** | **(317,999)** | **(346,618)** | **(28,619)** |
| **Agency** | (17) | (882) | (864) | (69) | (2,307) | (2,238) | (207) | (3,778) | (3,572) |
| **Bank** | (197) | (757) | (560) | (793) | (2,984) | (2,191) | (2,421) | (5,310) | (2,889) |
| **Seconded** | (10) | (28) | (18) | (40) | (123) | (83) | (120) | (286) | (166) |
| **Total Pay Expenditure** | **(26,809)** | **(30,179)** | **(3,370)** | **(106,906)** | **(120,474)** | **(13,568)** | **(320,747)** | **(355,992)** | **(35,245)** |

| Pay Expenditure by Directorate | Budget | Actual | Budget Variance fav/(adv) | Budget | Actual | Budget Variance fav/(adv) | Budget | Forecast | Budget Variance fav/(adv) |
|---|---|---|---|---|---|---|---|---|---|
| Central Corporate | (300) | (200) | 100 | (1,563) | (687) | 876 | (2,095) | (1,654) | 441 |
| Chief Executive | (186) | (187) | (0) | (747) | (717) | 30 | (2,198) | (2,208) | (9) |
| People & Culture | (420) | (350) | 70 | (1,650) | (1,340) | 310 | (5,023) | (4,482) | 541 |
| Communication & Engagement | (222) | (199) | 24 | (885) | (811) | 74 | (2,812) | (2,383) | 429 |
| Ambulance Services | (17,422) | (20,123) | (2,700) | (69,199) | (80,588) | (11,389) | (209,165) | (240,813) | (31,648) |
| 999 Operations | (2,984) | (3,372) | (388) | (11,876) | (14,944) | (3,068) | (35,967) | (41,716) | (5,750) |
| IUC Services | (976) | (1,862) | (885) | (3,894) | (6,770) | (2,876) | (12,164) | (17,474) | (5,311) |
| Projects & Programmes | (147) | (400) | (253) | (587) | (491) | 96 | (1,744) | (1,399) | 345 |
| COO Management | (89) | (83) | 6 | (355) | (314) | 40 | (1,087) | (906) | 180 |
| Corporate Governance | (36) | (39) | (3) | (144) | (140) | 3 | (437) | (345) | 91 |
| Finance | (277) | (260) | 17 | (1,110) | (923) | 187 | (3,287) | (2,952) | 335 |
| Performance | (132) | (81) | 51 | (531) | (297) | 234 | (1,555) | (958) | 598 |
| Strategy, Tech & Development | (53) | (73) | (20) | (210) | (244) | (34) | (545) | (736) | (191) |
| IM&T | (500) | (324) | 177 | (2,014) | (1,328) | 687 | (6,019) | (4,273) | 1,746 |
| Medical | (1,867) | (1,399) | 468 | (7,363) | (6,060) | 1,303 | (22,345) | (20,228) | 2,117 |
| Quality & Assurance | (476) | (430) | 46 | (1,900) | (1,748) | 152 | (5,621) | (5,259) | 362 |
| Strategic A&P Management | (30) | (21) | 9 | (121) | (53) | 68 | (364) | (149) | 215 |
| Property | (66) | (123) | (58) | (264) | (424) | (160) | (793) | (799) | (6) |
| Fleet & logistics | (623) | (652) | (29) | (2,493) | (2,595) | (102) | (7,526) | (7,258) | 269 |
| **Total Pay Expenditure** | **(26,809)** | **(30,179)** | **(3,370)** | **(106,906)** | **(120,474)** | **(13,568)** | **(320,747)** | **(355,992)** | **(35,245)** |

**YTD Position**

Pay expenditure is currently £13.4m adverse to pre-COVID plan YTD. Key items include:

- COVID-19 response costs of £10.7m 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 (£0.1m) and Non Emergency Service staff (net £0.2m) excluding COVID due to staffing over budget levels (net 23 WTE and 16 WTE respectively) to support frontline vacancies.
- Corporate and frontline operations and control staff underspend in relation to vacancies excluding COVID (£8.1m net positive variance YTD) has been more than offset by increased overtime and incentives spend (£8.9m negative variance YTD), agency, bank and secondee spend (£2m 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 £35.2m adverse to pre-COVID plan. Key items include:

- COVID-19 response costs of £35.7m (the forecast for which has now been extended to cover 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 (£0.2m) and Non Emergency Service staff (net £0.6m) excluding COVID due to staffing over budget levels (net 22 WTE and 14 WTE respectively) to support frontline vacancies.
- Corporate and frontline operations and control staff underspend excluding COVID in relation to vacancies forecast to be held (£17.3m net positive variance forecast) offset by overtime and incentives spend (£12.6m negative variance – a forecast improvement to run rate), agency, bank and secondee spend (£3.9m negative variance) and non-pay spend on professional fees and managed services.

# Non Pay and Financial Charges

| Non Pay by Type | Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | YTD Month 4 2020-21 £000 Budget | Actual | Budget Variance fav/(adv) | Full Year 2020-21 £000 Budget | Forecast | Budget Variance fav/(adv) |
|---|---|---|---|---|---|---|---|---|---|
| **Non Pay Expenditure** | | | | | | | | | |
| Establishment Expenses | (727) | (671) | 56 | (2,914) | (3,490) | (576) | (8,751) | (10,458) | (1,707) |
| General Supplies & Services | (2,144) | (2,249) | (106) | (8,806) | (7,615) | 1,192 | (26,132) | (22,991) | 3,141 |
| Technology & Communications | (1,023) | (2,726) | (1,703) | (4,087) | (7,764) | (3,677) | (12,259) | (17,221) | (4,962) |
| Operations Supplies & Services | (2,432) | (4,020) | (1,588) | (9,789) | (21,616) | (11,827) | (28,395) | (51,818) | (23,423) |
| Premises & Fixed Plant | (1,093) | (1,947) | (854) | (4,467) | (6,101) | (1,634) | (13,157) | (17,921) | (4,764) |
| Transport | (1,741) | (2,394) | (652) | (6,988) | (9,832) | (2,844) | (20,852) | (29,191) | (8,339) |
| **Total Non Pay Expenditure** | **(9,159)** | **(14,006)** | **(4,847)** | **(37,050)** | **(56,417)** | **(19,367)** | **(109,546)** | **(149,599)** | **(40,053)** |
| **Financial Charges** | | | | | | | | | |
| Depreciation & Amortisation | (1,288) | (1,291) | (3) | (5,220) | (4,145) | 1,075 | (16,356) | (15,863) | 493 |
| Other Financial Charges | (395) | (973) | (579) | (1,580) | (2,156) | (576) | (4,738) | (5,731) | (993) |
| **Total Financial Charges** | **(1,683)** | **(2,265)** | **(582)** | **(6,800)** | **(6,301)** | **499** | **(21,095)** | **(21,595)** | **(500)** |
| **Total Non Pay & Financial Charges** | **(10,842)** | **(16,271)** | **(5,429)** | **(43,850)** | **(62,719)** | **(18,868)** | **(130,641)** | **(171,194)** | **(40,553)** |

| Non Pay by Directorate | Budget | Actual | Budget Variance fav/(adv) | Budget | Actual | Budget Variance fav/(adv) | Budget | Forecast | Budget Variance fav/(adv) |
|---|---|---|---|---|---|---|---|---|---|
| Central Corporate | (2,582) | (2,184) | 398 | (10,553) | (8,123) | 2,430 | (31,993) | (25,783) | 6,211 |
| Chief Executive | (49) | (24) | 25 | (198) | (115) | 82 | (530) | (378) | 152 |
| Chairman & Non-Executives | (13) | (12) | 1 | (52) | (21) | 31 | (157) | (114) | 43 |
| People & Culture | (462) | (309) | 153 | (1,936) | (797) | 1,140 | (5,674) | (5,348) | 327 |
| Communication & Engagement | (48) | (16) | 32 | (161) | (90) | 71 | (435) | (279) | 157 |
| Ambulance Services | (1,072) | (1,485) | (413) | (4,284) | (6,522) | (2,238) | (12,870) | (16,980) | (4,110) |
| 999 Operations | (72) | (106) | (34) | (286) | (465) | (179) | (867) | (1,291) | (423) |
| IUC Services | (1,336) | (2,371) | (1,035) | (5,413) | (10,654) | (5,241) | (15,868) | (25,416) | (9,548) |
| Projects & Programmes | (74) | (2,566) | (2,491) | (297) | (2,954) | (2,657) | (941) | (4,822) | (3,881) |
| COO Management | 0 | (23) | (23) | 0 | (86) | (86) | (31) | (237) | (206) |
| Central Income | (3) | 0 | 3 | (26) | 0 | 26 | (32) | 0 | 32 |
| Corporate Governance | (35) | (33) | 3 | (141) | (124) | 18 | (424) | (386) | 37 |
| Finance | (86) | (49) | 37 | (345) | (269) | 76 | (1,035) | (794) | 241 |
| Performance | (3) | (33) | (30) | (11) | (147) | (136) | (38) | (480) | (442) |
| Strategy, Tech & Development | (38) | (12) | 26 | (153) | (65) | 89 | (459) | (275) | 184 |
| IM&T | (726) | (988) | (262) | (2,906) | (5,803) | (2,897) | (8,742) | (14,070) | (5,328) |
| Medical | (235) | (296) | (61) | (957) | (1,016) | (59) | (3,175) | (3,007) | 168 |
| Quality & Assurance | (484) | (478) | 6 | (1,934) | (1,887) | 47 | (5,779) | (5,767) | 12 |
| Strategic A&P Management | (0) | 4 | 4 | (1) | (9) | (8) | (3) | (15) | (12) |
| Property | (809) | (1,477) | (668) | (3,329) | (4,685) | (1,356) | (9,797) | (13,418) | (3,621) |
| Fleet & logistics | (2,714) | (3,815) | (1,100) | (10,866) | (18,889) | (8,023) | (31,791) | (52,335) | (20,544) |
| **Total Non Pay & Financial Charges** | **(10,842)** | **(16,271)** | **(5,429)** | **(43,850)** | **(62,719)** | **(18,868)** | **(130,641)** | **(171,194)** | **(40,553)** |

**YTD Position**

Non pay expenditure is £18.9m adverse to pre-COVID plan. Key items include:

- COVID-19 response costs of £23m in relation to increased 111 IUC external resourcing, increased external vehicle maintenance and prep services, increased vehicle and premises cleaning, PPE, medical equipment, operational consumables and IT equipment and services to enable home working and expand systems and telephony capacity and capability.
- Write back of £2.3m of previously capitalised technology and general supplies and services costs in relation to the CAD project.
- 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 excluding COVID 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 £40.6m adverse to pre-COVID plan. Key items include:

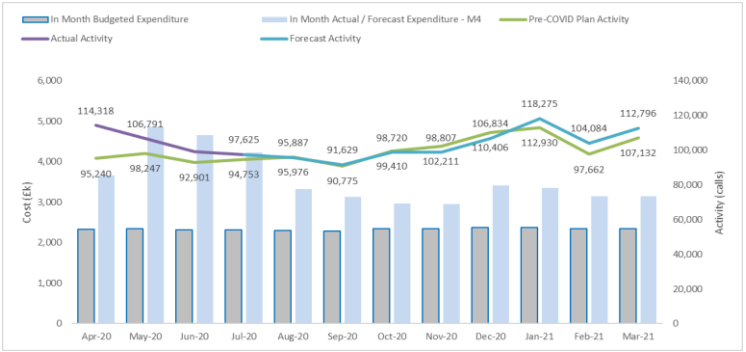
- COVID-19 response costs of £43m (the forecast for which has been extended to cover phase 2 response costs to the end of the financial year) in relation to increased 111 IUC external resourcing, increased external vehicle maintenance and prep services, increased vehicle and premises cleaning, PPE, medical equipment, operational consumables, IT equipment and services to enable home working and expand systems and telephony capacity and capability, and depreciation impacts in respect of assets purchased in relation to the above.
- Write back of £2.3m of previously capitalised technology and general supplies and services costs in relation to the CAD project and PDC overspend associated with higher capital plan (£0.7m)
- Offset by:
  - Depreciation underspend against pre-COVID plan (£1.2m) due to the impact of asset life reassessment not incorporated in business plan and depreciation plan phasing differences; and
  - Reducing net non pay underspends excluding COVID against pre-COVID plan (£4.2m) due to forecast increased establishment, technology & communications, premises and operations supplies and services spend.

# IUC / 111 Services

| | 111 IUC Total YTD M4 2020-21 £000 | | | 111 IUC Total FY Forecast M4 2020-21 £000 | | |
|---|---|---|---|---|---|---|
| | Budget | YTD | Variance fav/(adv) | Budget | Full Year Forecast | Variance fav/(adv) |
| **Income** | | | | | | |
| Income from Activities | 9,467 | 30 | (9,437) | 28,481 | 76 | (28,405) |
| Other Income | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Income** | **9,467** | **30** | **(9,437)** | **28,481** | **76** | **(28,405)** |
| **Pay** | | | | | | |
| Substantive Staff | (3,894) | (5,242) | (1,348) | (12,164) | (15,017) | (2,853) |
| Agency | 0 | (1,096) | (1,096) | 0 | (1,976) | (1,976) |
| Bank | 0 | (432) | (432) | 0 | (482) | (482) |
| **Total Pay Expenditure** | **(3,894)** | **(6,770)** | **(2,876)** | **(12,164)** | **(17,474)** | **(5,311)** |
| **Non Pay** | | | | | | |
| Establishment Expenses | (10) | (16) | (6) | (29) | (36) | (7) |
| General Supplies & Services | (156) | (370) | (214) | (470) | (922) | (453) |
| Technology & Communications | (429) | (522) | (93) | (1,285) | (1,492) | (208) |
| Operations Supplies & Services | (4,398) | (9,289) | (4,891) | (12,823) | (21,321) | (8,498) |
| Premises & Fixed Plant | (303) | (370) | (67) | (910) | (1,385) | (474) |
| Transport | 0 | (4) | (4) | 0 | (11) | (11) |
| Depreciation & Amortisation | (117) | (83) | 34 | (350) | (248) | 102 |
| **Total Non Pay** | **(5,413)** | **(10,654)** | **(5,241)** | **(15,868)** | **(25,416)** | **(9,548)** |
| **Net Surplus/(Deficit)** | **160** | **(17,394)** | **(17,554)** | **450** | **(42,814)** | **(43,264)** |

**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 10% higher than the pre-COVID plan due to COVID related demand changes. Compounding this, calls requiring transfer to a clinician have increased by 13% and 19% YTD for SE and NE London respectively, and average length of call for clinicians has increased by 31% and 40% in SE and NE London respectively.
- Significant quantities of additional resource have been engaged to help manage this position - COVID-19 response costs in relation to IUC have been around £8m YTD.
- The YTD position includes £9.2m of managed services and GP costs (FY Forecast £21.1m) 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 | Actual (£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 | (1.603) | | | | | | | | | **5.562** |
| 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 | (1.603) | 4.426 | 4.594 | 4.002 | 3.938 | 4.983 | 4.685 | 4.650 | 7.726 | **44.567** |
| Disposals | | | | (0.355) | | | | | | | | | **(0.355)** |
| Revised forecast net of disposals | 3.554 | 1.842 | 1.770 | (1.959) | 4.426 | 4.594 | 4.002 | 3.938 | 4.983 | 4.685 | 4.650 | 7.726 | **44.211** |
| Cumulative actual | 3.554 | 5.396 | 7.166 | 5.562 | | | | | | | | | |
| 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 | 5.207 | 9.633 | 14.226 | 18.229 | 22.167 | 27.150 | 31.835 | 36.485 | 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 (excl Disposals) | YTD as % of forecast |
|---|---|---|---|
| CAD Essentials | (2.187) | (1.870) | 117% |
| Digital 999 | 0.753 | 7.455 | 10% |
| COVID-19 Response - Phase 1 | 5.237 | 8.258 | 63% |
| COVID-19 Response - Phase 2 | 0.000 | 7.700 | 0% |
| Fleet | 0.367 | 7.767 | 5% |
| IM&T Essentials | 0.002 | 3.360 | 0% |
| IM&T Cyber | 0.000 | 0.023 | 0% |
| OneLondon | 0.000 | 0.850 | 0% |
| Ready Set Go | 0.605 | 4.209 | 14% |
| Spatial Development | 0.753 | 6.783 | 11% |
| Other | 0.033 | 0.033 | 100% |
| **Total** | **5.562** | **44.567** | **12%** |

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 expected 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 PDC (£14.6m).

A further £6.1m has been identified which is likely to increase the Trust's 2020-21 CRL limit to £50.3m.

**YTD and Full Year Position**

- YTD capital expenditure is £5.6m compared to planned capital expenditure of £8.6m (£3m behind plan) primarily due to the in month reversal of £2.3m of capital work in progress in conjunction with the CAD upgrade project.
- 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 £5.2m 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 | Jul-20 Actual £000 | Jul-20 YTD Move £000 | Jul-20 YTD Plan £000 | Jul-20 Var £000 |
|---|---|---|---|---|---|---|---|
| **Opening Balance** | **25,964** | **57,387** | **58,796** | **57,028** | **25,964** | **25,964** | **0** |
| Operating Surplus | 1,360 | 1,319 | 1,465 | 2,259 | 6,403 | 6,403 | 0 |
| (Increase)/decrease in current assets | (8,741) | (2,906) | 2,709 | 2,168 | (6,770) | (6,770) | 0 |
| Increase/(decrease) in current liabilities | 46,479 | 4,778 | (3,108) | (4,349) | 43,800 | 43,800 | 0 |
| Increase/(decrease) in provisions | 93 | 88 | 213 | (198) | 196 | 196 | 0 |
| Net cash inflow/(outflow) from operating activities | 39,191 | 3,279 | 1,279 | (120) | 43,629 | 43,629 | 0 |
| **Cashflow inflow/(outflow) from operating activities** | **39,191** | **3,279** | **1,279** | **(120)** | **43,629** | **43,629** | **0** |
| Returns on investments and servicing finance | (4) | 0 | (8) | 0 | (12) | (12) | 0 |
| Capital Expenditure | (7,764) | (1,870) | (3,039) | 1,430 | (11,243) | (11,243) | 0 |
| Dividend paid | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing obtained | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing repaid | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cashflow inflow/(outflow) from financing** | **(7,768)** | **(1,870)** | **(3,047)** | **1,430** | **(11,255)** | **(11,255)** | **0** |
| Movement | 31,423 | 1,409 | (1,768) | 1,310 | 32,374 | 32,374 | 0 |
| **Closing Cash Balance** | **57,387** | **58,796** | **57,028** | **58,338** | **58,338** | **58,338** | **0** |

**Due to COVID-19, NHSE and NHSI suspended the financial planning process for 2020/21. Given this, the plan is depicted here as equivalent to the outturn statement of financial position.**

There has been a net inflow of cash to the Trust of £32.4m, this is due to NHSI paying one months block income in advance each month.

Cash funds at 31 July stand at £58.4m.

**Operating Surplus**

- The operating surplus is on target.

**Current Assets**

- The movement on current assets is (£6.8m).
- The movement is due to a decrease in trade receivables £0.5m, increase in accrued income (£5.4m) and prepayments (£1.9m).

**Current Liabilities**

- The movement on current liabilities is £43.8m.
- The movement is due to an increase in deferred income £36.7m (block contract payments in advance), accruals £12.5 and payables (£5.4m).

**Provisions**

- The movement on provisions was £0.2m, this relates to legal and international student payments.

**Capital Expenditure**

- Capital cash outflow was £11.3m.

# Statement of Financial Position

| | Mar-20 Act £000 | Apr-20 Act £000 | May-20 Act £000 | Jun-20 Act £000 | Jul-20 Act £000 | Jul-20 Plan £000 | Jul-20 Var £000 | Jul-20 % |
|---|---|---|---|---|---|---|---|---|
| **Non Current Assets** | | | | | | | | |
| Property, Plant & Equip | 177,186 | 178,766 | 179,499 | 179,669 | 177,641 | 177,641 | 0 | 0.0% |
| Intangible Assets | 8,183 | 9,241 | 9,366 | 10,173 | 8,942 | 8,942 | 0 | 0.0% |
| Trade & Other Receivables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total Non Current Assets** | **185,369** | **188,007** | **188,865** | **189,842** | **186,583** | **186,583** | **0** | **0.0%** |
| **Current Assets** | | | | | | | | |
| Inventories | 4,508 | 4,770 | 4,688 | 4,575 | 4,354 | 4,354 | 0 | 0.0% |
| Trade & Other Receivables | 22,270 | 30,749 | 33,737 | 31,141 | 29,194 | 29,194 | 0 | 0.0% |
| Cash & cash equivalents | 25,964 | 57,387 | 58,796 | 57,028 | 58,338 | 58,338 | 0 | 0.0% |
| Non-Current Assets Held for Sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total Current Assets** | **52,742** | **92,906** | **97,221** | **92,744** | **91,886** | **91,886** | **0** | **0.0%** |
| **Total Assets** | 238,111 | 280,913 | 286,086 | 282,586 | 278,469 | 278,469 | 0 | **0.00%** |
| **Current Liabilities** | | | | | | | | |
| Trade and Other Payables | (47,012) | (89,719) | (94,805) | (90,977) | (87,061) | (87,061) | 0 | 0.0% |
| Provisions | (6,584) | (7,170) | (7,179) | (7,335) | (7,401) | (7,401) | 0 | 0.0% |
| Borrowings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Working Capital Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Capital Investment Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total Current Liabilities** | **(53,596)** | **(96,889)** | **(101,984)** | **(98,312)** | **(94,462)** | **(94,462)** | **0** | **0.0%** |
| **Total Assets Less Current Liabilities** | **184,515** | **184,024** | **184,102** | **184,274** | **184,007** | **184,007** | **0** | **0.0%** |
| **Non Current Liabilities** | | | | | | | | |
| Trade and Other Payables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Provisions | (8,436) | (7,945) | (8,026) | (8,085) | (7,823) | (7,823) | 0 | 0.0% |
| Borrowings | (107) | (107) | (107) | (107) | (107) | (107) | 0 | 0.0% |
| Working Capital Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Capital Investment Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total Non Current Liabilities** | **(8,543)** | **(8,052)** | **(8,133)** | **(8,192)** | **(7,930)** | **(7,930)** | **0** | **0.0%** |
| **Total Assets Employed** | **175,972** | **175,972** | **175,969** | **176,082** | **176,077** | **176,077** | **0** | **0.0%** |
| **Financed by Taxpayers Equity** | | | | | | | | |
| Public Dividend Capital | 66,178 | 66,178 | 66,178 | 66,178 | 66,178 | 66,178 | 0 | 0.0% |
| Retained Earnings | 54,593 | 54,593 | 54,590 | 54,703 | 54,698 | 54,698 | 0 | 0.0% |
| Revaluation Reserve | 55,620 | 55,620 | 55,620 | 55,620 | 55,620 | 55,620 | 0 | 0.0% |
| Other Reserves | (419) | (419) | (419) | (419) | (419) | (419) | 0 | 0.0% |
| **Total Taxpayers Equity** | **175,972** | **175,972** | **175,969** | **176,082** | **176,077** | **176,077** | **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 £186.6m, £1.2m movement in year.

**Current Assets**

- Current assets stand at £91.9m, £49.1m movement in year.
- Cash position as at 31 July is £58.3m, £32.4m above plan.
- Within Trade & Other Receivables, Receivables (debtors) at £5.4m, (£0.5m) movement in year, accrued income at £21.4m is a £5.4m movement in year and prepayments at £6.7m is a £1.9m movement in year.

**Current Liabilities**

- Current liabilities stand at £94.5m, £40.9m movement in year.
- Within Trade and Other Payables and Capital Payables £17.6m, (£9.1m) in year movement. Accruals at £32.6m, £12.5m in year movement. The increase in movement is due to Covid-19 costs.
- Deferred Income at £36.9m, £36.7m in year movement. This is due to the Trust receiving one month block income in advance.
- Current provisions at £7.4m, £0.8m movement in year.

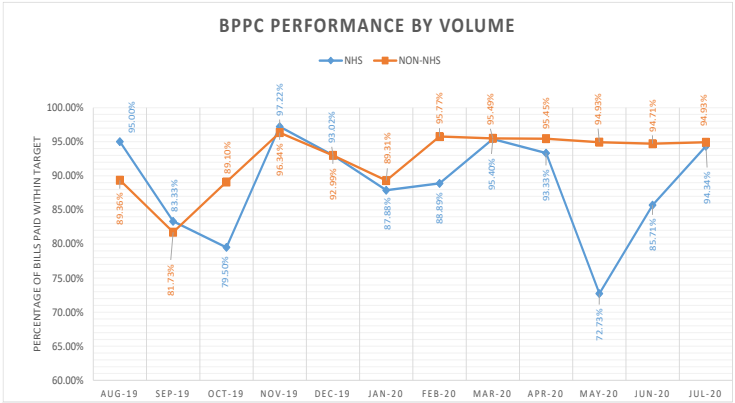
**Non Current Liabilities**

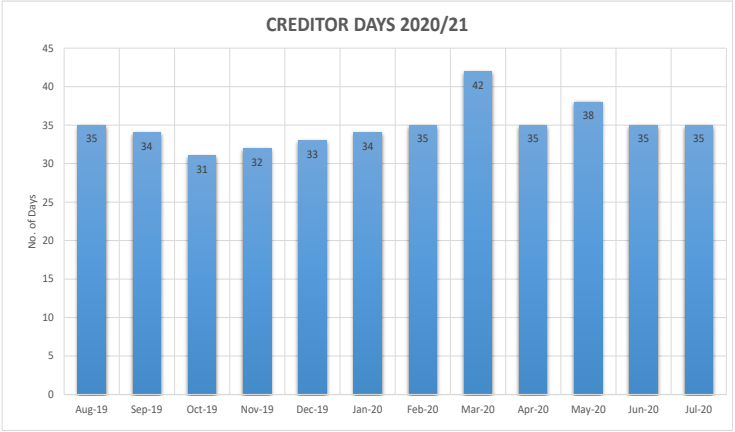
- Non current provisions at £7.8m, (£0.6m) movement in year.
- Borrowings at £0.1m, no movement in year.

**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**

- 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 4 months to the end of July 2020 is 17,935 and 185 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**

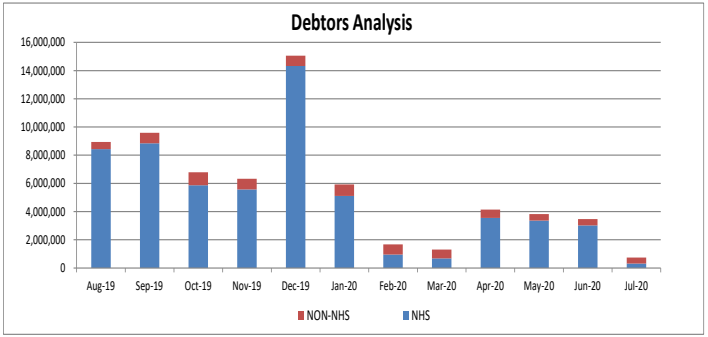
- The increase in creditor days in August (M5), September (M6) and March (M12) was due to an increase in capital creditors and COVID spend.
- There has been a steady increase in creditor days over the winter months. The Trust is looking into the cause of the increase.

# Debtors Analysis

Aged Debtors Summary 31st July 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 | 106 | - | - | - | 106 |
| West Midlands Ambulance Service Univ. NHS FT | 1 | 52 | - | - | 10 | 41 |
| North East London CSU | 1 | 45 | 7 | - | 3 | 35 |
| Barts Health NHS Trust | 1 | 29 | 1 | 3 | - | 25 |
| NHS Waltham Forest CCG | 1 | 20 | - | - | - | 20 |
| NHS Newham CCG | 1 | 15 | - | - | - | 15 |
| <£3,500 | 1 | 48 | 7 | 11 | - | 31 |
| **NHS Debtors** | | **315** | **15** | **14** | **13** | **274** |
| | | | | | | |
| **Non-NHS Debtors** | | | | | | |
| Heathrow Airport Ltd | 2 | 99 | 99 | - | - | - |
| Kings College London | 3 | 65 | 17 | - | - | 48 |
| University Of West London | 4 | 21 | 21 | - | - | - |
| London Fire Brigade | 5 | 16 | - | - | - | 16 |
| Tottenham Hotspur FC | 6 | 14 | - | - | - | 14 |
| <£13,000 | 7 | 213 | 12 | - | 1 | 201 |
| **Total Non NHS Debtors** | | **428** | **149** | **-** | **1** | **279** |
| | | | | | | |
| **TOTAL DEBTORS 31st July 2020** | | **743** | **163** | **14** | **14** | **552** |

Source: Debtors Ledger 31st July 2020




**Debtors Position: 31st July 2020**

Total outstanding NHS and Non-NHS debtors as at 31st July 2020 amounted to £743k. The NHS over 60 day's debt currently stands at £287k.

1. NHS Debtors over 60 days:
   - 148 x CCG Invoices (£155k). 1 Cohorting invoice for £13k, 1 part paid CQUIN invoice for £4k and 146 small balance Extra Contractual Journey (ECJ) fees, all of which the Trust is actively pursuing. The Trust are awaiting feedback from NWL in respect of clearing these items and we expect to see many of these small value fees paid during August 2020.
   - 3 x West Midlands Ambulance Service Univ. NHS FT Invoices (£52k). 2 invoices totalling £32k were paid on 3rd August 2020. Rachael Henderson of WMAS advised the remaining invoice will be paid during August.
   - 4 x North East London CSU Invoices (£45k). 3 invoices totalling £42k were paid on 1st August 2020. The remaining invoice for £3k will be paid during August.
   - 22 x Barts Health NHS Trust Invoices (£29k). We've had ongoing issues in respect of Barts raising the required purchase orders. We are in the process of resolving these individually with the respective budget holders and expect payment for all the overdue invoices during August.
2. Heathrow Airport Ltd - £99k (1 invoice) – The invoice does not fall due for payment until 31st August 2020. Full payment is expected during August 2020.
3. Kings College London - £48k (2 invoices) - Both invoices have been approved for payment but KCL are awaiting verification of our bank account details, signed by the Trust CFO. We are in the process of arranging this and expect full payment in August 2020.
4. University Of West London - £21k (1 invoice) – The invoice does not fall due for payment until 30th August 2020. Full payment is expected during August 2020.
5. London Fire Brigade - £16k (1 invoice) - This invoice is to be credited in full in August, the fees were paid under another invoice.
6. Tottenham Hotspur FC - £14k (2 invoices) - THFC believed they had paid these invoices but they had made an error by confusing the charges with 2 other invoices. We expect full payment in August 2020.
7. Non-NHS Debtors <£13k - £213k consists of; £179k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £10k of stadia events, the stadiums are being chased for payment on a regular basis. The remaining £24k 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

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Financial Plan 2020/21 | | | |
| **Agenda item:** | 9.2 | | | |
| **Report Author(s):** | James Corrigan, Financial Controller | | | |
| **Presented by:** | Lorraine Bewes, Chief Finance Officer | | | |
| **History:** | Executive Committee on 16 September 2020<br>Finance and Investment Committee on 22 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☒ | Approval |
| | ☐ | Discussion | ☐ | Noting |

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

This paper sets out for approval a revised financial plan for the remainder of 2020/21 to support the business plan objectives following the publication of the Phase 3 planning guidance from NHS England.

At the time of writing this report the national financial arrangements for the remainder of 20/21 have just been issued and the Trust is working with the NWL Healthcare Partnership system to set a financial envelope as part of the system financial submission on 5th October.

The Trust has agreed with the NWL STP to use the month 4 forecast in support of the NWL HCP submission on this basis and the financial plan is predicated on these assumptions. This will need to be confirmed back to the Board for approval once the finance, activity and performance negotiation has been completed with NWL HCP. Whilst contracts will not be in place for the remainder of 2020/21 the Trust will be agreeing the assumptions that the forecast is based on with Commissioners and agreeing a break glass process for any additional surge in demand through winter.

The Trust operations were required to scale up significantly in response to the COVID 19 pandemic and this resilience capacity has been retained in the face of the possibility of future demand spikes. Phase 3 planning also requires a response to support the Think111 First which will increase 111 calls and Critical Care inter-facility transport. Any specific sector requests for additional emergency response that are not already in place are assumed to be funded in addition to the forecast envelope.

The Trust has been successful in securing agreement to proceed with a capital plan of £50.3m in recognition of the urgent need for transformation of a number of legacy estate issues. This is the largest settlement in its history and nearly twice the normal budget. This paper sets out the details of its capital plan for approval and further assurance with respect to governance and risk management are set out in a separate paper (Item 9.3 Capital expenditure and programme).

| Recommendation(s) / Decisions for the Board / Committee: |
|---|
| The Board is asked to approve the Trust financial plan for 2020/21 subject to affordability in terms of both available capital and revenue funding. |

| 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 | | |

## 1.0 Background

The Trust has received funding for the first six months of 2020/21 through the nationally mandated process of a core allocation and central top up based on the Trust's expenditure run rate for months 8-10 2019/20 adjusted for inflation. The Trust currently also receives a retrospective top up to ensure income matches expenditure (largely COVID 19 related costs).

The phase three planning guidance retains the core allocation and central top up on the same basis, however the retrospective top up is being replaced by a COVID 19 allocation (or budget) for the remainder of year. The value of this allocation remains uncertain at the time of writing this report, however the Trust had agreed with NWL STP that it will use the month 4 forecast outturn as the basis for its funding request.

On this basis, it is proposed that the forecast outturn at month 4 is approved as the budget for the remainder of the financial year. When allocations are confirmed then a further paper will be brought to set out the impact (if any) this has on the Trust's ability to deliver a break even position and any further actions required to deliver this including a further efficiency requirement.

The Board will receive an update on the Business Plan for the remainder of 2020/21, which will detail the performance, activity and workforce assumptions. These are reflected in the forecast outturn at month 4 and allow the Trust to continue to deliver C2 mean consistently and remain resilient. The additional costs of a further surge are included in the forecast to the value of £5m and it is assumed that any costs above this level would need additional funding.

## 2.0 Forecast assumptions

The Trust included a number of assumptions in developing the month 4 forecast.

Key demand assumptions driving the forecast outturn are as follows:

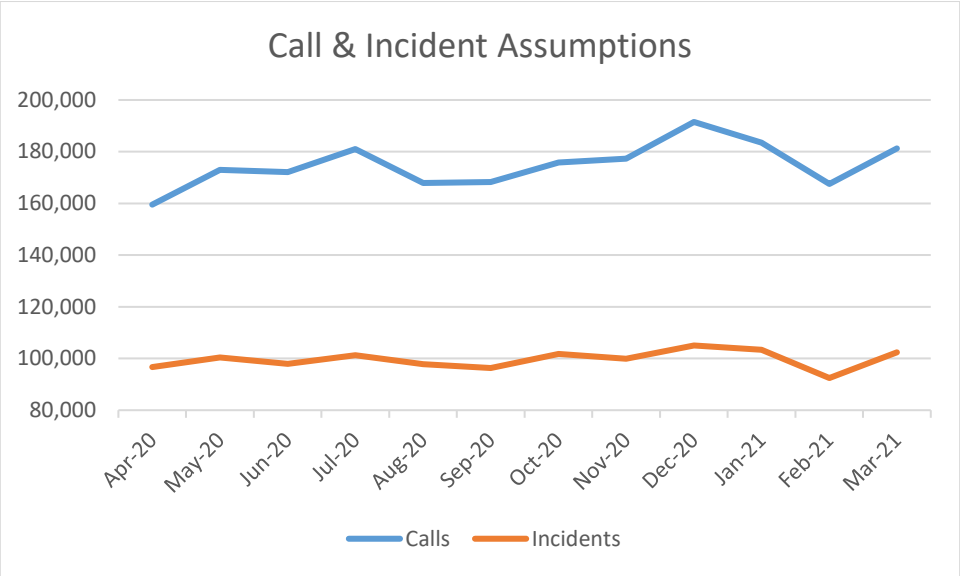
- 2020/21 Demand – the STP guidance set out an activity growth rate of 3.27% which was included in the LAS financial submission on 5 March 2020. LAS demand forecasts suggest a more likely demand increase of 4% in ambulance services and 18% (including new covid 19 activity) in 111. Current exclusions from this forecast are the Critical Care Transfer Service and on boarding of North West and South West London IUC Services, and any additional activity relating to 'Think 111' which is unspecified at this time, funding to support this increased activity will be in addition to the forecast outturn.

- Meet Contractual Performance - For the remainder of 2020/21, meeting contractual performance requirements has been modelled to resource: (a) 111 Call Answering at 95% <60 seconds every day (b) 111 CAS at 95% average across all KPIs (c) EOC 999 Call Answering Mean of <5 seconds daily (d) deliver a C2 mean of <18 min on a daily basis for the remainder of the year.

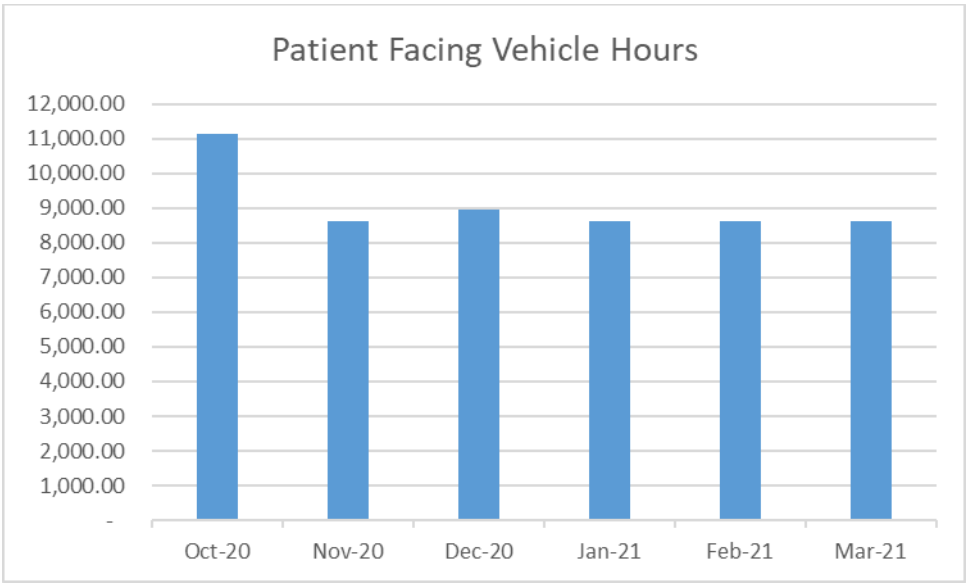
- Demand related costs – includes 9/12 of the cost of: (a) new covid 19 activity above 2019/20 plan totalling £4.6m (including one off pro rate HR and governance infrastructure uplift of £1.5m) (b) variable non-pay costs of covid 19 totalling £16.6m (including AA, InHealth, PPE costs, consumables) (c) estimated cost of

additional Covid 19 surge for one month of £5m and (d) Covid surge costs of £33.7m for M1-4 (as per COVID 19 retrospective arrangements.

The forecast performance is based on the assumption that the Trust will take over 2.1 million calls and attend 1.2m incidents in 2020/21 profiled in the table below:

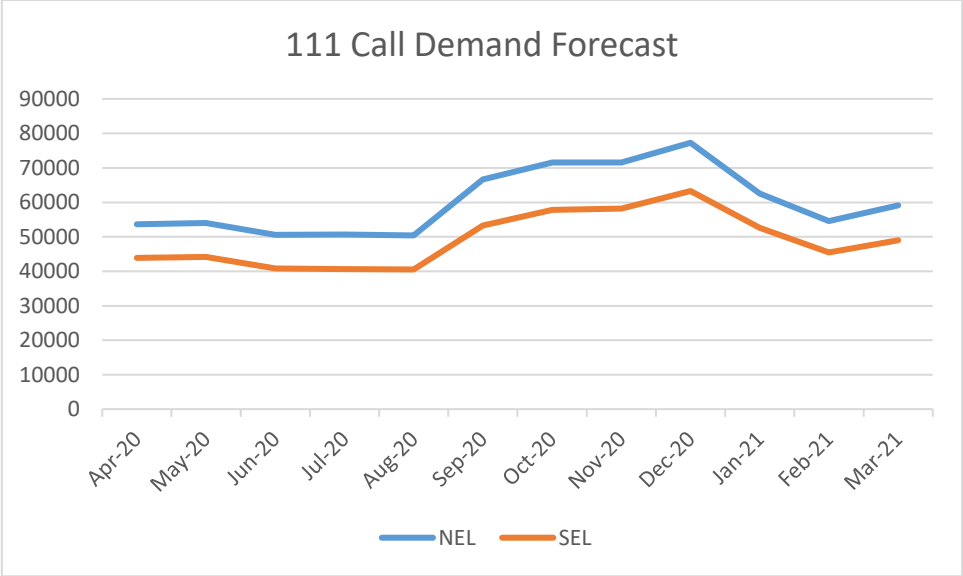



To deliver a C2 mean of <18 min on a daily basis for the remainder of the year for the forecast level of incidents above the Trust will need to maintain a daily patient facing vehicle hours of 8,500. This has been included in the forecast as follows:

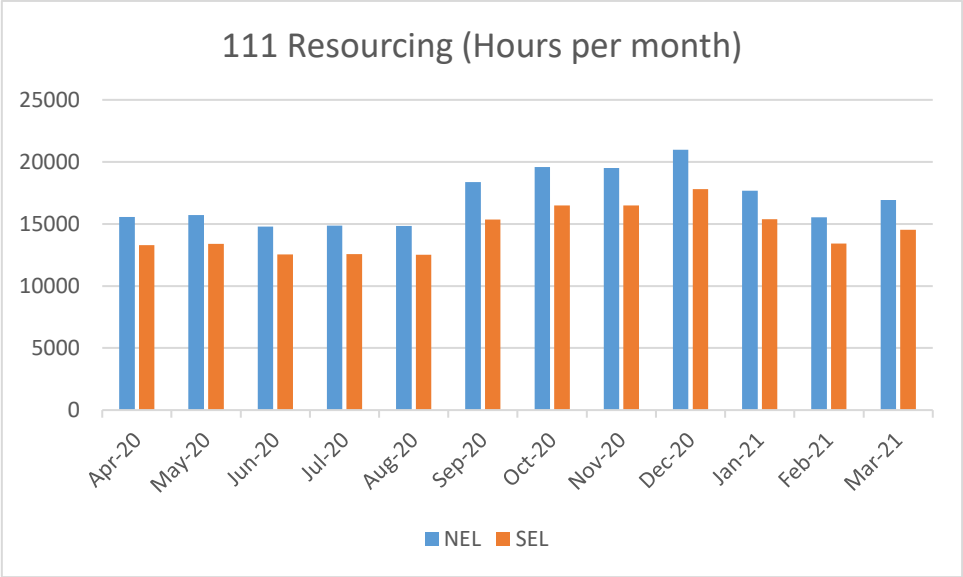



The £527.3m plan currently includes an assumption of £5.0m COVID 19 surge in October which explains the higher level of patient facing vehicle hours above.

111 call demand is forecast to be 1.3m calls for 2020/21 and with an expected increase in the final 6 months of the year of 22.7% compared the first 6 months. The call demand forecast is included in the table below:




To meet this demand forecast and deliver the performance standards outlined above the Trust financial forecast includes an additional 30,486 hours in the second half of the year and a total forecast of 378,198 hours across both North East and South East London.



## 3.0 Statement of Comprehensive Income

The table below sets out the forecast Statement of Comprehensive Income as at month 4 reported to the Finance and Investment Committee, which is consistent with the submission to NWL STP for funding for the remainder of 2020/21.

| | Full Year Forecast |
|---|---|
| **Income** | |
| Income from Activities | 411,276 |
| Other Operating Income | 115,978 |
| **Total Income** | **527,254** |
| | |
| **Operating Expense** | |
| Pay | (355,992) |
| Non Pay | (149,599) |
| **Total Operating Expenditure** | **(505,592)** |
| | |
| **EBITDA** | **21,662** |
| **EBITDA margin** | 4.1% |
| | |
| **Depreciation & Financing** | |
| Depreciation & Amortisation | (15,863) |
| PDC Dividend | (5,340) |
| Finance Income | (4) |
| Finance Costs | (34) |
| Gains & Losses on Disposals | (354) |
| **Total Depreciation & Finance Costs** | **(21,595)** |
| | |
| **Net Surplus/(Deficit)** | **68** |

The table below sets out the monthly run rate to the end of July and the forecast for the remainder of the year.

| | Apr-20 (£k) | May-20 (£k) | Jun-20 (£k) | Jul-20 (£k) | Aug-20 (£k) | Sep-20 (£k) | Oct-20 (£k) | Nov-20 (£k) | Dec-20 (£k) | Jan-21 (£k) | Feb-21 (£k) | Mar-21 (£k) | Total (£k) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Income:*** | | | | | | | | | | | | | |
| Block Income | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | 34,084 | **409,002** |
| Top Up Income | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | 2,657 | **31,886** |
| Retrospective Top Up Income | 10,733 | 8,110 | 7,592 | 9,368 | 7,059 | 5,575 | 10,323 | 3,932 | 5,317 | 4,754 | 4,124 | 4,254 | **81,139** |
| Other Income | 861 | 879 | - 1,544 | 337 | 555 | 598 | 580 | 630 | 613 | 581 | 552 | 585 | **5,227** |
| **Forecast Income at M4** | **48,335** | **45,730** | **42,788** | **46,445** | **44,355** | **42,914** | **47,643** | **41,303** | **42,670** | **42,076** | **41,416** | **41,579** | 527,254 |
| ***Expenditure:*** | | | | | | | | | | | | | |
| Pay Expenditure | 29,441 | 29,908 | 30,946 | 30,179 | 28,838 | 28,613 | 34,635 | 28,267 | 29,508 | 28,775 | 28,378 | 28,505 | **355,992** |
| Non Pay Operating Costs excl Depr & Amort | 17,529 | 14,503 | 10,380 | 14,006 | 13,734 | 12,518 | 11,092 | 11,121 | 11,247 | 11,320 | 11,057 | 11,093 | **149,599** |
| Depreciation and Amortisation | 915 | 983 | 955 | 1,291 | 1,341 | 1,341 | 1,473 | 1,473 | 1,473 | 1,539 | 1,539 | 1,539 | **15,863** |
| PDC and Financing Costs | 453 | 339 | 391 | 973 | 447 | 447 | 447 | 447 | 447 | 447 | 447 | 447 | **5,731** |
| **Forecast Expenditure** | **48,338** | **45,732** | **42,672** | **46,450** | **44,360** | **42,918** | **47,648** | **41,307** | **42,675** | **42,081** | **41,421** | **41,584** | 527,186 |
| **Forecast Surplus / (Deficit)** | **- 3** | **- 2** | **115** | **- 5** | **- 5** | **- 5** | **- 5** | **- 5** | **- 5** | **- 5** | **- 5** | **- 5** | **68** |

## 4.0 Budgets by Directorate

The table below sets out the budgets proposed for issue to the Trust directorates for the remainder of 2020/21 based on the forecast outturn as at the end of July.

| Directorate | Forecast | COVID | Actual excl COVID |
|---|---|---|---|
| Chief Executive | (2,578) | | (2,578) |
| Chairman & Non-Executives | (114) | | (114) |
| People & Culture | (8,074) | | (8,074) |
| Communication & Engagement | (2,444) | | (2,444) |
| Ambulance Services | (254,465) | (28,714) | (225,751) |
| 999 Operations | (42,822) | (3,476) | (39,346) |
| IUC Services | (42,814) | (14,968) | (27,846) |
| Performance | (1,437) | | (1,437) |
| Programmes & Projects | (5,854) | | (5,854) |
| COO Management | (1,144) | | (1,144) |
| Corporate Governance | (732) | | (732) |
| Finance | (3,746) | | (3,746) |
| Strategy, Tech & Development | (1,011) | | (1,011) |
| IM&T | (18,343) | (3,789) | (14,555) |
| Medical | (22,807) | (984) | (21,823) |
| Quality & Assurance | (10,752) | | (10,752) |
| Strategic A&P Management | (164) | | (164) |
| Property | (14,216) | (1,536) | (12,680) |
| Fleet & logistics | (59,593) | (21,723) | (37,870) |
| **Directorate Sub-Total** | **(493,111)** | **(75,189)** | **(417,922)** |
| Central Income | 520,369 | 78,961 | 441,408 |
| Central Corporate | (27,190) | (3,771) | (23,418) |
| **Total** | **68** | **0** | **68** |

## 5.0 Cash flow

The table below sets out the cash flow forecast for the remainder of 2020/21 based on the month 4 forecast outturn. There is a risk to the Trust cash position if the level of funding requested is not agreed and the Trust is unable to reduce operating expenditure sufficiently.

The table below sets out the revised cash forecast using the following assumptions:

- Covid-19 expenditure and income have been ignored in the cash flow on the basis that we will receive full reimbursement for any Covid-19 expenditure or capital purchases for 2020/21. There is a risk to the cash flow if the reimbursements are delayed.
- The Flowers legal case will not be settled before 31 March 2021.
- Annual leave carried forward into 2020/21 will be taken rather than paid in lieu.

| | Apr-20 (£k) | May-20 (£k) | Jun-20 (£k) | Jul-20 (£k) | Aug-20 (£k) | Sep-20 (£k) | Oct-20 (£k) | Nov-20 (£k) | Dec-20 (£k) | Jan-21 (£k) | Feb-21 (£k) | Mar-21 (£k) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Opening Cash Balance** | 25,969 | 57,780 | 59,085 | 57,357 | 58,338 | 57,833 | 51,980 | 9,080 | 8,398 | 17,090 | 20,012 | 20,969 |
| **Cash Receipts** | | | | | | | | | | | | |
| Block Income | 73,370 | 36,685 | 36,685 | 36,685 | 36,685 | 36,685 | 0 | 36,685 | 36,685 | 36,685 | 36,685 | 36,685 |
| Retrospective Top Up Income | 0 | 6,948 | 10,733 | 8,110 | 7,592 | 9,368 | 7,059 | 5,575 | 10,323 | 3,932 | 5,317 | 4,754 |
| Other Income | 2,184 | 2,513 | 1,226 | 1,014 | 611 | 654 | 636 | 686 | 669 | 637 | 608 | 641 |
| Vat Recovered (COS) & QBE | 488 | 609 | 476 | 878 | 417 | 417 | 417 | 417 | 417 | 417 | 417 | 1,017 |
| PDC rec'd for Capital Investment | | | | | | | | | 5,945 | 5,945 | 5,945 | 5,947 |
| **Total Cash Receipts** | **76,042** | **46,755** | **49,120** | **46,687** | **45,305** | **47,124** | **8,112** | **43,363** | **54,039** | **47,616** | **48,972** | **49,044** |
| | | | | | | | | | | | | |
| **Payments** | | | | | | | | | | | | |
| Employee Salaries | 26,021 | 27,653 | 28,211 | 29,126 | 28,838 | 28,613 | 34,635 | 28,267 | 29,508 | 28,775 | 28,378 | 28,505 |
| Supplier Payments | 15,431 | 13,832 | 19,398 | 15,823 | 14,161 | 15,995 | 11,509 | 11,538 | 11,664 | 11,737 | 11,474 | 11,510 |
| Capital Payments | 2,713 | 3,913 | 3,154 | 583 | 2,522 | 5,411 | 4,579 | 3,951 | 3,887 | 3,893 | 7,874 | 10,839 |
| PDC Payable and Financing Cos | 0 | 0 | 0 | 0 | 0 | 2,670 | 0 | 0 | 0 | 0 | 0 | 2,670 |
| Other Payments | 66 | 52 | 85 | 174 | 289 | 289 | 289 | 289 | 289 | 289 | 289 | 5,489 |
| **Total Payments** | **44,231** | **45,450** | **50,848** | **45,706** | **45,810** | **52,978** | **51,012** | **44,045** | **45,348** | **44,694** | **48,015** | **59,013** |
| | | | | | | | | | | | | |
| **Net Cash inflow\(Outflow)** | **31,811** | **1,305** | **-1,728** | **981** | **-505** | **-5,854** | **-42,900** | **-682** | **8,691** | **2,922** | **957** | **-9,969** |

## 6.0 Capital Plan

The Trust Board approved a capital plan of £44.2m for 2020/21 in July 2020 subject to the programme detail presented at the August Development session. The Trust subsequently received confirmation from NWL STP to utilise up to £50.3m capital in 2020/21 on the assumption that both COVID-19 submissions would be fully funded by the central team and therefore the £6.1m NWL system support would be available in addition to the £44.2m.

| | Jul | | Aug | |
|---|---|---|---|---|
| **Source of Capital** | **£'000** | **Memo** | **£'000** | **Type** |
| Internally Generated Capital | 20,429 | | 20,429 | CRL |
| HSLI | 1,670 | | 1,670 | PDC |
| Grant (Low Floor Ambulance Project) | 316 | | 316 | Grant |
| LHCRE | 850 | | 850 | PDC |
| 2019/20 COVID 19 | 6,358 | | 6,358 | PDC |
| 2020/21 COVID 19 - of which: | 14,588 | | 14,588 | |
| NWL transfers | | 6,100 | 6,100 | CRL |
| Balance awaiting confirmation | | 8,488 | | PDC |
| **Total Source** | **44,211** | **14,588** | **50,311** | |

It is important to ensure the additional funding is utilised in year and any slippage in planned projects is covered by bringing forward future year projects. This will ensure availability of internally generated capital in future years to complete projects and maintain the asset base.

The table below sets out the latest update of existing and new projects by programme against the originally approved plan in July 2020.

| | Original Capital Plan (£k) | Business Case Capital Approved (£k) |
|---|---|---|
| **Existing Projects** | | |
| Digital 999 | 6,740 | 7,261 |
| Estates Consolidation | 1,400 | 1,400 |
| Fleet | 3,260 | 3,261 |
| IM&T | 913 | 1,134 |
| Medicines Modernisation | 81 | 81 |
| Other | 7,158 | 7,158 |
| Spatial | 4,738 | 4,738 |
| **Existing projects (Total)** | **24,290** | **25,033** |
| New Projects | | |
| Estates Consolidation | 8,665 | 11,639 |
| Estates | 300 | 359 |
| Fleet | 4,500 | 4,504 |
| IM&T | 4,029 | 2,723 |
| Medicines Modernisation | 2,429 | 1,934 |
| **New projects (Total)** | **19,923** | **21,159** |
| **Grand Total** | **44,213** | **46,192** |

The Trust has brought forward a number of further schemes that it would need to undertake in future years to enable it to cover any slippage in the agreed capital plan and ensure it delivers the full £50.3m capital resource signalled as available by NWL STP. These are set out in the table below:

| | Business Case Capital Not Approved (£k) |
|---|---|
| **Additional Projects** | |
| Clinical Equipment | 671 |
| Estates Consolidation | 6,051 |
| Fleet | 3,385 |
| Logistics | 3,387 |
| Spatial | 2,600 |
| **Additional Projects Total** | **16,094** |

The Trust is currently working through development of business cases to support all these projects so that they are approved subject to available funds and can then be mobilised immediately once the overall financial forecast for capital is updated on a monthly basis. The Portfolio Management Board will then decide which projects can be mobilised quickly enough to ensure capital is utilised in year. The Portfolio Management Board (as a sub-committee of the Exco) will be accountable for assuring that the additional projects are within available funds and forecasts.

The total revenue requirement for the programme for 2020/21 is £6.9m of which £5.0m is already included in the forecast position and a further £1.9m would require

offsetting efficiencies from within the month 4 forecast. The revenue impact by programme is set out as follows:

| Programme | Revenue Impact (£k) |
|---|---|
| Clinical Equipment | 0 |
| Digital 999 | 2,355 |
| Estates Consolidation | 1,418 |
| Fleet | 170 |
| IM&T | 516 |
| Logistics | 486 |
| Medicines Modernisation | 1,698 |
| Other | 134 |
| Spatial | 122 |
| **Grand Total** | **6,900** |

The Trust has submitted its revenue forecast as at month 4, which includes the assumption of £5.0m for the known revenue consequences of the capital plan to NHS London Region. At the time of writing this paper there is no guarantee that this will be funded and the Trust may need to further increase the level of efficiency and productivity to fund the impact of this capital plan.

## 7.0 Risk Assessment and Mitigation

There are a number of significant risks to the plan as presented. These are as follows:

- There is a risk that the Trust does not receive the required level of revenue funding to maintain the planned level of performance for the remainder of 2020/21. The Trust full year forecast submitted for approval is £527.3m. Of our £527.3m income plan, we have so far received confirmation of our block and top up allocation of £495.4m i.e. £31.8m is unconfirmed (this assumes that the Trust breaks even in the first six months of the year). NWL has received a total of £39m for growth and £147m Covid to be allocated.

  In mitigation of this, the Trust is currently working with NHS region and NWL STP to secure the required level of funding and submitted the forecast outturn to NWL as part of the phase 3 planning submission. Whilst contracts will not be in place for the remainder of 2020/21 the Trust will be agreeing the assumptions that the forecast is based on with Commissioners and agreeing a break glass process for any additional surge in demand through winter.

  The Trust continues to develop an efficiency plan for implementation from the end of October for the remainder of the financial year to optimise the level of performance that can be delivered within available resources once finalised.

- There is a risk that the Trust does not receive the planned level of Capital allocation to deliver its capital programme once NHS England/Improvement confirms capital allocations. The Trust continues to develop programmes and projects to ensure delivery of the full £50.3m capital allocation; however, these will have to be further prioritised once capital allocations are confirmed if any shortfall arises. The Trust is also increasing focus on benefit identification and realisation across programmes and projects.

## 8.0 Conclusion and Recommendations

The Trust Board is asked to approve the Trust financial plan for 2020/21 and to note that a further review and update will be brought back when the financial arrangements for the 2nd half of the year have been confirmed. Approval is therefore subject to this assessment of affordability in terms of both available capital and revenue funding.

London Ambulance Service NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report to:** | **Trust Board** | | | |
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Capital expenditure and programme | | | |
| **Agenda item:** | 9.3 | | | |
| **Report Author(s):** | James Corrigan, Financial Controller<br>Nic McCullagh, Director of Programmes and Projects | | | |
| **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 purpose of this paper is to set out the revised capital plan for 2020/21 following support from NWL STP to work to a capital allocation of £50.3m. This is yet to be confirmed through an adjustment to the Trust CRL at the time of writing this paper. The paper also sets out the current governance, financial risks, benefits for current programmes and prioritisation of further schemes that the Trust will over programme to ensure the full capital allocation is utilised in 2020/21.

At the time of writing this report the Trust has still not received confirmation of the revenue funding arrangements for the remainder of 2020/21, however the revenue funding requirement has been identified through review of business cases and currently stands at £6.9m of which £5.0m is already included in the forecast position and a further £1.9m would require offsetting efficiencies from within the month 4 forecast.

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

The Board is asked to approve the Trust capital plan subject to affordability both in terms of available capital and revenue funding.

**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 | | |

## 1.0 Background and Purpose

The Trust Board approved a capital plan of £44.2m for 2020/21 in July 2020 subject to the programme detail presented at the August Development session. The Trust subsequently received confirmation from NWL STP to utilise up to £50.3m capital in 2020/21 on the assumption that both COVID-19 submissions would be fully funded by the central team and therefore the £6.1m NWL system support would be available in addition to the £44.2m.

| | Jul | | Aug | |
|---|---|---|---|---|
| **Source of Capital** | **£'000** | **Memo** | **£'000** | **Type** |
| Internally Generated Capital | 20,429 | | 20,429 | CRL |
| HSLI | 1,670 | | 1,670 | PDC |
| Grant (Low Floor Ambulance Project) | 316 | | 316 | Grant |
| LHCRE | 850 | | 850 | PDC |
| 2019/20 COVID 19 | 6,358 | | 6,358 | PDC |
| 2020/21 COVID 19 - of which: | 14,588 | | 14,588 | |
| NWL transfers | | 6,100 | 6,100 | CRL |
| Balance awaiting confirmation | | 8,488 | | PDC |
| **Total Source** | **44,211** | **14,588** | **50,311** | |

The purpose of this paper is to update on the further work undertaken to identify and prioritise the additional projects. It is important to ensure the additional funding is utilised in year and any slippage in planned projects is covered by bringing forward future year projects. This will ensure availability of internally generated capital in future years to complete projects and maintain the assets base. This paper also sets out programme arrangements across the following areas:

- Governance
- Risk of over-programming and revenue impact
- Deliverability
- Benefits realisation
- Prioritisation

## 2.0 Governance – Business Cases and Approval Route

The Trust is going through the largest transformation in its history. This unprecedented time is combined with receiving a capital investment of more than double the annual norm. A large proportion of this capital investment will enable a move away from outdated and unsuitable premises (owned, or with legacy leasehold arrangements) to modern infrastructure and fit-for-purpose premises (largely lease-held). This presents both opportunities and threats.

There are opportunities to improve patient safety, quality, efficiency, and productivity through a modern fit-for-purpose estate and infrastructure. The main threat is the cost pressure this presents to the underlying provision. Although the Trust is in the process of finalising all of the business cases to support the capital investment, this paper presents the work to date on scoping the revenue implications. Given this is M6 this paper sets a range for the revenue implications predicated on the business cases agreed to date, and those in the pipeline that have yet to be finalised.

This paper sets out the capital investment programme that is consistent with the CRL, and that Trust Board is being asked to commission. In later sections of this paper tables 2-5 clearly indicate the business cases approved to date, and those in development. This section sets out the governance and approval process that provides assurance the portfolio will be delivered to time and budget. Project and programme boards are either already established, or for recently approved projects are in the process of being established, and these report through to the Portfolio Management Board.

Business cases clearly state what the purpose of the project is. Simply put it answers the “Why are we doing it?” question. The focus is on the benefits to patients, staff, and the Trust, plus the viability of the project in relation to its objectives. Part of the approval process for business cases is ensuring that projects are in alignment with and enable Trust strategy, rather than simply seeing completion of the project as an end in itself.

The business case template is dependent on the size of expenditure involved, and follows the five case model used in the public sector. The process of writing the business case is the start of ensuring that stakeholders, including project sponsors and resource providers, are properly represented in planning and decision making. Business cases are based on the whole life of the project, including the cost of any extension periods and irrecoverable VAT.

The governance and routing of business cases is in line with the scheme of delegation and financial limits (table 1). Approval of the business case by the requisite governance group provides the authority to undertake the project. The business case is revisited during the life of the project to ensure the project is, and remains, desirable, viable, and achievable. Not only is this good practice but additionally provides the necessary flexibility for projects to be paused and / or stopped if circumstances change.

Table 1: Scheme of Delegation and Financial Limits

| Expenditure | Programmes and Projects | BAU / Other |
|---|---|---|
| £50k to £1m | Programme Management Board | Supply Chain Management Board |
| £1m to £2m | Portfolio Management Board | Executive Committee |
| £2m to £5m | Logistics Investment Committee / Finance Investment Committee | |
| £5m to £15m | Trust Board | |
| Above £15m | NHS I | |

## 3.0 Risk of over-programming and revenue impact

The table below sets out the latest update of existing and new projects by programme against the originally approved plan in July 2020.

| | Original Capital Plan (£k) | Business Case Capital Approved (£k) |
|---|---|---|
| **Existing Projects** | | |
| Digital 999 | 6,740 | 7,261 |
| Estates Consolidation | 1,400 | 1,400 |
| Fleet | 3,260 | 3,261 |
| IM&T | 913 | 1,134 |
| Medicines Modernisation | 81 | 81 |
| Other | 7,158 | 7,158 |
| Spatial | 4,738 | 4,738 |
| **Existing projects (Total)** | **24,290** | **25,033** |
| New Projects | | |
| Estates Consolidation | 8,665 | 11,639 |
| Estates | 300 | 359 |
| Fleet | 4,500 | 4,504 |
| IM&T | 4,029 | 2,723 |
| Medicines Modernisation | 2,429 | 1,934 |
| **New projects (Total)** | **19,923** | **21,159** |
| **Grand Total** | **44,213** | **46,192** |

The Trust has brought forward a number of further schemes that it would need to undertake in future years to enable it to cover any slippage in the agreed capital plan and ensure it delivers the full £50.3m capital resource signalled as available by NWL STP. These are set out in the table below:

| | Business Case Capital Not Approved (£k) |
|---|---|
| **Additional Projects** | |
| Clinical Equipment | 671 |
| Estates Consolidation | 1,051 |
| Estates Consolidation (Hub) | 5,000 |
| Fleet | 3,385 |
| Logistics | 3,387 |
| Spatial | 2,600 |
| **Additional Projects Total** | **16,094** |

The detailed projects underpinning these programme summaries are set out in appendix 1

The Trust is currently working through development of business cases to support all these projects so that they are approved subject to available funds and can then be mobilised immediately once the overall financial forecast for capital is updated on a monthly basis. The Portfolio Management Board will then decide which projects can be mobilised quickly enough to ensure capital is utilised in year. The Portfolio Management Board (as a sub-committee of the Exco) will be accountable for assuring that the additional projects are within available funds and forecasts.

The total revenue requirement for the programme for 2020/21 is £6.9m of which £5.0m is already included in the forecast position and a further £1.9m would require offsetting efficiencies from within the month 4 forecast. The revenue impact by programme is set out as follows:

| Programme | Revenue Impact (£k) |
|---|---|
| Clinical Equipment | 0 |
| Digital 999* | 2,355 |
| Estates Consolidation | 1,418 |
| Fleet | 170 |
| IM&T | 516 |
| Logistics | 486 |
| Medicines Modernisation | 1,698 |
| Other | 134 |
| Spatial | 122 |
| **Grand Total** | **6,900** |

*A further £2.6m has been recognised in 20/21 as a non-recurrent write down of the existing CAD and this has been funded from contingencies with nil revenue impact.

The Trust has submitted its revenue forecast as at month 4, which includes the assumption of £5.0m for the known revenue consequences of the capital plan to NHS London Region. At the time of writing this paper there is no guarantee that this will be funded and the Trust may need to further increase the level of efficiency and productivity to fund the impact of this capital plan.

## 4.0 Deliverability

This section sets out progress to date on delivery of the portfolio. As would be expected the projects that were already in flight are well underway and will deliver in-year, with the exception of the replacement CAD which has always been planned to deliver in FY21/22. The remainder are going through the business case approval stage which provides the authority to proceed. The next phases, from writing the project initiation document (PID) through to design, establish the delivery plan and governance frameworks for each project. This enables deployment of the right resources for the delivery phase. Projects are managed via stage gates to ensure quality and governance checks are completed. Then approval is granted and funding released to move to the next stage.

To enable a greater focus on the major capital projects in the following four tables the portfolio has been split into major capital projects (defined as £1m+), followed by grouping of the smaller capital projects into the relevant programmes (e.g. IM&T, Estates, etc.), and finally the projects prioritised for additional capital monies listed in rank / prioritised order:

- Table 2 – This illustrates which delivery phase each major capital project is currently within. This table includes two projects that were added once the availability of additional capital monies was known. For completeness they are listed in table 5.
- Table 3 – This illustrates which delivery phase each smaller capital project for IM&T, Estates, and Fleet is currently within.
- Table 4 – This illustrates which delivery phase each smaller capital project for Spatial and Medicines Management is currently within.
- Table 5 – This illustrates the additional capital projects that have been prioritised since the availability of additional capital monies was known. These are listed in rank order. These also form the over programming to ensure the full capital allocation is utilised within this financial year. Business cases will be developed so that projects can be quickly mobilised as and when required.

Table 2: Major Capital Projects (>£1m) Phases of Delivery

| | Sponsor | Business Case Status / Approval | PID*2 Status | Scoping (stage gate 1) | Initiation (stage gate 2) | Design (stage gate 3a) | Delivery (stage gate 3b) | Live / Transition (stage gate 4) | Close (stage gate 4) |
|---|---|---|---|---|---|---|---|---|---|
| 1. Resilience CAD | BT | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | In progress | |
| 2. New CAD | KM | ✓ | ✓ | ✓ | ✓ | In progress | | | |
| 3. ePCR | KM | ✓ | ✓ | ✓ | ✓ | ✓ | In progress | | |
| 4. Secure Drugs Rooms | AB | ✓ | – | ✓ | ✓ | ✓ | In progress | | |
| 5. UPS and Generators | BT | ✓ | ✓ | ✓ | ✓ | In progress | | | |
| 6. Purchase of 37 Ambulance Chassis and Conversions | JW | ✓ | – | ✓ | ✓ | In progress | | | |
| 7. IM&T Infrastructure Refresh | BT | Oct | | | | | | | |
| 8. Control Room – 999 / 111 SEL Expansion | BT | Oct | | | | | | | |
| 9. Bow Modernisation | BT | Oct | | | | | | | |
| 10. Training Consolidation (North / South) | KM | Sept LIC | | | | | | | |
| 11. Ambulance Station Consolidation (Phases 2 & 3) and Remedial Works | AB | Oct | | | | | | | |
| 12. Drugs Packing Unit | AB&FW | ✓ | Oct | | | | | | |
| 13. Logistics Supply Unit*3 | KM | Sept LIC | | | | | | | |
| 14. Proof of Concept Ambulance Deployment Centre*3 | AB | Oct | | | | | | | |
| 15. Estates BAU Backlog Maintenance | JW | Not started | | | | | | | |

Table 3: IM&T, Estates, and Fleet Smaller Capital Projects Phases of Delivery

| | | Business Case Status / Approval | PID Status | Scoping | Initiation | Design | Delivery | Live / Transition | Close |
|---|---|---|---|---|---|---|---|---|---|
| IM&T | Telephony (Avaya) upgrade to CM7 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| | EOC upgrade to windows 10 | ✓ | - | ✓ | ✓ | | | | |
| | Data Security & Protection | ✓ | Oct | ✓ | | | | | |
| | Unified Comms (Avaya) & Telephony Improvements | Oct | | | | | | | |
| | Telephony – 999/111 integration enablers | Sept PMB✓ | Oct | | | | | | |
| | WiFi Phase 2 | ✓ | Oct | ✓ | | | | | |
| | LAN Refresh (core switches) | ✓ | ✓ | ✓ | | | | | |
| | Develop Data Warehouse | Oct | | | | | | | |
| | Body Worn Cameras - Pilot | ✓ | Oct | | | | | | |
| | IPads for Frontline staff (replacement) | Sept PMB✓ | Oct | | | | | | |
| Estates | Equality Act 2010 Access & Compliance (HQ Front of House) | ✓ | Oct | ✓ | ✓ | | | | |
| | Covid Funded Ambulance Consolidation Works | Colt / Gold | – | – | – | – | – | – | ✓ |
| | Covid Funded Expansion Project | Colt / Gold | – | – | – | – | – | – | ✓ |
| Fleet | Interim Fleet Management System | ✓ | Oct | ✓ | ✓ | ✓ | | | |
| | Project Zerro (SLF) | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| | EPRR Vehicle Replacement | ✓ | - | ✓ | ✓ | ✓ | | | |
| | Bunkered Fuel | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |

Table 4: Spatial and Medicines Management Smaller Capital Projects Phases of Delivery

| | | Business Case Status / Approval | PID Status | Scoping | Initiation | Design | Delivery | Live / Transition | Close |
|---|---|---|---|---|---|---|---|---|---|
| Spatial | EOC Training Relocation | – | – | – | – | – | – | – | ✓ |
| | Bow VRV | – | – | – | – | – | – | – | ✓ |
| | HQ Refurbishment | – | – | – | – | – | – | – | ✓ |
| | Bow Data Centre Cooling | ✓ | ✓ | ✓ | In progress | In progress | | | |
| Medicines Modernisation | Multi-Dose Packs | ✓ | Oct | | | | | | |
| | Kit Prep 2 | ✓ | Oct | | | | | | |
| | Drugs Traceability | Sept PMB ✓ | Oct | | | | | | |
| | Automated Temperature Monitoring | Sept PMB ✓ | Oct | | | | | | |
| | ALS Bags | – | – | – | – | – | – | – | ✓ |
| | Primary Response Bags | – | – | – | – | – | – | – | ✓ |

Table 5: Additional Capital Projects Prioritised for Approval

| Priority Order | Programme | Project | Original Capital Allocation (£k) | Business Case Started? |
|---|---|---|---|---|
| 1 | Estates | 999/111 Expansion at HQ (Overhang) – Additional | 21 | |
| 2 | Fleet | Satellite Navigation Upgrade | 373 | |
| 3 | Fleet | Crew Safety System Units | 1,680 | |
| 4 | Estates | 24 Hour Chairs for 111 Service | 100 | |
| 5 | Spatial | SEL IUC Expansion | 1,250 | |
| 6 | Estates | Ambulance Consolidation (Phase 3) | 800 | |
| 7 | Estates | Ambulance Deployment Centre | 5,000 | In progress by Alan Bristow and team |
| 8 | Logistics | Replacement Logistics Supply Unit | 3,000 | Sep PMB / LIC |
| 9 | Estates | Maritime House 1st Floor Reconfiguration for CES | 130 | |
| 10 | Spatial | Tactical Operations Centre at Waterloo EOC | 750 | In progress by Jon Goldie and team |
| 11 | Spatial | UPS Expansion at Maritime House and HQ | 600 | |
| 12 | Logistics | Orderwise Expansion for Medical Equipment | 150 | |
| 13 | Logistics | RFID to Track High Value Equipment in Vehicle Preparation Hubs and Logistics Unit | 200 | |
| 14 | Logistics | 2 Fork Lifts, 1 Reach and 1 Counterbalance | 37 | |
| 15 | Fleet | 6 Logistics Vans | 110 | |
| 16 | Fleet | 7 Incident Response Officer (IRO) Vehicle Conversions | 140 | |
| 17 | Fleet | 2 IRO Vehicles | 102 | |
| 18 | Fleet | 4 Fast Response Unit (FRU) Electric Vehicles (EV) (FRU) | 200 | |
| 19 | Fleet | 1 FRU EV (EPRR) | 50 | |
| 20 | Fleet | 5 FRU EV (Sector Vehicles) | 250 | |
| 21 | Fleet | 4 FRU EV (Volunteer Responders) | 200 | |
| 22 | Clinical Equipment | ~300 MIBS Stretchers for CTM and IRO Cars | 21 | |
| 23 | Clinical Equipment | CTM Life Support Training Equipment for all Complexes (e.g. Mannequins) | 650 | |
| 24 | Fleet | New Generation MDT Systems for Operations (MDT to National Mobilisation Application) | 280 | |
| | | Total | 16,094 | |

## 5.0 Benefits Realisation

The table below sets out the four key themes that both financial and non-financial benefits will be measured against. The Trust is currently developing a financial efficiency plan to capture and report on the tangible cash and non-cash releasing benefits and will work with each programme to define KPIs to measure and track benefit realisation.

| Building the Basics | Achieving Safety | Delivering Efficiencies | Modernisation |
|---|---|---|---|
| • Telephony (Avaya) upgrade to CM7<br>• Resilience CAD<br>• EOC upgrade to Windows 10<br>• UPS and generators<br>• EOC training relocation<br>• Bow VRV (air-con)<br>• HQ refurbishment<br>• 37 chassis and box body conversions<br>• EPRR vehicle replacements<br>• Telephony and recording systems expansion<br>• iPads, PCs, laptops, and associated accessories<br>• Data security and protection<br>• WiFi phase two<br>• LAN refresh core switches<br>• Develop data warehouse<br>• Infrastructure refresh<br>• Bow data centre cooling<br>• Control room – 999 / 111 SEL expansion<br>• Bow modernisation<br>• Ambulance station remedial works<br>• Fleet management system (interim solution)<br>• SEL Integrated and Urgent Care (IUC) expansion<br>• Two forklifts, one reach, and one counterbalance<br>• Logistics vans, IRO vehicles and conversions, fast response unit electric vehicles<br>• Sat nav upgrades<br>• New generation mobile data terminal (MDT) systems for operations | • Primary response bags<br>• Advanced life support bags<br>• Secure drugs rooms<br>• OneLondon LHCR<br>• Lifepak 15 defibrillators<br>• Tempus Pro monitors / defibrillators<br>• Critical care transfer service equipment<br>• Data security and protection<br>• Body worn cameras (pilot)<br>• HQ front of house<br>• Covid funded ambulance consolidation project<br>• Covid funded expansion project<br>• Drugs packing unit<br>• Multi-dose packs (interdependency with Kit prep 2)<br>• Kit prep 2 (interdependency with Multi-dose packs)<br>• Drugs traceability<br>• Automated temperature monitoring<br>• Tactical operations centre at Waterloo EOC<br>• 24 hour chairs for 111 service<br>• Crew safety system units<br>• Sat nav upgrades<br>• MIBS stretchers<br>• CTM life support training equipment for all complexes | • Primary response bags<br>• Advanced life support bags<br>• Bunkered fuel<br>• Stock management system for PPE and medical equipment<br>• Unified communications and telephony improvements<br>• Telephony – 999 / 111 integration enablers<br>• Ambulance station consolidation<br>• Training consolidation<br>• Drugs packing unit<br>• Multi-dose packs<br>• Automated temperature monitoring<br>• Replacement logistics supply unit<br>• RFID to track high-value equipment<br>• MIBS stretchers | • ePCR<br>• New CAD<br>• Super low floor double crewed ambulance (DCA)<br>• Training consolidation<br>• Drugs packing unit<br>• Ambulance deployment centre<br>• Replacement logistics supply unit<br>• OneLondon LHCR |

## 6.0 Prioritisation of additional funding

The ‘long list’ of proposed projects were assessed against the critical success factors listed below to make the short list (table below left). This was further prioritised (table below right)


Score each element 1 (low) to 5 (high) = Prioritised short list (maximum total score is 25)

| Programme | Project | Capital Requirement (£k) |
|---|---|---|
| Estates | Ambulance Deployment Centre | 5,000 |
| | Ambulance Consolidation (Phase 3) | 800 |
| | 999/111 Expansion at HQ (Overhang) – Additional | 21 |
| | Maritime House 1st Floor Reconfiguration for CES | 130 |
| | 24Hour Chairs for 111 Service | 100 |
| Spatial | Tactical Operations Centre at Waterloo EOC | 750 |
| | UPS Expansion at Maritime House and HQ | 600 |
| | SEL IUC Expansion | 1,250 |
| Logistics | Replacement Logistics Supply Unit | 3,000 |
| | Orderwise Expansion for Medical Equipment | 150 |
| | RFID to Track High Value Equipment in Vehicle Preparation Hubs and Logistics Unit | 200 |
| | 2 Fork Lifts, 1 Reach and 1 Counterbalance | 37 |
| Fleet | Crew Safety System Units | 1,680 |
| | 6 Logistics Vans | 110 |
| | 7 Incident Response Officer (IRO) Vehicle Conversions | 140 |
| | 2 IRO Vehicles | 102 |
| | 4 Fast Response Unit (FRU) Electric Vehicles (EV) (FRU) | 200 |
| | 1 FRU EV (EPRR) | 50 |
| | 5 FRU EV (Sector Vehicles) | 250 |
| | 4 FRU EV (Volunteer Responders) | 200 |
| | Satellite Navigation Upgrade | 373 |
| | New Generation MDT Systems for Operations (MDT to National Mobilisation Application) | 280 |
| Clinical Equipment | ~300 MIBS Stretchers for CTM and IRO Cars | 21 |
| | CTM Life Support Training Equipment for all Complexes (e.g. Mannequins) | 650 |
| | **Total** | **16,094** |

| Priority Order | Programme | Project | Original Capital Allocation (£k) |
|---|---|---|---|
| 1 | Estates | 999/111 Expansion at HQ (Overhang) – Additional | 21 |
| 2 | Fleet | Satellite Navigation Upgrade | 373 |
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| 24 | Fleet | New Generation MDT Systems for Operations (MDT to National Mobilisation Application) | 280 |
| | | **Total** | **16,094** |

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Business Plan | | | |
| **Agenda item:** | 10 | | | |
| **Report Author(s):** | Donna Fong, Strategy Team Support | | | |
| **Presented by:** | Ross Fullerton, Director of Strategy and Transformation | | | |
| **History:** | Executive Committee 16 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☒ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

The Trust is still yet to receive a confirmed financial settlement for the remainder of 2020/21, therefore the content of the business plan document has been developed based on the key deliverables to be prioritised for the remainder of this financial year.

Prior to the pandemic, the Trust was set to enter the third year of the five year strategy. In the course of responding to the pandemic it was necessary to accelerate certain aspects of our strategy in order to respond effectively to unprecedented levels of demand. Taking into account the changes made in response to the first peak of the pandemic, our learning from this experience, and the changes in how patients access healthcare, the Trust has reset the priorities for the next 5-years across six strategic themes.

This document sets out our objectives and plan in 2020/21 to:

- Provide a resilient service that delivers the right care first time for our patients, every time
- Deliver our national performance and quality standards every day
- Consistently deliver our financial targets and drive economic benefits in the London system

This paper should be considered the context of two accompanying papers – one providing an update on financial arrangements, and the other on the operational resourcing plans to deliver performance for the remainder for this year.

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

The Trust Board are asked to review and agree the content of the business plan, recognising the financial context.

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

# London Ambulance Service NHS Trust 2020/21 Business Plan

September 2020

# Contents

# Overview

*The Covid-19 pandemic has profoundly affected the way patients access urgent and emergency care. This plan sets out how the Trust is responding to changes in the wider health and social care system, and how we are continuing to drive forward our overall vision to become London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'.*

The LAS remains committed to the vision and goals set out in our 5-year strategy, and prior to the pandemic the Trust was making good progress towards delivery of our strategic objectives. To tackle the challenges presented by the first peak of the pandemic, it was necessary for the organisation to accelerate aspects of our strategy in order to provide an effective response and maintain organisational resilience.

**Our vision and goals:**

**To be a world class ambulance service for a world class city: London's primary integrator of access to urgent and emergency care 'on scene', 'on phone' and 'on line'**

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

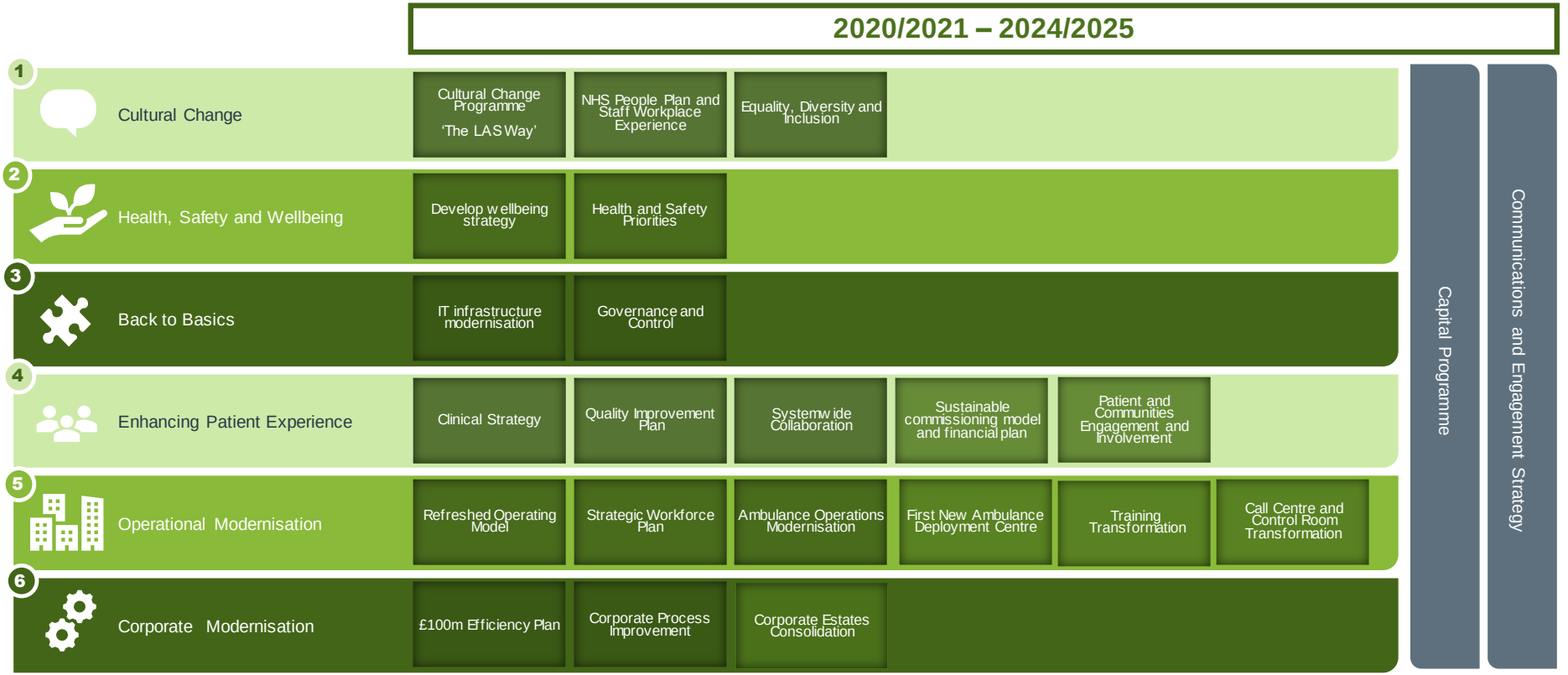
## 1.1 Our five-year plan

The Trust's response to Covid-19 has shown how we are able to respond quickly and effectively to challenges and deliver faster change, but it also surfaced areas of our operations that are inefficient and not fit for a modern ambulance trust. The plans for transformation over the next five years marks a radical rethinking of how the organisation will work differently in the future and how it will deliver an updated model of care in support of patients receiving the right care, first time.

Our priorities over the next five years will therefore be focused on six strategic themes (described in section 1.2) in order to:

- Deliver our national performance and quality every day
- Provide a resilient service that delivers the right care first time for our patients, every time
- Consistently deliver our financial targets and drive economic benefits in the London system

## 1.2 The Trust's six strategic themes



## 1.3 Immediate planning priorities

Our planning assumes that Covid-19 will continue to contribute to demand for the foreseeable future, therefore it is essential the Trust continues to maintain resilient services in the event of subsequent pandemic peaks and other seasonal demand pressures. Specific measures have been put in place to give early indication of increased pandemic activity and will trigger deployment of our surge plans as required.

Guidance issued by NHS England and NHS Improvement issued at the end of July set out the third phase of the NHS response to Covid 19 to be delivered before winter peaks. This includes three key priorities for the system to accelerate the return to near-normal levels of non-Covid health services, prepare for winter demand pressures alongside continuing vigilance in the light of further probable Covid spikes, and to take account of lessons learned during the first Covid peak to lock in beneficial change - explicitly tackling fundamental challenges including support for our staff, and action on inequalities and prevention.

In addition, health and social care leaders are currently analysing the implications of the UK's exit from the European Union and to make decisions about next steps. The LAS will be represented in the working group established by NHS England.

The LAS are responding to this directive through a number of initiatives, some of which include:

- the development of surge and resilience plans for all our operational teams, including access a flexible and trained workforce through arrangements with the London Fire Brigade, student paramedics, and establishment of a staff bank
- Working to deliver greater integrated care across the system through 111 First to provide patients increased access to care in primary and community care settings, reducing the number of avoidable admissions to EDs
- Expansion of call handling facilities to accommodate a greater number of call handlers and clinicians in 111 and 999 EOC.
- the active recruitment of staff to the establishment levels required to deliver performance
- introduction of a new non-registrant role to supplement anticipated shortages in frontline workforce

# 2 Cultural Change

*We are committed to making the LAS the best place to work. Our purpose is to be a first class employer, valuing and developing skills, diversity and quality of life for our people.*

## 2.1 Cultural Change Programme 'The LAS Way'

Rapid delivery of the Trust's transformation agenda will present a number of complex challenges that will require the efforts of the whole organisation, therefore we will invest in our people to develop an organisational culture that will drive forward successful and lasting change.

To ensure clarity of the target culture the Trust wants to achieve, we will carry out an in depth cultural assessment across the organisation to identify the clear interventions needed to achieve 'The LAS Way'. Coaching and equipping our leaders with the right skills will be essential in making cultural shifts, therefore dedicated programmes of work will be initiated to support leadership development.

**2020/21 Cultural Change Deliverables**

- Cultural assessment carried out by December 2020 with clear action plan and detailed delivery timescale
- Learning content, competency framework and supporting toolkit for the LAS Leadership academy 'Emerging LAS Leaders' (Band 6 and line managers) programme formally launched

## 2.2 NHS People Plan and Staff Workplace Experience

*We are the NHS: People Plan 2020/21* sets out what our NHS people can expect from their leaders and from each other, and focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care. The Trust is committed to progressing all aspects of the NHS People Plan, as well as the establishment of a dedicated action plan to promote dignity and respect at work, enforcing our zero tolerance to bullying and harassment and creation of a positive working environment for our staff and volunteers.

The annual NHS Staff Survey is a key indicator about how our staff are feeling about LAS as a place to work and informs targeted areas for improvement. We will complete delivery of our staff survey action plan from 2019/20, alongside development of bespoke people plans for each directorate to address local challenges, and to ensure each staff member is offered an opportunity to feedback through their annual appraisal.

**2020/21 Staff Workplace Experience Deliverables**

- Improvements on 2019/20 staff survey scores across all workplace experience metrics
- Recovery from the Covid response and return to target of all staff having annual appraisals completed, achieving 85% compliance across the Trust
- Dignity at work action plan implemented from January 2021 to reduce the number of cases bullying and harassment with the aim to be in the upper quartile of organisations for reducing bullying and harassment in the 2021 staff survey
- A 50% reduction in 2019/20 employment tribunal cases

## 2.3 Equality, Diversity and Inclusion

Creating an inclusive organisation where equality and diversity is paramount has always been an important priority for the Trust, especially for our protected communities. As an employer, we will support positive change for all our staff and volunteers and to ensure that all staff are treated fairly, not discriminated against, and that their talents are valued and developed

Our plans to grow as an inclusive organisation will be achieved through delivery of national NHS WRES and WDES guidance, which aims to improve the experience of staff and volunteers through core HR processes such as recruitment and selection, training opportunities, and disciplinary action. In response to Black Lives Matter, the Trust Board has agreed a specific delivery plan to tackle specific matters affecting out BME staff across three strands to: Educate, Respond, Enable.

**2020/21 Equality, Diversity and Inclusion Deliverables**

- 95% of all staff to complete mandatory inclusion training
- Achieving a workforce profile across the Trust made up of 17.5% BAME staff across all staffing groups (Bands 2-4; Bands 5-7; Band 8+, and non AfC) by 2022
- Diversity and Inclusion Strategy approved by the Board in Q4 2020/21
- WDES the annual report by the Trust Board and published on the LAS website in Q3
- All actions under the three strands of the Black Lives Matter delivery plan concluded, with the “Stamp Out Racism” Campaign launched in January 2021

# 3 Health, Safety and Wellbeing

*Improving the health, wellbeing, and safety of our staff and volunteers is an essential component in making the NHS the best place to work.*

## 3.1 Wellbeing Strategy

Research shows that where NHS trusts prioritise staff health and wellbeing and actively engage with staff to develop work in this area, levels of engagement increase, as does staff morale, loyalty, innovation, productivity, all resulting in higher quality patient care. The Trust wants to encourage and enable our staff to lead healthy lives and make choices that support positive wellbeing, and to make accessible mental and physical health services to support individuals when they need it.

The challenges of responding to the pandemic highlighted the enormous pressure placed on our staff and volunteers, and the Trust has now embedded the Wellbeing Hub as part of our routine HR function and continues to work proactively with AACE on suicide prevention plans.

**2020/21 Wellbeing Deliverables**

- Improvements across all wellbeing scores in the 2020/21 staff survey:
  - Organisation takes positive action on health and wellbeing – 2022 target 25%
  - In the last 12 months, have not experienced musculoskeletal problems as a result of work activities – 2022 target 60%
  - Not felt unwell due to work related stress in last 12 months – 2022 target 55%
- Maintaining staff absences rates of 5% and less across the Trust
- Ratification of the Wellbeing Strategy by the Trust Board in Q3 2020/21
- Bereavement support / resources available for managers

## 3.2 Health and Safety Priorities

It is our greatest priority to protect the health and safety of our staff and volunteers. This includes addressing the number of incidents of violence and aggression towards ambulance staff, ensuring staff and volunteer are working in Covid secure environments, and the right PPE is available to staff caring for potential Covid patients. In recognition that frontline BME staff are more susceptible to Covid, specific PPE provisions are made available at local stations to ensure the safety and protection of staff.

**2020/21 Health and Safety Deliverables**

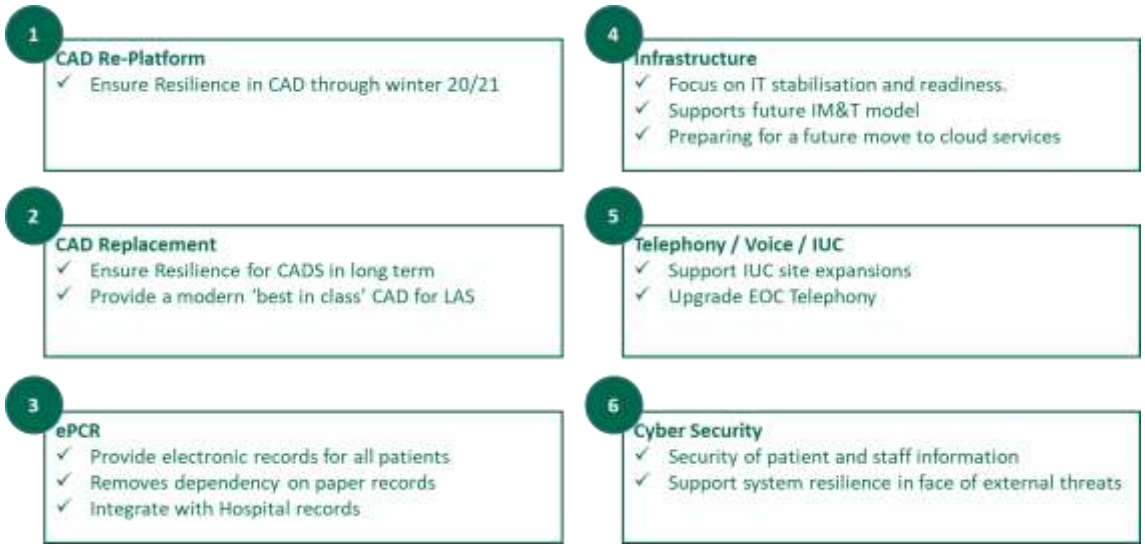
- Reduction of violence and aggression incidents on frontline staff following the roll-out of body worn cameras
- Increase in successful prosecutions for staff assaults from Sept 2020 baseline to March 2021
- 100% of active LAS estate to achieve and maintain Covid-secure status
- Reduction in the number of incidents relating to access to PPE
- Reduction in Musculoskeletal incidents from current baseline (Sept 2020) by 35% at March 2021.

# 4 Back to Basics

*Setting strong foundations in the organisation will provide a stable platform to deliver outstanding organisational performance and drive forward our bold transformation agenda.*

## 4.1 IT infrastructure modernisation

Our digital and technology plans place a clear focus on improving the technology used by the Trust and builds resilience with existing systems. The digital roadmap for 2020/21 therefore has six key focus areas:




**2020/21 IT Infrastructure Deliverables**

- Increased resilience over winter in 999 EOC with the implementation of the CAD replatform
- Infrastructure improvements to support stability of our IT estate and preparations to move to hosted solutions, including NHS Mail, O365, Wifi redesign and Intune
- A single consolidated telephony and voice recording platform across 111/999 call handling services
- Rollout of ePCR allowing our frontline clinicians to access patient records
- Cyber security measures in place to protect the Trust's data and support resilience against external threats

## 4.2 Governance and Control

The CQC defines a well-led organisation as one that has a leadership, management and governance framework in place that assures the delivery of high quality person-centered care, support learning and innovation, and promote an open and fair culture. Our improvement plan to strengthen our governance system includes a firm grip on our procurement and contract management processes, ensuring a high standard of information governance compliance, and building the capacity and capability of our Executive Team.

**2020/21 Governance and Control Deliverables**

- Trust Executive capacity and capability enhanced by individual growth plans, targeted recruitment plans and developing delivery partnerships
- 'Culture of Compliance' established through educating and training staff on the importance of the Standing Financial Instructions and Scheme of Delegation- seeking to improve the way in which we procure, and contract manage third party services
- Due diligence review of contractors completed by the end of September 2020
- Achieve 90% target for Freedom of Information requests being responded to within 20 working days.
- Standards continued to be met in the Data Security and Protection Toolkit.
- All Trust policies are kept up-to-date and are available for staff to access.

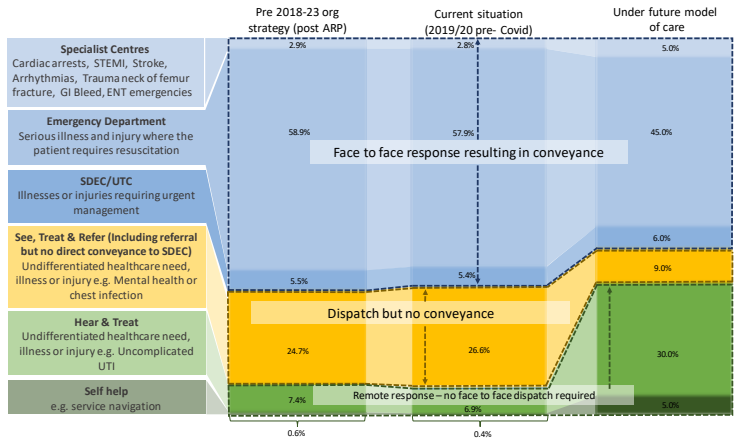
# 5 Enhancing Patient Experience

*The COVID-19 pandemic has led to a change in the way the NHS manages patients and how patients might seek treatment, with a recognition that more care can be provided out of hospitals enabling patients to receive care closer to home.*

## 5.1 Clinical Strategy

Achieving the best health outcomes for the population of London is our priority. In response to the changes we have seen in the way patients seek treatment and the planned service reconfigurations in each of London's Integrated Care Systems (ICS), we have reviewed our model of care to ensure that patients continue to receive the right care, first time in the right healthcare setting.

Our updated clinical strategy looks to influence a number of changes to our model of care that will result in significantly fewer patients conveyed to EDs, with all other options being more effectively utilised in treating more of our patients remotely with no face to face dispatch. The four underpinning principals that will shift the current model of care to a future state include:




1. Enhancing our **clinical assessment capabilities** to help patients get the right response for their needs
2. Enhancing the '**on scene' clinical assessment** and diagnostic capabilities
3. **Understanding our patients presenting condition** to ensure they receive an appropriate timely response
4. Ensuring we **treat patients holistically**, with appropriate consideration of their broader health and well being

Patient outcomes is an essential measure of our clinical strategy, and therefore we will be including a greater focus on this through the inclusion of patient outcome metrics in the Integrated Performance Report. Potential indicators may include:

- Proportion of patients conveyed to a type 1 or type 2 emergency department
- See and treat recontact rates
- Time to commencement of bystander cardiopulmonary resuscitation (CPR) during a 999 call
- Category 1 identified via nature of call (NoC) questions
- The proportion of patients who receive the ST elevation myocardial infarction (STEMI) bundle of care
- Return of spontaneous circulation (ROSC) sustained to hospital
- The proportion of patients who receive the post-return of spontaneous circulation (ROSC) care bundle
- The proportion of patients who receive the sepsis bundle of care
- Provision of e-prescriptions
- Consult and complete rates
- % of calls recommended to ED
- % of calls transferred to 999
- Proportion of patients who receive clinical input into a 111 call

**2020/21 Clinical Strategy Deliverables**

- Monitoring of patient outcome metrics in the Integrated Performance Report (IPR)
- Introduce statistical process control (SPC) for selected patient outcome metrics in the IPR to support a focus on improvement
- Ensuring an appropriate skill mix is employed by the Trust to better enable the clinical strategy
- Clinical feedback system in developed during this financial year, for roll out from mid-2021 accompanied by access to case based learning discussions which foster a culture of open and blame-free learning.
- Learning review of conveyance (patients not admitted or Length of Stay >0 days) pilot commenced
- Hear and treat rates increased from the 2019/20 position and increased use of out of hospital clinical care pathways from scene, and reduced ED conveyance rates on an improving trend.

## 5.2 Quality Improvement Plan

The Quality Account for 2020/21 focusses on the quality of clinical care and patient experience to ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of everything that we do. We want to strive for 'outstanding' CQC rating across our sites and services by 2021, therefore our quality priorities will be focussed on the areas illustrated.

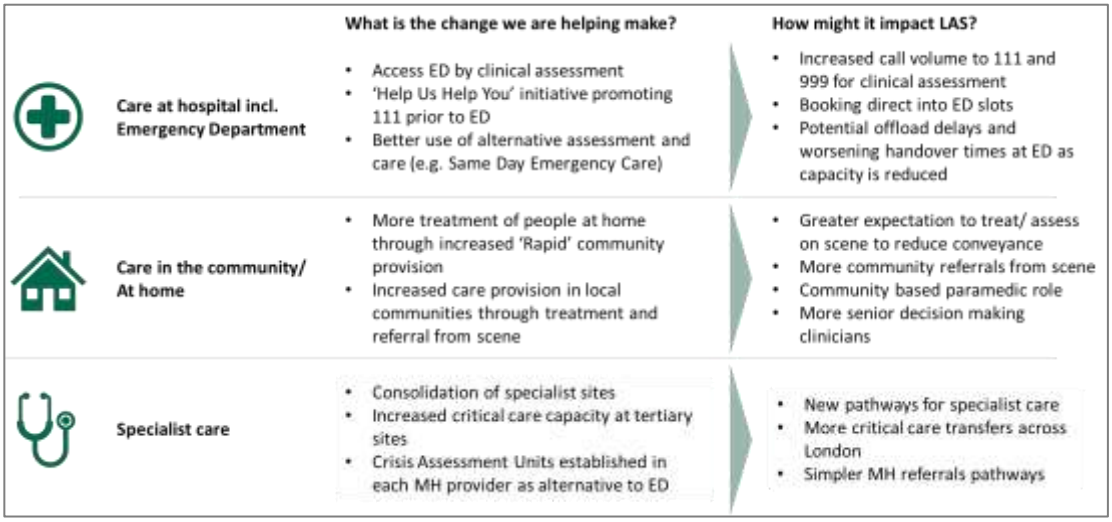
| | | | | | |
|---|---|---|---|---|---|
| **Safe**<br>People are protected from abuse and avoidable harm | **Target 1**<br>The administration of thrombolysis by APP – Critical Care for patients in cardiac arrest with pulmonary embolus | **Target 2**<br>Pilot of non-medical prescribing for paramedics in conjunction with HEE. | **Target 3**<br>Implement the new Patient Safety Incident Response Framework and be a pioneer in the new process for other Ambulance Trusts. | **Target 4**<br>Ongoing testing of Trust security measures to ensure continuous improvement Trust arrangements to secure vehicles stations and equipment. | **Target 5**<br>Completion of the medicine management room project to ensure medicines are correctly stored. . |
| **Caring**<br>Staff involve and treat people with compassion, kindness, dignity and respect | **Target 1**<br>Invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service. | **Target 2**<br>Reduction in Violence & Aggression | **Target 3**<br>Develop the stress policy in relation to wellbeing of staff. | | |
| **Effective**<br>People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence | **Target 1**<br>Continue with efforts to achieve the IUC service's staff rota to ensure comprehensive covers at all times | **Target 2**<br>Assess the use of the IUC service's escalation plan triggers to ensure key factors are being considered. | | | |
| **Responsive**<br>Services are organised so they meet people's needs | **Target 1**<br>Undertake a deep dive review into delays (2x90th centile) to patients due to recent high demand and COVID19 | **Target 2**<br>Integrating the 999 and 111/IUC CAS systems to provide seamless care for patients regardless of access point. | **Target 3**<br>Clinical development of ePCR and a new CAD system to capture clinical care of patients | **Target 4**<br>Ensure key performance indicators are developed to provide patient outcomes that are regularly reported and monitored against the new model of care delivery. | |
| **Well Led**<br>The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture | **Target 1**<br>Develop Quality Improvement Hubs for sharing best practice through a formalised operations & management structure | **Target 2**<br>A continuous focus on improving the Staff Survey results particularly around B&H culture. | **Target 3**<br>Explore and develop the paramedics in Primary Care Network (PCN) proposal to provide a broader training opportunity for paramedics. | **Target 4**<br>Ensuring that the Trust adopts and maintains the optimal health & wellbeing strategies and culture for both existing LAS staff and the expanded workforce during and after the COVID-19 pandemic | **Target 5**<br>Governance review of contracting and procurement processes to ensure robust assurance mechanisms are in place and adhered to |

**2020/21 Quality Improvement Deliverables**

- Quality governance and assurance delivery model reviewed and trialled by end of September, and quality improvement hubs established in each sector and service by February 2021
- Quality Improvement Hub trialled and evaluated in one Ambulance Hub and plan for the ratified model to be rolled out to seventeen additional hubs aligned to the Ambulance Operations Modernisation Programme
- Reduction in inappropriate conveyance of patients at end of life in the pre hospital setting addressed through system wide initiatives, reducing current baseline by 10%
- On-going reduction in conveyance of mental health patients to emergency departments through expansion of dedicated mental health cars, staff training and improving pathways with system partners

## 5.3 Systemwide Collaboration

The Integrated Care System (ICS) is now the primary level at which the London health and social care system is designed and delivered. Change will be provider-led, and the aim will be to shift away from hospital care to primary care, community, mental health services, and other local care services. Healthcare leaders across London's emerging ICS are currently reassessing their population's health needs and are preparing detailed plans as per the 'Journey to a New NHS' framework that will be used to change the way health and care is delivered, going beyond the changes that were planned as part of the London Vision and the NHS Long Term Plan. The LAS will work closely with system partners to support delivery of shared strategic priorities, ensuring a once for London approach.
Some of the system changes expected to be prioritised in 2020/21 include:




**2020/21 System Collaboration Deliverables**

- Evaluation of Merton pilot for Primary Care Network (PCN) paramedics completed, which will inform the broader rollout
- Redesigned clinical pathways as part of the 111 First initiative developed and implemented by December 2020
- Pathways for Same Day Emergency Care and improved non-conveyance guidance developed

## 5.4 Sustainable Commissioning Model and Financial Plan

The Trust is working through its host ICS, NWL HCP, to negotiate a financial envelope for the rest of 2020/21 that will enable capacity for the continued delivery of national performance standards, resilience against Covid demand spikes and standing up our ambitious modernisation programme which is targeting to deliver a revenue-neutral envelope over the next 3-5 years. Part of this negotiation is the review of current commissioning and contract oversight arrangements and financial levers and incentives to ensure these provide a LAS commissioning model which optimises benefits for patients through increased hear and treat and reduced ED conveyances and recognises where it can provide region-wide services to improve system resilience as well as economies of scale for both organisation and system-wide efficiencies. Going forward the Trust is also working with commissioners to integrate contracting and governance meetings across all its 999 and 111/IUC contracts.

**2020/21 Sustainable Commissioning Model and Financial Plan Deliverables**

- Improved governance arrangements across all its 999 and 111/IUC contracts due to commence in Q3 2020/21.

## 5.5 Patient and Communities Engagement and Involvement

To help deliver the best possible care for our patients and their families, the Trust works with a wide number of patient groups and charities to seek their advice and input into the decisions we make. Our commitment to improving our patient and public engagement will be bolstered through a newly created London Ambulance Service Public and Patients Council. The Council will provide a voice for patients, the public and carers in the design, development and delivery of Trust services and advises on ways to gain broader engagement, as necessary.

**2020/21 Patient and Communities Engagement and Involvement Deliverables**

- Regular engagement with the London Ambulance Service Public and Patients Council

# 6 Operational Modernisation

*The majority of the LAS' patient facing services are delivered by the three operational areas of the Integrated Urgent Care services (IUC), the Emergency Operations Centre (EOC) and Ambulance Services. Modernisation of our core operations will promote improved productivity and performance, allowing maximum time for patient care.*

## 6.1 Operating Model Review

The realise the future model of care, we will look to operationalise the clinical strategy across all the core teams, to ensure we have the right capacity and skill mix in place to deliver high standards of patient care, to consistently meet our performance standards in a manner which offers value for money.

**2020/21 Operating Model Review Deliverables**

- Increased recruitment to substantive 111 / 999 EOC call handling roles, and providing training to allow multidisciplinary working across call handling function
- Clarity on the clinical staffing model in the Clinical Assessment Service and Clinical Hub, based on a skill mix review and varied caseloads
- All patient facing resources consolidated under the management of the Ambulance Services Directorate
- Non registrant Band 4 Associate Ambulance Practitioners (AAP) role established and circa 184 frontline staff recruited and trained by spring 2021
- Formalised arrangements with the London Fire Brigade and Paramedic students to supplement our operational workforce
- Strengthened integration of LAS volunteers into ambulance operations
- Capacity of non-emergency transport is increased to support Cat2 APP(UC) dispatch

## 6.2 Strategic Workforce Plan

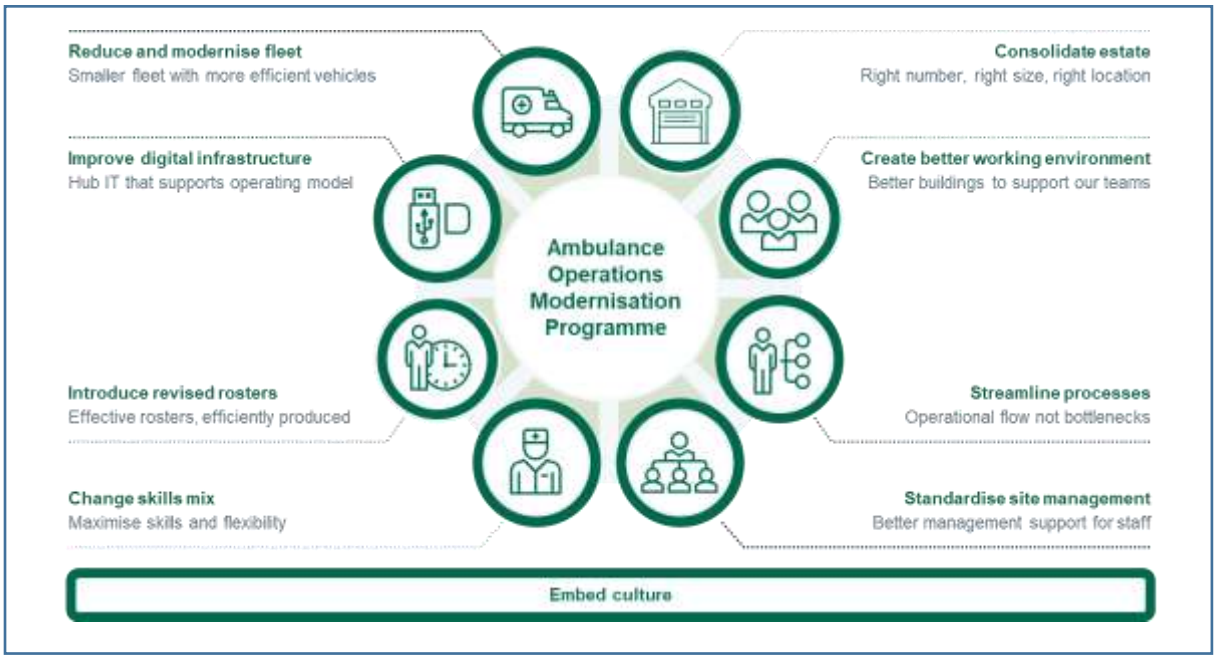
As ambulance trusts continue to face challenges around long-standing workforce supply issues, it is necessary for the LAS to understand the future workforce requirements and to put in place strategies to deliver a sustainable pipeline of staff aligned to the requirements of our operating models. The Strategic Workforce Planning Team is charged with delivering the operational recruitment requirements for the remainder of this financial year, ensuring there is sufficient capacity of flexible workforce that can be accessed in times of surge, and to commence strategic recruitment planning from 2022/22 onwards.

**2020/21 Strategic Workforce Plan Deliverables**

- A staff bank facility operationalised
- Confirmed recruitment plans for the remainder of 2020/21 aligned to the operating model, and a staff vacancy rates of less than 5%
- Maintaining staff turnover rate below 10%
- Strategic recruitment plan for the next 2-3 years in place

## 6.3 Ambulance Operations Modernisation

The Trust's ability to deliver improvements in Ambulance Operations is heavily constrained by outdated operational estate and working practices, and continued investment into these inefficient systems is unsustainable. Our plan is to commence realisation of the Trust's estate vision and to use the consolidation of the ambulation station estate as the catalyst to deliver wide wide-ranging change across people, processes and infrastructure.




**2020/21 Ambulance Operations Modernisation Deliverables**

- Programme Business Case approved by the Trust Board and endorsed by external stakeholders by the end of 2020
- Scoping work and option appraisals completed to identify the preferred locations of hubs 2 - 18
- Estimated commercial value of the estate completed through a desktop evaluation
- Modelling to inform the design of demand-led rosters completed

## 6.4 First New Ambulance Deployment Centre

Our proposed plan is to implement an ambulance deployment which is centred on a main station hub with associated response points. A modern ambulance deployment model provides the opportunity for LAS to re-redesign and re-engineer the foundations of how we operate, therefore by the end of 2020/21 we will have established the first centre which will provide:

- early learning around all aspects of the hub
- demonstrate to our workforce the benefits to wellbeing, operating practices, support and the ability to deliver patient care.
- demonstrate to stakeholders the potential wider patient and system benefits that can be realised when well equipped, clean ambulances are available when and where they are needed and are crewed by highly motivated clinicians.

**2020/21 First Ambulance Deployment Centre Deliverables**

- Business case, capital investment and estate work for the Ambulance Deployment Hub 1 approved and realised by end FY2020/21

## 6.5 Training Transformation

It is our priority that our staff are provided with the necessary training required to carry out their role and duty, and that facilities are able to deliver digital and modern training methods. For local sector teams, we are delivering two modern and dedicated learning sites in the South and North sectors which are fit for purpose to deliver high quality education, and to make good the sites being exited for release. Our plans also include a dedicated interactive training centre for our 111/999 call handling workforce to be operational from August 2020.

**2020/21 Training Transformation Deliverables**

- Interactive training centre for 111/999 call handlers based at Maritime House operational by August 2020
- Two dedicated training centres based in North and South London operational by March 2021

## 6.6 Call Centre and Control Room Transformation

Our 111 Call Centre and 999 Control Room is the front door to urgent and emergency care in London and play a pivotal role as central navigators to manage the flow of patients across the wider health and social care system so that they receive care in the most appropriate setting. Increased resilience in these teams require increased call handling and clinical resources as well as the availability of space to expand these services. It is through this integrated working approach across 111/999 where the substantial benefits of 'consult and complete' and 'hear and treat' can be realised.

**2020/21 Call Centre and Control Room Transformation Deliverables**

- Two way video conferencing functionality in 111 embedded via the national procurement team
- Dedicated accommodation for the Tactical Operational Centre based in Waterloo HQ by Q4
- 999 Contact Centre and Clinical Assessment Hub at Waterloo, refurbishment or relocation Bow HQ, and extended capacity at Maritime House and Southern House completed
- An evidence based, responsive approach to resourcing, building on robust demand modelling and capacity forecasting in place, and simpler and more resilient scheduling processes to support effective roster management
- Robust and flexible call balancing arrangements across the North and South London teams that will stabilise performance and staffing across the sites to maximise efficiency

# 7 Corporate Modernisation

*The Lord Carter review into unwarranted variation within the ambulance services identified a large opportunity for efficiency for LAS.*

## 7.1 Efficiency Plan

The Trust has an ambition to achieve financial balance over the next five years, by delivering efficiencies of over £100m across the portfolio. This is based on the overall expenditure growth from 2019/20 actual to 2020/21 forecast outturn position of £527m, and a commitment to Commissioners that we will return to a reduced revenue position by the end of 2024/25.

The Trust has worked to identify a large number of efficiency opportunities contributing towards delivery of the six strategic themes, underpinned by transformation, capital investment and productivity, which will undergo a validation process prior to delivery and implementation.

It is anticipated the efficiency target will be collectively achieved through a number of modernisation initiatives to be delivered across the Trust as illustrated

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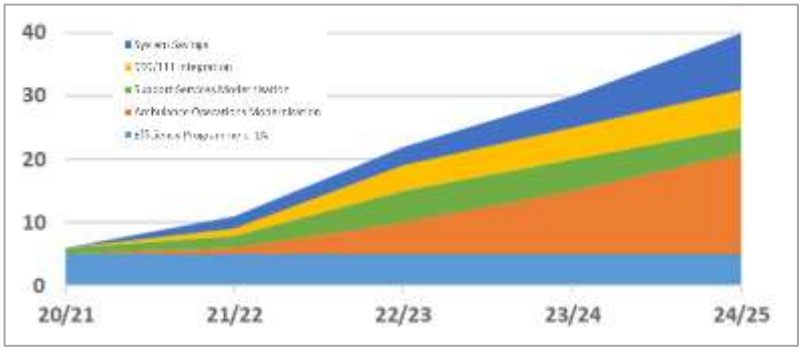


**2020/21 Efficiency Plan Deliverables**

- Governance in place via the Portfolio Management Board to oversee programme assurance and delivery
- Establishment of a task and finish group to validate the list of efficiency initiatives, and a roadmap of planned works in place to deliver annual efficiency targets to achieve £100m+ at the end of 2024/25

## 7.2 Corporate Process Improvement

The objective of this programme is to radically transform our Corporate Services processes to make them lean and fit for purpose aligned with Trust's Target Operating Model. This will include a review of trust turnover spend on corporate services functions, including finance, governance and risk, people and culture, I&MT, legal, procurement, pensions and payroll.

The first step will be to agree specific functional processes that will be in and out of scope on commencement, followed by the identification of existing processes and the design of "to-be" processes aligned with new ways of working. We will then establish the end-to-end process cost and benchmark with best in class and NHS Improvement guidelines. This will lead us in identifying short and long term opportunities which will improve the speed of execution and level of quality, as well as decreasing costs. Options appraisal will include; consolidation, collaboration or merging some processes into NHS National shared services.

**2020/21 Corporate Process Improvement Deliverables**

- Programme Board in place and governance via the Portfolio Management Board to overs programme assurance and delivery
- Programme Business Case approved by the Trust Board and endorsed by relevant external stakeholders by the end of 2020
- Scoping work and option appraisals completed to identify the key areas to focus savings target
- Establishment of a task and finish group to deploy the new process models

## 7.3 Corporate Estates Consolidation

In 2019/20 the Trust carried out substantial works to Waterloo HQ and Pocock Street which enabled consolidation of Union Street and Morley into these two sites, releasing recurrent savings of c£500K per annum. There are no further plans to consolidate corporate estate in 2020/21, however exploration of opportunities to develop the site at Bow is under consideration which could prospectively mean the chance to consolidate the Trust site at Pocock Street.

# 8 Enabling Strategies

*Achievement of our strategic objectives will be underpinned by a dynamic communications and engagement strategy to capture the voice of our staff and volunteers as we progress through the transformation journey, and the delivery of a capital programme as key enablers to deliver change across the Trust.*

## 8.1 Capital Programme

The 2020/21 Capital Plan is focused on supporting the organisation to get the basics right, and to provide a stable platform on which to build and deliver our ambitious transformation programme over the next 5 years. The value of the 2020/21 capital plan sits at £52.8m and comprises three key elements, including a further mitigation against in-year slippage to identify further projects with a view to over-provision portfolio delivery by a further £10m.

| 2020/21 Capital Programme | Value £m |
|---|---|
| Existing Projects (multi-year and paused projects) | 24.3 |
| New projects approved for 2020/21 | 19.9 |
| Further projects enabled by additional capital | 8.6 |
| **TOTAL** | **52.8** |

**2020/21 Capital Programme Deliverables**

- Prioritised capital business cases delivered to scope, time, and quality and expected benefits realised

## *8.2* Communications and Engagement Strategy

It is essential that our staff and volunteers are aware, understand and involved with our transformation ambitions and plans to deliver the Trust vision. This year we will develop our focus on improving the way the Trust communicates and engages with its staff and volunteers by upgrading our digital offer including a new intranet and app to enable better access to essential information and news and ensuring there are forums for everyone, across the Trust, to engage with our senior leadership team and access peer support.

**2020/21 Internal Communications Plan Deliverables**

- New intranet launched
- Communications and Engagement developed and approved by the Trust Board in March 2021
- Visits programme developed
- Patient surveys launched

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Patient and Communities Involvement and Engagement Strategy | | | |
| **Agenda item:** | 11 | | | |
| **Report Author(s):** | Antony Tiernan, Director of Communications and Engagement | | | |
| **Presented by:** | Antony Tiernan, Director of Communications and Engagement | | | |
| **History:** | Executive Committee 16 September 2020 | | | |
| **Purpose:** | ☐ | Assurance | ☒ | Approval |
| | ☐ | Discussion | ☐ | Noting |

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

The London Ambulance Service NHS Trust (LAS) is the busiest ambulance service in the UK and one of the busiest in the world. Over recent years, the context within which we work has changed significantly, and it will continue to change into the future.

Recognising the opportunities and challenges emerging, our 2018/19 to 2022/23 organisational strategy sets out how we intend to respond to achieve our ambitions and goals. As part of that strategy we acknowledge that there is an opportunity to significantly enhance the way we engage with patients and communities to improve the care we provide.

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

The Trust Board is asked to review and approve the London Ambulance Service NHS Trust Patient and Communities Involvement and Engagement Strategy.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | | No | | TBC |
| Finance | Yes | | No | | N/A |
| Chief Operating Officer Directorates | Yes | | No | | N/A |
| Medical | Yes | | No | | TBC |
| Communications & Engagement | Yes | x | No | | Director of Communications and Engagement |
| Strategy | Yes | | No | | TBC |
| People & Culture | Yes | x | No | | Director of People and Culture |
| Corporate Governance | Yes | x | No | | Director of Corporate Governance |

London Ambulance Service
NHS Trust


# Our patients and communities engagement and involvement strategy 2020 – 2023

**OUR PATIENTS AND COMMUNITIES ENGAGEMENT AND INVOLVEMENT STRATEGY – 2020 TO 2023**

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**OUR PATIENTS AND COMMUNITIES ENGAGEMENT AND INVOLVEMENT STRATEGY – 2020 TO 2023**

## 1. INTRODUCTION

The London Ambulance Service NHS Trust (LAS) is the busiest ambulance service in the UK. We handle over 1.9 million 999 calls each year and attend more than 1.2 million incidents. We also deliver NHS111 integrated urgent care services in south east and north east London handling circa 1.4 million urgent care calls annually.

Over recent years, the context within which we work has changed significantly, and it will continue to change into the future. Recognising the opportunities and challenges emerging, our 2018/19 to 2022/23 organisational strategy sets out how we intend to respond to achieve our ambitions and goals. As part of that strategy we acknowledge that there is an opportunity to significantly enhance the way we engage with patients, carers and communities to improve the care we provide.

## 2. OUR ORGANISATIONAL STRATEGY

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

Our organisational strategy, which followed an extensive engagement exercise, describes how we will achieve our vision. It details what we will look like in five years' time, and how we will get there, achieving our four goals:

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

The strategy focuses on three themes:

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

Our organisational strategy is ambitious, comprehensive and has implications for all aspects of the way we work now. Delivering it will further transform and improve the

care that Londoners can expect from the LAS. We recognise the importance of having a patients and communities engagement and involvement strategy to help us achieve our vision.

Moreover, our patients and communities engagement and involvement strategy is intrinsically linked to other related LAS strategies including our quality account/strategy, clinical strategy, people and culture strategy, estates vision and volunteering strategy.

## 3. WHY INVOLVE PATIENTS AND COMMUNITIES?

Key to the success of any NHS organisation is the involvement of patients, carers, their relatives and the community to give them the best experience of care possible.

Patient, carer and public involvement is enshrined in the NHS Constitution and we know that a positive experience during care leads to positive clinical outcomes. If a patient feels listened to and involved in their care they will respond better to clinical interventions and also be better able to manage their own journey of care.

The importance of patient, carer and public engagement in the NHS has been emphasised by findings from a number of key reviews relating to failures of care in the NHS, including Berwick (2013), Francis (2013) and Keogh (2013).

The Berwick review into patient safety recommended that patients and their carers should be “present, powerful, and involved at all levels of healthcare organisations from wards to boards and be listened to and involved in every organisational process at every step of their care”. Berwick argues for a broad level of engagement of patients in the processes of design, regulation and scrutiny of the system, not just in the individual clinician/patient relationship.

> “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.”
>
> **Olivia Butterworth, Head of Public Participation, NHS England**

## 4. HOW WE INVOLVE PATIENTS, COMMUNITIES AND OTHER STAKEHOLDERS

To help ensure we deliver the best possible care for our patients, carers and their families, we work with a wide number of patient groups, charities and other stakeholders to seek their advice and input into the decisions we make.

Patients and communities are important to us because they help us improve all aspects of care, including patient safety, patient experience and health outcomes.

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 the 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.

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

- Patients, carers, members of the public and communities
- London's five ICSs, including the Primary Care Networks, acute, mental health and community provider trusts
- Regional and national NHS bodies
- Emergency services partners including Metropolitan Police Service and London Fire Brigade
- The Mayor of London, Greater London Authority and London Assembly
- Members of Parliament and Governmental bodies.

## 5. HOW DO WE ENGAGE PATIENTS AND COMMUNITIES

Our engagement with patients, carers and communities focuses on gaining feedback on four key areas:


- Individual care and treatment – this includes the way in which our staff/volunteers interact with individual patients (i.e. how they greet them), through to how we treat cohorts of patients with certain conditions.

- Research – this includes how we involve patients in our in-house clinical audit and research activity, which incorporates providing a public and patients involvement 'link' for projects as required, and also providing representation on the Trust's Clinical Audit and Research Steering Group.

- Service delivery, design and transformation – this moves away from the individual to all our patients and the public, for example how we identified the need for, the provision and impact of our new mental health care service.

- Strategy and forward planning – this provides a formal mechanism for engaging in the development of our Trust strategy and enabling strategies.

The principles of equality and inclusion should be at the heart of everything we do as a Trust and it is important that our work to engage and involve patients, carers and local communities is representative of the groups that we serve. We must challenge ourselves to make sure we hear from – and involve – the broadest possible range of people, and make a particular effort to engage 'seldom heard' groups.

## 6. RECENT DEVELOPMENTS – 2019/2020

Over the last 12 months, we have made a number of changes to improve the way we engage with patients, carers, local communities, staff and volunteers. This includes the creation of the LAS Public and Patients Council, LAS Staff and Volunteer Advisory Panel and an independent review of our approach to public engagement.

### 6.1 LAS PUBLIC AND PATIENTS COUNCIL

In January 2020, the Board agreed to launch a LAS Public and Patients Council (LASPPC). The aim of the LASPPC is to bring together a wide range of patients and 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 also advises the Trust on ways to gain broader engagement, as necessary.

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

The LASPPC, which will meet circa four times a year, has 20 members and is chaired by Dame Christine Beasley, former Chief Nursing Officer for England. The minutes of meetings are formally recorded and submitted to the Trust Board. In addition, the LASPPC will report annually to the Board in respect of the fulfilment of its functions in connection with its agreed Terms of Reference.

The membership includes a wide range of individuals and organisations, including: Carers Trust; Healthwatch Enfield; Healthwatch Haringey; Healthwatch Harrow; Healthwatch Havering; Healthwatch Merton; Healthwatch Sutton; London Clinical Senate; Mayor's Fund; Samaritans; St John Ambulance; and, Terence Higgins Trust.

A Terms of Reference have been agreed and members have received a comprehensive induction with presentations from executive directors/senior leaders. Two meetings have taken place covering, amongst other subjects, the Ambulance

Operations Modernisation Programme, Electronic Patient Care Record and the Trust's response to COVID-19.

We have welcomed representatives from Healthwatch England and our commissioners, North West London Collaboration of Clinical Commissioning Groups, to the meetings with both providing very positive feedback (see below).

"I feel there is a good level of inclusiveness in the council whereby everyone is able to make a contribution and in the future get involved in projects they are interested in and where they can offer their expertise.

"I like that the meetings, projects and programmes of the council will be reviewed and evaluated as per the Terms of Reference and believe that after a year or so the members will be able to evidence their contributions and hopefully that of their extended networks."

**Alvin Kinch, Regional Network (London) Manager, Healthwatch England**

"There was clear engagement that allowed people to voice their thoughts/views, concerns and sharing of experiences that stimulated thoughts of how to deliver the next steps on the multiple pieces of work currently taking place.

"The chair and LAS members of staff who participated in the meeting were able to explain some complex and highly technical strategic elements with clarity through simple plain language that provided powerful insights into key issues and challenges the Trust faces.

"Genuine openness and transparency was demonstrable in the specific areas that were discussed and this is instrumental in forging meaningful relationships and the effectiveness of the group."

**Simba Tome, Assistant Director of Quality, North West London Collaboration of Clinical Commissioning Groups**

### 6.2 LAS STAFF AND VOLUNTEER ADVISORY PANEL

In late 2019, the Board agreed to establish a LAS Staff and Volunteer Advisory Panel (SVAP) as part of our commitment to improve the way we engage with staff and volunteers (emergency responders).

The SVAP is made up of colleagues from across the Trust, including representatives from our staff networks (Lesbian Gay Bisexual and Transgender, Black Asian and Minority Ethnic and ENABLE, our disability forum), a representative from our international group, a representative from the retirement association and volunteers.

The SVAP is chaired by the Trust Chair, Heather Lawrence OBE. The group will meet every two months and a Terms of Reference has been agreed by the Board.

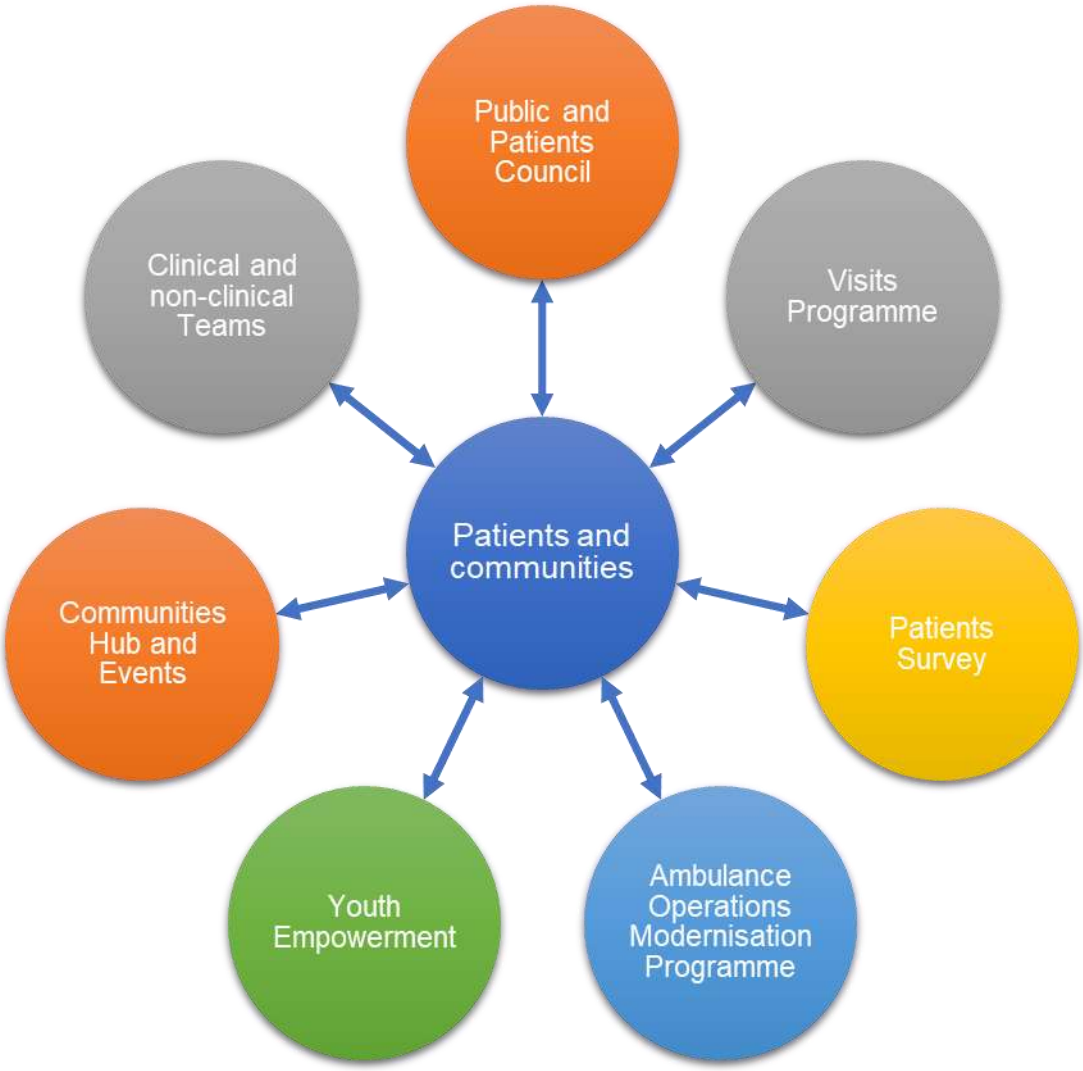
### 6.3 INDEPENDENT REVIEW

In early 2020, the Chair, Heather Lawrence OBE, commissioned Mike Cooke, Independent Chair, North Central London Integrated Care System to undertake a review of LAS's previous public engagement so that we could learn lessons for the future, including what has gone well.

The review was presented to the Board in July 2020 and its findings were welcomed and approved. This included: there appears to be a shared and deep commitment to patient and public involvement within the Trust; and, LAS had appropriately identified that it needed to expand and broaden its approach to public patient involvement. As such, Mr Cooke supported the creation of the new LASPPC.

## 7. KEY PRIORITIES – 2020 to 2023

Following engagement with a range of organisations and individuals, this strategy proposes a number of measures to further enhance the way we involve and listen to patients and communities. Over the two years, we will focus on seven priority areas:



Importantly, each priority area relies on further and comprehensive engagement with a range of patient representatives and public groups.

The priorities 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 partners.

**7.1** Embed the **London Ambulance Service Public and Patient Council** within the structures and governance of the organisation – developing a clear 'work plan' for 2020/21, 2021/22 and 2022/23.

Whilst still new, feedback about the LASPPC has been very positive, including from LASPPC members themselves and LAS staff who have attended meetings to provide briefings and updates.

The LASPPC now has its full complement of members (20), so it is important that we develop a focused programme of activity which best utilises their skills, experience and networks and engages them within the key priority areas for the Trust.

**Key deliverables:** over the next two years, we will:

- Co-create a detailed work plan for the Council which aligns to LAS priorities
- Elect a Co-Chair and provide bi-monthly updates to the Board
- Establish a number of 'work groups' from within the LASPPC which allow us to focus on more areas and maximise their skills and networks
- Survey members on an annual basis about their experience of being on the LASPPC and produce an annual review of activity for the Board.

**7.2** Working with Healthwatch England, local Healthwatch and the LASPPC, co-design a **visits (enter and view) programme** – giving patient and public representatives access to our 999, 111 and ambulance services so they can provide constructive feedback.

NHS organisations benefit when patient groups and representatives are able to access services and provide direct feedback about what they have seen.

The local Healthwatch power to Enter and View is one approach. This helps them to identify what is working well with services and where they could be improved. This sits alongside their statutory activities that include involving local people in Healthwatch delivery'.

Whilst this Enter and View approach can be effective for hospitals and other similar services, it isn't used as much for ambulance trusts, recognising that care is provided in a very different way.

With this in mind, we will establish a working group which includes representatives from London's 32 Healthwatch, as well as members of the LASPPC and our own staff/volunteers.

Together, we aim to develop a co-designed approach whereby 'accredited' groups can undertake visits to our services and, through speaking with staff/volunteers and interacting, as appropriate, with patients, carers and their families, they can provide us with constructive feedback about the care we provide, what they liked and what could be improved.

Whilst the approach is still to be confirmed, it is likely that this would take the form of a report which the Trust would have time to review, respond to and, as appropriate, make changes to services.

The visits are likely to include our emergency operations centres (EOCs), NHS111/integrated urgent care centres, ambulance stations and, as appropriate, other places where we deliver care, for instance as patients wait to be 'handed over' to the care of a hospital A&E department.

**Key deliverables:** over the next two years, we will:

- Co-create and launch a comprehensive visits programme
- Facilitate at least six visits, providing feedback to relevant directorates and the Trust Board
- Publish visit reviews on our intranet and website.

**7.3** In partnership with the LASPPC, Clinical Audit and Research Unit (CARU), patient experiences department and others, develop a **LAS patient survey/s** – allowing the Board and others to better understand the experience patients have when using our services.

Ambulance services are not included within the NHS patient survey. However, some ambulance trusts do offer patients and their families an opportunity to complete surveys about the care we provide. This is not something we do.

The NHS Constitution states that NHS services must reflect the needs and preferences of patients, their families and their carers. It is therefore important that trusts carry out local surveys asking patients their views on the services they have received.

Patient surveys can help: make the NHS more patient-centred; provide information to support local quality improvement initiatives; track changes in

patient experience locally over time; and, provide information for the Care Quality Commission's programme of reviews, monitoring and inspections.

The introduction of the new Electronic Patient Care Record offers an opportunity to engage patients with surveys through new technology.

**Key deliverables:** over the next two years, we will:

- Co-design and launch surveys for patients who have used our 111, 999 and ambulance services
- Establish mechanisms to increase uptake, for instance via the new Electronic Patient Care Record
- Produce regular reports on the feedback for the Board
- Publish feedback on our intranet and website.

**7.4** Engage a wide range of patient and public representatives within our **Ambulance Operations Modernisation Programme** – empowering them to shape our thinking and the way care is delivered in the future.

In 2019, the Trust Board agreed an estates vision which set out high level plans to transform our ambulance operations estate by replacing our existing 68 stations with a network of circa 18 state-of-the-art ambulance deployment centres or 'super-hubs'.

The Ambulance Operations Modernisation Programme will deliver the estates vision, as well as other changes to improve the care we provide to patients.

It is vital that the programme engages with a wide cross section of people across London so that they understand our plans and the benefits they offer to patients, carers, communities and our staff and volunteers.

At its meeting in August 2020, the LASPPC agreed to create a dedicated group of members who could advise the Trust on how to involve patients and the public with the planned changes as they come to fruition.

The group will form part of a much wider engagement programme, which will include working with local authorities, MPs, Greater London Assembly, Mayor of London and ICSs.

**Key deliverables:** over the next two years, we will:

- Co-create with the LASPPC and others, a dedicated engagement plan for the modernisation programme
- Establish a dedicated LASPPC sub-group to support the programme and help us track progress in the way we engage patients, carers and communities.

**7.5** Establish a **London Ambulance Service Youth Empowerment Squad** – supporting young people to learn more about our work, share their feedback and influence our decision-making.

Each year, LAS provides services to thousands of children and young people. Whilst we have a number of younger members on the LASPPC, we are keen to increase our engagement with young people so that we can better tackle issues that are important to them and improve the experience of all young people who use our services.

Based on work in other NHS organisations, we propose to establish a LAS Youth Empowerment Squad. The LASYES would be made up of a group of young people who have experience and knowledge of healthcare. Their mission is to get all LAS 'young people' sharing their views about the care they have received and making and influencing decisions. The LASYES will also support our work to encourage children and young people to consider a career in the ambulance service, which aligns with similar schemes run by our volunteering and education teams.

**Key deliverables:** over the next two years, we will:

- Co-create with children, young people, the LASPPC and other groups, a LASYES
- Co-create a detailed work plan for the LASYES which aligns to LAS priorities.

**7.6** Launch a virtual **LAS Communities Hub and Events** for our patients, carers and communities – to learn more about our work and provide feedback about the services we provide.

We will create a dedicated online hub for patients, carers and communities to find out more about our engagement work including links to surveys, visit reports and minutes, as well as updates from the LASPPC and LASYES.

In addition, we will host bespoke events where patients and communities can hear more about the services we offer and give feedback. These will be similar to the events foundation trusts provide for their members.

**Key deliverables:** over the next two years, we will:

- Launch a virtual LAS Communities Hub
- Host at least five events for local communities to learn more about our work
- Launch a bi-monthly bulletin for patients, carers and local communities.

**7.7** Support **clinical and non-clinical teams** to involve patients, carers and the public with their work, so that they can inform and influence the way we deliver care. Examples underway include:

i. **Pregnant women** – in collaboration with a number of London Healthwatch and CARU, we are co-creating a project to allow us to better understand the care we provide to pregnant women, including those from Black Asian and Minority Ethnic communities, where English is not their first language and 'seldom heard' groups – helping to shape the care we provide to other pregnant women

ii. **Electronic Patient Care Record (EPCR)** – as well as involving staff/volunteers, the EPCR project team has been working closely with the LASPPC and have used their feedback to shape their approach, including how they communicate with patients and their families.

We are now establishing a longer-term EPCR advisory group of patients and public representatives to help further shape the project as it rolls out. The group will advise on ways to reassure the public and patients about how their private data will be used and kept secure, as well as how medics, as they use iPads more frequently when interacting with patients, don't impact on the quality of the care they receive, for instance because of less eye contact.

iii. **Research and audit** – we are currently supporting CARU to enlist a member of the LASPPC to sit on their Clinical Audit and Research Steering Group (CARSG). The CARSG provides oversight and advice to the Trust's clinical audit and research function.

As a member of CARSG, the patient representative plays an active role by providing input on approximately one clinical audit report per month and attending CARSG meetings.

iv. **Integrated Urgent and Emergency Care Platforms Task and Finish Group** – the Trust aims to integrate 111/Integrated Urgent Care and 999 services and provide a seamless flow for patients using the service.

To support this, it has convened a working group which focuses on the 'platforms' we will use to deliver the services and to produce an options analysis which sets out and addresses the clinical, operational, technical and economic considerations for these decisions.

A representative of the LASPPC has been co-opted onto the group to help keep what is important to patients at the forefront of its mind and to act as a critical friend to the group and provide a patient 'lens' to their thinking.

v. **Quality improvement programmes** – the Trust has previously involved patients and communities within its quality improvement work, including the development of our joint mental health response car. This activity will continue, with possible areas for development noted below.

Each of these areas will have their own key deliverables, which can be measured by specific groups/committees and/or the LASPPC.

Following early conversations with clinical teams, below are some areas where we might want to engage with people and communities more widely. We will work closely with the LASPPC, Strategic Stakeholder Group, Sector Stakeholder Group and others to prioritise and develop our approach:

- Cancer
- Children and young people
- Carers
- Elderly care
- Dementia
- Homeless people
- Learning disabilities
- Mental health
- Sickle Cell.

## 8. KEY ENABLERS TO DELIVER THIS STRATEGY

The ambitions set out in the strategy will significantly enhance the way we engage and involve patients, carers and communities. However, we know that in order to deliver upon these ambitions we must commit the right resources to implementing this strategy. We must invest in patient and community engagement and support colleagues to work with and involve our patients and local communities. We will also need to work more closely with our partners and develop new partnerships.

### 8.1 GOVERNANCE

As a Trust, we already use patient and carer feedback within our governance structure, including patients, carers and relatives sharing their stories at the Trust Board. We also involve patient groups in signing off our annual quality account and share information about patient complaints and feedback at a number of committees, including the Quality Assurance Committee and Board.

**STRATEGIC STAKEHOLDER GROUP AND SECTOR STAKEHOLDER GROUP**

To support our relationship with patients, communities and other stakeholders, we will establish a Strategic Stakeholder Group and Sector Stakeholder Group.

These groups will meet regularly to exchange intelligence about all aspects of engagement, including with patients, carers and communities, and share best practice and experiences.

Chaired by the Trust Chair, members of the Strategic Stakeholder Group will include the Chief Executive, Chief Operating Officer, Chief Medical Officer, Director of Communications and Engagement, other directors, the Chief of Staff, Head of External Communications and Chair of the LASPPC.

This group will focus on international, national and regional stakeholders, for instance ICSs, Association of Ambulance Chief Executives, central Government including the Department for Health and Social Care, The Mayor's Office, Greater Local Authority, NHS England, Care Quality Commission, other arms-length bodies, Healthwatch England, Patients Association and national charities.

The Sector Stakeholder Group, which includes the Assistant Directors of Operations, Chief Operating Officer, Director of Communications and Engagement and Head of External Communications, will focus on sub-regional stakeholders and report to the Strategic Stakeholder Group. This group will focus on local healthcare systems (trusts and Primary Care Networks), boroughs and local MP's constituency issues.

### 8.2 INTERNAL CULTURE CHANGE

As our patients and communities engagement and involvement strategy expands within the organisation, we will ensure that we are communicating effectively with our staff and volunteers to keep them informed about the changes and help them to understand the benefits that increased engagement will bring. It will inevitably take time to embed this strategy within our organisation, but ultimately our aim is for staff and volunteers to welcome greater engagement with patients, carers and communities. Our executive and leadership teams will lead the way in promoting our patient and public engagement and the substantive senior manager role (see below) will ensure that it receives appropriate support and management.

### 8.3 WORKING IN PARTNERSHIP

A key factor in successfully realising our patient and public engagement ambitions will be forming partnerships with other organisations who we can work alongside in order to engage and involve the broadest range of patients and communities.

Collaborating with others will allow for the sharing of best practice and the Trust will gain greater 'pulling power' amongst patients, carers and communities through our association with experts in the field.

For some partnerships, we may enter into formal arrangements with a Service Level Agreement and for others it may be a more informal association with a series of meetings and the sharing of knowledge and expertise.

There are a large number of organisations who we would want to work with. For some this would mean the continuation of long-standing and productive partnerships, whilst for others we would seek to set up new arrangements.

### 8.4 RESOURCES TO INVEST IN PATIENT AND COMMUNITY ENGAGEMENT

In order to deliver effective patient, carer and public engagement, we will need to invest in its set up and management.

Our patient, carer and community engagement will be overseen by the Director of Communications and Engagement as Senior Responsible Officer. This executive oversight will ensure that the scheme will be given the appropriate prominence and organisational reputation. Progress updates will be reported to the executive team and Trust Board.

In addition, we will recruit a Senior Stakeholder Manager and Stakeholder Manager who will have responsibility for managing our patient and community engagement.

## 9. GLOSSARY

**Clinical Commissioning Groups (CCGs)**
NHS bodies responsible for the planning and commissioning of health care services for their local area. They were created following the Health and Social Care Act in 2012 and took over from Primary Care Trusts.

**Community/ies**
A community is a group of people living or working together in the same area.

**Co-production (or co-creation)**
The principle of staff/volunteers working together in an equal partnership with patients, carers, families and the public to design services.

**Healthwatch England**
The national champion for people using health and care services. Each local area has its own Healthwatch with significant statutory powers to ensure the voice of people is strengthened and heard by those who commission, deliver and regulate health and care services.

**Integrated care systems (ICSs)**
In some areas, a partnership will evolve to form an integrated care system (ICS), a new type of even closer collaboration. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. See also STPs.

**Sustainability and Transformation Partnerships (STPs)**
In 2016, NHS organisations and local councils came together to form sustainability and transformation partnerships (STPs) covering the whole of England, and set out their proposals to improve health and care for patients. In some areas, a partnership will evolve to form an integrated care system (ICS). See also ICSs.

**ENDS**

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Trust Response to Black Lives Matter | | | |
| **Agenda item:** | 12 | | | |
| **Report Author(s):** | Ali Layne-Smith, Director of People & Culture | | | |
| **Presented by:** | Ali Layne-Smith, Director of People & Culture | | | |
| **History:** | Executive Committee 16 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☐ | Approval |
| | ☒ | Discussion | ☒ | Noting |

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

Following the tragic death of George Floyd earlier this year, the Trust has responded with a wide ranging action plan to respond to the needs of its BAME staff from "Board to Ward". This paper is a summary of the progress to date and includes the Black Lives Matter delivery plan which is currently being implemented across the Trust

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

Trust Board are requested to review the summary and updated plan.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | X | No | | Dr 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 | | Dr Fenella Wrigley, Chief Medical Officer |
| Communications & Engagement | Yes | X | No | | Antony Tiernan, Director of Communications and Engagement |
| Strategy | Yes | X | No | | Ross Fullerton, Director of Strategy & Transformation |
| People & Culture | Yes | X | No | | |
| Corporate Governance | Yes | X | No | | Syma Dawson, Director of Corporate Governance |

## Background

Since George Floyd's tragic death on 25 May 2020, and the rise of the Black Lives Matter movement in the UK, the Trust has sought opportunities to better understand the experiences of BAME staff and identify a range of activities and actions that will lead to an improved workplace experience for its Black and BAME staff.

These activities were collated into the "Black Lives Matter Delivery Plan" which is a living and evolving document. The current plan is attached in Appendix 1 and has been updated to reflect progress to date and incorporate additional interventions and commitments for the recently published NHS People Plan and the forthcoming London Workforce Race Equality Strategy.

Achievement of the Black Lives Matter Delivery Plan will lead to positive step change for the Trust's Black and BAME staff by the end of the financial year 2020/201 which can be evident through to improvements in the Trust's WRES action plan and annual staff survey engagement index.

## Key interventions to date

### Board and Executive Communications

Both the Trust Chair and Chief Executive have written to every member of the Trust's staff outlining their stance that there is no place for racism at the London Ambulance Service.

In addition the Trust Board has participated in two development sessions exploring the issues behind the "Black Lives Matter" movement. Sessions have been facilitated by Yvonne Coghill who has prepared the London Workforce Equality strategy which will be launched later this Autumn; the Lead of the Trust's BAME network, Diversity & Inclusion Consultant and Director of People & Culture.

### Core Leaders' "Silence is not the Answer" Workshops

Between 15th July and 15th September more than 630 line managers from all areas of the Trust took part in 8 virtual conversations about race in groups of 100. The workshops were hosted by Garrett Emmerson, Chief Executive and Melissa Berry, Diversity & Inclusion Consultant supported by 10 facilitators from People & Culture, the BAME Network and the Executive Committee. The methodology was tested with 75 members of the Extended Leadership Group (ELG) on 17th June – 3 weeks after George Floyd's death.

The purpose of the sessions were to educate staff about the lived experiences of their BAME colleagues at work and in general. After a brief introduction, each staff member was asked to talk about a situation where they experienced or witnessed racism and how they felt about it. There was deliberately no action planning at the end of the sessions but staff were asked to contribute to a word cloud (See Appendix 2 for examples) using the Slido app to capture how they would take what they had learnt form the session back to their teams.

For the first time the Trust has been able to provide a safe environment where the managers of the majority of our people were given the time and space to listen, learn and talk about racism. This "big conversation" will continue and third phase of this

conversation will be scheduled during quarter 3 and 4 so that the entire organisation has the same opportunity.

## Understanding what is behind the likelihood that BAME staff will disproportionately enter disciplinary processes

One of the Workforce Race Equality Standard (WRES) indicators records the likelihood of BAME staff to enter into disciplinary processes versus their white colleagues.

### WRES Indicator 3

| Indicators | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|
| National | 1.56 | 1.37 | 1.24 | 1.22 |
| Ambulance | 1.8 | 1.73 | 1.69 | 1.39 |
| LAS | 2 | 2 | 1.6 | 1.62 |

WRES Indicator is the likelihood of BAME staff to enter disciplinary action vs. white staff. The NHS target is 1:1 by 2022

Initial analysis of 84 disciplinary cases for the 12 months up to July 2020 showed that BAME staff were disproportionately represented in disciplinary processes and that in areas where the Trust had larger numbers of BAME staff, this phenomenon was further exacerbated.

A pilot deep dive exercise was carried aimed at understanding why BAME staff were over represented in disciplinary cases in these areas and bespoke action plans have been created to address these issues.

In addition, all current disciplinary cases will be reviewed by a diverse panel form across the Trust using a new triage approach to score incidents and assign them to the relevant resolution pathways utilising informal mechanisms such as mediation and facilitated conversations to resolves disciplinaries and grievances at the informal stage.

## Our Strategy

Work is underway to revise and reinvigorate the Trust's Diversity & Equality strategy which will build on many of the initiatives outlined in the BLM plan as well as setting out how we will honour our commitment to eradicating discrimination of any form. There is an intrinsic link to between our organisation's culture and the work life experience of our staff. To that end, the initial focus will be on articulating our Trust's destination culture and our D&I strategy will be one of a number of pathways that will enable us to attain our desired culture.

London Ambulance Service
NHS Trust

# BLACK LIVES MATTER

# A DELIVERY PLAN FOR LONDON AMBULANCE SERVICE NHS TRUST

## SEPTEMBER UPDATE

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **EDUCATE** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Build engagement and ownership of conversation on race agenda with Extended Leaders across the Trust (Top 75) | • Initial workshop with the 75 Senior Managers in ELG: ***Silence is not the answer conversation***<br>• Allyship Resource pack to be shared with ELG<br>• ELG members to facilitate workshops during Core Leaders conversation – see below.<br>• Continue the conversation, share this plan, inform of new initiatives | Melissa Berry<br>Ali Layne–Smith<br>Garrett Emmerson | Jun 2020<br><br>Jun 2020<br>Jul/Aug 2020<br><br>Sep 2020 | Complete<br><br>Complete<br>Completed<br><br>Completed | **High** |
| Build engagement and ownership of conversation on race with Core Leaders (Top 700) | • 8 virtual sessions in total have taken place and 633 leaders have participated to date.<br>• "Word Cloud" of responses captured and key messages distilled<br>• Extension required to include band 5 and 6 line managers | Garrett Emmerson<br>Melissa Berry<br>Mandy Dryden<br>Anna Booth | Aug 2020 | Completed | **High** |
| All staff Conversation | • Core Leaders to facilitate small, safe conversations about race with their staff<br>• Briefing pack and session guide to be created to provide template for Core leaders and HR Managers to assist with this | Internal Communications<br>Ali Layne-Smith | Aug – Dec 2020 | In flight | **High** |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **EDUCATE** | | | | New Thinking<br>In Flight<br>Complete | High<br>Medium<br>Low |
| Virtual Allyship Workshops to engage non BAME staff and enable them to learn more about race issues | • Weekly workshops to learn about how to be an ally to BAME LAS staff and the importance of allies in encouraging effective/changing dialogue around racism. **250 places booked to date**<br>• Sustain and embed Allyship network | Melissa Berry<br><br>New Diversity & Inclusion Lead | Completed<br><br>October onwards | In flight | **High** |
| Demonstrable Executive Leadership on race conversation and issues | • CEO, COO, Board regular discussions on LAS TV Live, LiA, Pulse, internal and external messaging | Garrett Emmerson<br>Khadir Meer<br>Executive Directors | Ongoing | In flight | **High** |
| Trust Board apology | • The board to write a formal letter to staff | Heather Lawrence | Completed 4th August 2020 | New Thinking | **High** |
| Public campaign to highlight staff verbal and physical assaults | • Continue to highlight issues of staff physical and verbal abuse in media – personalise wherever possible<br>• As part of zero tolerance approach to racially motivated abuse be clear that racist verbal abuse of staff will not be tolerated and such incidents will be reported to the police and strongest possible action sought<br>• Ensure effective processes are in place to support staff suffering racist abuse from members of the public so that they feel comfortable and empowered to raise complaints and progressing police action<br>• *Publicise to staff actions taken by the organisation and outcomes of any criminal proceedings. Through LAS TV / Daily Senior Leadership Team (DSLT)* | Ali Layne-Smith<br>Antony Tiernan<br>Mandy Dryden<br>Pauline O'Brien<br>Trisha Bain | Ongoing | In flight | **High** |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **RESPOND** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Weekly BAME virtual drop-ins | • Drops in to support staff and a place for sharing, healing and learning | Diversity & Inclusion Manager<br>BAME Network | Ongoing (every week) | In flight | **High** |
| Diverse panel to urgently review and triage all open disciplinary and capability cases | • Review all current/on-going disciplinary and capability cases across the organisation for disproportionality and potential amnesty for all but most serious /repeat cases. Proposal to be put to Exec/CEO for approval.<br>• Panel sits 17th September 2020<br>• Staff side invited but have agreed not to participate | Elizabeth Dighton<br>Jason Rosenblatt<br>Antony Tiernan<br>Lisa Taylor<br>Dabs Lynch<br>Averil Lynch<br>Lee Williams | By August 2020 | In flight | **High** |
| Zero tolerance approach to proven racially motivated abuse - Case review of BLM race related cases | • Summary of disciplinary actions in response to these events.<br>• All investigations and hearings completed by end of September 2020<br>• Communicate actions taken against those involved in racist incidents – propose follow up all staff email from Garrett<br>• Paper to Trust Board / ExCo / P&CC | Ali Layne-Smith | 28 July 2020<br><br>~~Aug 2020~~<br>September 2020 | In flight | **High** |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **RESPOND** | | | | **New Thinking**<br>**In flight**<br>**Complete** | **High**<br>**Medium**<br>**Low** |
| "Stamp Out Racism" Campaign | • P&C and Communications Teams meeting to plan campaign elements. Initial Meeting 8th September<br>• Create a 'Stamp out Racism Campaign' that reflects a zero tolerance approach to racism at LAS:<br>○ Raise awareness - create opportunities for discussion, listening, learning, and organisational cultural awareness and acceptance;<br>○ Opportunity through FTSU to 'Speak up, Speak out, Stamp out' unacceptable behaviours, actions;<br>○ Create lasting, positive change and improved experiences for our BME workforce and communities; and take a zero tolerance stand against racism and race discrimination, harassment and victimisation;<br>○ Opportunity to call out that inappropriate jokes and comments are not acceptable when dismissed as "banter"<br>○ Put respect and compassionate the heart of our systems, processes, organisational behaviours and cultures to enable BEM people to be confident, feel valued and express their true selves in the workplace.<br>○ Create a calendar of cultural and faith events to celebrate our workforce's diversity and educate each other about differing beliefs and festivals<br>○ Provide each staff network with a budget for workshops, publicity and bespoke events | Antony Tiernan<br>Mandy Dryden<br>New Diversity & Inclusion Lead<br>Ali Layne-Smith | Launch January 2021 | New Thinking | **High** |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **RESPOND** | | | | **New Thinking**<br>**In flight**<br>**Complete** | **High**<br>**Medium**<br>**Low** |
| Develop a focussed action plan for EOC and 111/IUC, progressing deep dive of these areas, analysing data and priority areas for action, training and staff development | • Melissa Berry to visit each Watch over a period of 5 weeks to talk with staff face to face and understand any issues<br>• Analysis of the historic disciplinaries and capabilities in (by Watch) to understand where there is obvious disproportionality.<br>• Analysis of the nature/type of disciplinaries and capabilities that are being pursued by managers, to understand justification, whether there are any underlying issues of racism within them or whether they relate to specific issues that might disproportionately impact on BME Staff.<br>• In parallel, urgently analyse the latest staff survey results by Watch (WRES indicators) to understand differential issues across the Watches.<br>• Analysis of staff survey free text comments (by Watch if possible) for race related comments – both from BME staff citing issues of racism and also for evidence of generally racist comments.<br>• Using the above, build statistical evidence and cross reference with anecdotal evidence obtained during BME drop-in and allyship sessions; build an initial picture of the issues as they relate to each area of EOC/111.<br>• Review against Civility Report for evidence of issues relating to bullying and harassment and racism and whether any proposed actions need to be brought forward/changed.<br>• Initial meeting with the EOC/111 management teams and SMEs to enable an informed discussion on any issues and agree the urgent actions that need to be taken to address them. Completed 4th August 2020<br>• Specific and more granular action plans to be developed for EOC/111 areas, for delivery over the remainder of the financial year. Plan reviewed 3rd September and further iterations will follow | Khadir Meer<br>Garrett Emmerson<br>Ali Layne-Smith<br>New Diversity & Inclusion team<br>Jon Goldie<br>Jacqui Niner<br>Alison Blakely<br>Paul Cook<br>Julie Cook HRBP | By 21 Jul 2020<br>By 21 Jul 2020<br>By 21 Jul 2020<br>By 21 Jul 2020<br>By 28 Jul 2020<br>By 28 Jul 2020<br>28 Jul 2020<br>Aug 2020 – Apr 2021 | New Thinking | High |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **RESPOND** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Develop a focussed action plan for Fleet, progressing a deep dive of the area, analysing data and priority areas for action, training and staff development | • An immediate analysis of the historic disciplinaries and capabilities in Fleet to understand if there is any obvious disproportionality.<br>• An analysis of the nature/type of disciplinaries and capabilities that are being pursued by managers, to understand whether they are justified, whether there are any underlying issues of racism within them or whether they relate to specific issues that might disproportionately impact on BME Staff.<br>• In parallel with this, urgently analyse the latest Fleet staff survey results (WRES indicators and free text) for race related issues and/or comments.<br>• Using the above, build statistical evidence and cross reference with anecdotal evidence obtained during BME drop-in and allyship sessions to build an initial picture of the issues.<br>• Review against Civility Report to determine if there is any evidence of issues relating to bullying and harassment and racism and whether any of the proposed actions need to be brought forward/changed.<br>• Initial meeting with the Fleet management teams and SMEs to enable an informed discussion on any issues within Fleet and agree the urgent actions that need to be taken to address them.<br>• Specific and more granular action plans to be developed for Fleet, for delivery over the remainder of the financial year. | Khadir Meer<br>Garrett Emmerson<br>Ali Layne-Smith<br>Justin Wand<br>Alan Bristow<br>Marcus Whalley<br>HRBP | TBC once EOC pilot completed | New Thinking | High |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **RESPOND** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Root and branch review of Trust diversity and equality/anti-discrimination training to ensure it is modernised, fit for purpose and accessible to staff. | • Face to face and on-line equality and diversity training offering to be reviewed to ensure it is accessible and fit for purpose and is reflective of individual community needs. | Ali Layne-Smith<br>Melissa Berry as training provider<br>Julia Smyth | Sep-Nov 2020<br>New offering by end FY 20/21 | New Thinking | High |
| Implicit Bias Awareness Training | • Commencing with 200 Clinical Team Managers (CTMs) and c60 EOC Mangers -face to face 2 hour session | Khadir Meer<br>Julia Smyth | Dec 2020 | New Thinking | Medium |
| Introduce 360 Degree Feedback for Band 8a and above line managers | • Utilise trust values poor and strong behaviour matrix self-assessment developed by the Trust's Learning & Performance team | Julia Smyth | Nov 2020 | New Thinking | High |
| All ELG Leaders to have an equality and diversity objective | • Clear and measurable objective to be set through PDR process for all senior managers as part of broader worksteam to improve the quality of appraisals | Ali Layne – Smith<br>Julia Smyth | By Apr 2021 | New Thinking | Medium |
| Quality, Assurance and Risk Committee to consider any potential patient impact in respect of race | • Building on the sickle cell and JRCALC work, undertake review of relevant quality and patient data to ensure we provide appropriate care for members of the BAME community, based on their individual needs.<br>• LAS Participation in AACE / NASMED joint "Stamp Out Racism" meeting on 8th September with senior leaders across the ambulance sector. Focus in on BAME patient care. | Trisha Bain<br>Fenella Wrigley | From September 2020 | New Thinking | High |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **ENABLE** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Reinvigorate BME Staff Network Group | • Encourage new membership<br>• Run additional events, supported extensively by Internal and External Communications Team to promote the history and culture of the BME staff network.<br>• Line manager commitment required to release BAME staff to attend network events as majority BAME staff are in junior roles | Agatha Nortley-Meshe<br>Melissa Berry<br>Mandy Dryden | Ongoing | In flight | **High** |
| D&I Trust Strategy | • Re-write trust Diversity & Inclusion strategy for consultation Aug/Sep<br>• Will be delivered as part of broader cultural transformation programme across the Trust | D& I Lead<br>Angela Flaherty | ~~Oct~~ Dec 2020 | In flight | **Medium** |
| Building race into the cultural transformation programme | • Re-start the 'Building a Better Workplace – transforming our culture' sector leadership conferences.<br>• London-wide Race Equality Plan to be reflected in our cultural transformation programme. | Garret Emmerson Internal Communications<br>Trust feedback sent to YC 25th August | Aug/Sep 2020<br>Re-started 27th August | Completed | **High** |
| Invest in D&I capability and capacity for the Trust | • Recruit Head of Culture and Diversity and D&I team members | Ali Layne-Smith<br>Wayne Donaldson | Advertise<br>~~July~~<br>September 2020 | New Thinking | **High** |
| Development of the People & Culture Mangers | • Development programme to enable mangers to feel confident in areas of race and supporting managers | Ali Layne- Smith<br>Julia Smyth<br>D&I Lead | Dec 2020 | New Thinking | **High** |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| | | | | New Thinking | High |
| **ENABLE** | | | | In flight | Medium |
| Increase diversity of CTM leadership pool | • Positive Action to support BAME candidates in forthcoming CTM recruitment process<br>• Not achieved. New approach to internal recruitment, career development and progression for increase the representation of BAME staff at all levels | Darren Farmer<br><br>Khadir Meer<br>Ali Layne-Smith<br>Julia Smyth | August 2020<br><br>December 2020 | New Thinking | High |
| Schedule Executive Committee session to promote new thinking in this area | • Request support from the London wide race team<br>• John Brouder is mentoring leadership team in one of our "hot spot" areas on focussing on empathetic and inclusive leadership | Ali Layne –Smith | Ongoing | New Thinking | High |
| Embed EQIA practice across all areas of the Trust | • Audit all policies and process for EQIA compliance | Ali Layne-Smith<br>D&I Lead<br>HR Managers | Once fully resourced D&I team | New thinking | Medium |
| Continue to embed fair recruitment principles for all roles across the Trust | • Task & Finish group has been created to devise the plan for ensuring recruitment and selection processes are fit for purpose for improving access to jobs, training, education, career progression and wellbeing support for our BME workforce and members of diverse communities to ensure greater representation across the service;<br>• Embed our fair recruitment principles for all roles across the Trust<br>• Ensure Managers use abridged TRAC for all internal recruitment<br>• Ensure interview panels are diverse and feedback collected where BME candidates are not appointed | Khadir Meer<br>Ali Layne-Smith<br>Tracey Watts<br>Melissa Berry<br>Averil Lynch<br>Moorhouse Consultancy | Aug 2020 & ongoing | In Flight | High |

**Black Lives Matter – A Delivery Plan for London Ambulance Service**

| What? | How? | Prioritisation Lead | When? | Progress Stage | Impact Rating |
|---|---|---|---|---|---|
| **ENABLE** | | | | New Thinking<br>In flight<br>Complete | High<br>Medium<br>Low |
| Reinvigorate Reverse Mentoring Programme<br><br>Restart BAME Sponsorship Mentoring | • One cohort of mentors trained; train second cohort of mentors virtually<br><br>• One cohort of BAME staff already taken part in programme; train second cohort. | Ali Layne-Smith<br>New Diversity & Inclusion Lead<br>Julia Smyth | Sep/Oct 2020 | In flight | High |
| Embed race related elements of NHS People Plan and London WRES actin plan into our BLM / BAME plans | A detailed approach is required to:<br>• Embed the ongoing provision of BAME risk assessments<br>• Bring the NHS People Promise that "we are compassionate and inclusive" to life<br>• Zero tolerance of violence or verbal abuse against BAME staff<br>• Tackling the disciplinary gap<br>• Identify dedicated BAME resources in FTSU and counselling services<br>• Overhaul recruitment and promotion processes<br>• Maintain and enhance strong BAME representation at Band 8c and above (including NEDs) utilising the NHS "Model Employer" framework as required | Ali Layne-Smith | Sep 2020 until April 2021 | New Thinking | High |
| Track additional performance metrics at monthly Operational Performance Meetings | • Monitor number of BME staff going through disciplinary and capability<br>• Track interviews in team/sector – BME staff short-listed/appointed | Ali Layne-Smith<br>Lorraine Bewes | Ongoing | New Thinking | Medium |

London Ambulance Service NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | London Ambulance Service NHS Trust Response to COVID-19 | | | |
| **Agenda item:** | 13 | | | |
| **Report Author(s):** | Donna Fong, Strategy Team Support | | | |
| **Presented by:** | Ross Fullerton, Director of Strategy and Transformation | | | |
| **History:** | Executive Committee 16 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

This purpose of this document is to formally record the way in which the first peak of the Covid-19 pandemic impacted the LAS and how the Trust positively responded to the challenge, and have embedded new ways of working as a result of this experience.

The Trust has also taken the time to reflect on the actions and decision made during the first peak of the pandemic, and has taken the feedback from a wide range of stakeholder groups to capture the experience and to understand what went well and what could have been done differently from their perspective. These lessons learnt have been used to inform the development of resilience plans, in preparation of future surges in activity relating to Covid-19 or to manage peaks of seasonal demand.

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

The Trust Board are asked to review and note the content of this report.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | X | No | | Chief Quality Officer |
| Finance | Yes | X | No | | Chief Financial officer |
| Chief Operating Officer Directorates | Yes | X | No | | Chief Operating Officer |
| Medical | Yes | X | No | | Chief Medical Officer |
| Communications & Engagement | Yes | X | No | | Director of Communication and Engagement |
| Strategy | Yes | X | No | | Director of Strategy |

| | | | | | |
|---|---|---|---|---|---|
| People & Culture | Yes | X | No | | Director of People and Culture |
| Corporate Governance | Yes | X | No | | Director and Corporate Governance |

NHS
London Ambulance Service
NHS Trust


# London Ambulance Service NHS Trust Response to COVID-19

September 2020

# Purpose of this document

*On 30 January 2020, the COVID-19 pandemic was declared as a public health emergency of international concern by the World Health Organisation, and a level 4 incident on 2 March 2020 by NHS England and NHS Improvement.*

This document has been prepared to formally record the way in which COVID-19 ('Covid') impacted the LAS and how the Trust positively responded to the challenge. Since the initial peak demand resulting from the virus, the Trust has been able to conduct a series of 'After Action Reviews'. The purpose of these has been to identify and record opinions and lessons learnt from across the organisation.

The document captures this using the following structure:

- The Impact of COVID-19 on LAS
- The LAS response to COVID-19
- Learning from our experience of COVID-19
- Our future ways of working

## 1.1 The impact of COVID-19 on LAS

The COVID-19 pandemic hit London well before the rest of the UK. As the capital's ambulance service, the LAS was at the forefront of responding to this national emergency, with less time to prepare and less understanding of the outcomes of the disease than any other service.

During normal operating conditions, the LAS was routinely one of the better performing ambulance services in the country. On 20th January 2020 we met all main national targets with the national ambulance balanced score card achieving performance of 96.2%, and we were the top performing ambulance trust in the country that week. By the End of February, the Trust began to receive COVID-19 related 111 and 999 calls and in March attended our first official COVID-19 related incidents. With the introduction of lockdown measures across the UK at the end of March there was a reduction in the transient population of London, however the LAS saw a 300% increase in 111 calls, and a doubling in 999 calls (with calls peaking at over 11,500 per day).

The impact of this extraordinary and unprecedented demand on the Trust resulted in:

- Escalation to REAP 3 'Major Pressure' on 12 March 2020, and to REAP 4 'Extreme Pressure' on 23 March 2020
- Average 999 call answering times went from just a few seconds to a peak mean answering time of 3 min 22 seconds in March, putting national 999 telephony infrastructure at risk, and putting our control centres under huge operating pressure
- Calls to 111 waited over an hour to be answered (compared to the usual 60 second target)
- We were attending up to 750 COVID related face to face incidents per day, in addition to the normal BAU activity
- Category 2 response times increased to around 61.4 min (against an 18 minute mean target)
- Our ambulance out of service (OOS) doubled to 15% due to additional deep cleaning requirements. Our cleaning capability couldn't keep pace with the number of potentially contaminated vehicles.
- Job Cycle Times (JCT) became significantly extended due to the need for crews to don and doff PPE and allow time for vehicle decontamination.
- Our staff isolation and sickness levels exceeded 25% (prior to the introduction of NHS staff testing at the end of March) reducing our ability to staff ambulance control rooms, 111 services and produce ambulance hours.

## 1.2 The LAS response to COVID-19

Covid-19 had a unique impact on LAS, where high call volumes (first in 111 and then 999) and depleted resources, constrained our ability to respond. This rapidly consumed the surge capacity we had available.

Although all available clinical and non-clinical staff and vehicle resources able to respond were deployed, this was insufficient to meet the demand pressures placed on the service. This was in part due to historically high levels of utilisation the service operates at compared to other ambulance services.

Immediate and decisive action was taken to address the situation, with rapid upscaling of the capability and capacity of the organisation to meet the challenge of covid-19. This enabled us to:

- significantly increase our call answering capability (in 999 and 111) and put up to 200 additional ambulances on the road every day, an increase of over 50% in 6 weeks.
- accelerate the 999/111 integration (with the support of NHSE national and London) at a time when there was significant disruption to healthcare access in primary, secondary and community care.
- implement a new streamlined operating model, changing our clinical skills mix, sourcing additional ambulances, c.650 extra road staff, new call taking capacity with over 250 additional call takers and control room staff, transformed operational estate, fleet and logistics operations.
- Temporary closure of nearly half (33) of our ambulance stations necessary to consolidate our operations and enable the flexible deployment of vehicles and staff and efficient operationalisation of internal supply chain management (primarily for PPE)
- Direct access to virtual GP consultations from our ambulance crews and our 111 clinicians, managing patients closer to home.
- Co-design of 20 pathways with ICSs to meet the needs of COVID and non-COVID patients
- New control room and contact centre capacity, utilising space freed up by remote corporate and clinical working
- New fast-track clinical training methods to enable rapid onboarding of new and returning staff
- Coordinating pan-London patient transportation and establishing a bespoke ambulance station and vehicle logistics support for NHS Nightingale
- Provision of temporary accommodation to frontline staff who moved out their home to protect shielding family members
- A Critical Care Transfer Service set up for critical care patients into NHS Nightingale and to support inter hospital transfers

As a result, by 10 April 2020 we were meeting national performance targets every day. By the end of April 2020, we had the capacity to handle a future COVID peak of up to 10,000 calls per day (3,000 COVID / 7,000 non-COVID) anticipated to potentially be needed in the event of a second peak in addition to seasonal demand pressures. The Trust returned to REAP 2 ‘Moderate Pressure’ on 15 May 2020.

## 1.3 Reflections from the Non-Executive Directors on the Board of Directors

In light of the unprecedented demand which the Trust faced during the peak of the COVID-19 pandemic and the overwhelming operational pressures this gave rise to, the Trust's governance and assurance arrangements were amended from March 2020. The rationale for this focused approach was to enable the organisation to focus on the operational response and importantly, patient safety and quality.

### 1.3.1 NED weekly briefings

The way in which the Board engaged in Trust business changed during the COVID peak pandemic. The Non-Executive Directors (NEDs) held weekly briefing calls with the Chief Executive (CE) / Executive Directors. The NEDs reflections on this set-up concur that this was a helpful means of being kept informed / engaged on relevant business but questioned whether the frequency could have reverted to fortnightly sooner, with further consideration as to whether the CE / Executive Directors found them as useful (there was a suggestion to consider having a 30 minute call as opposed to an hour). One NED commented that given the scale of the crisis and their responsibility as a unitary board, NEDs needed to be informed and engaged. NEDs also had "offline" individual discussions with relevant Directors to lend support and keep in touch on key issues; the Chair and CE in particular kept in contact on a regular basis.

### 1.3.2 Reduced governance arrangements

Board meetings and Board Committee meetings were generally shortened with the exception of the People and Culture Committee which were held weekly / fortnightly and with limited membership. The NEDs commented that this revised governance approach was important to focus decision making via shorter papers. However, one NED commented that they struggled to manage the volume of issues in shorter meetings but did not want to intrude on the busy Executive. The revised governance approach has prompted general thinking regarding the length and frequency of meetings. The use of Zoom/ Microsoft Teams was welcomed and helped work through agendas efficiently.

### 1.3.3 Areas for consideration

- Determining which issues are presented to the relevant Board meetings / briefings and monitoring how decisions are made at Board level in a crisis;
- Reporting data / sharing reports with Board members although recognising that in a fast-moving situation like COVID this can be a challenge;
- Think about what data items are important for clinical audit and research;
- Applying the innovation, flexibility and resourcefulness into day to day activities while providing governance and oversight necessary "in peacetime";
- Culture is a key priority and the organisation should be mindful that just because important work was achieved at pace during COVID, that the culture has changed too. One NED in particular commented that it has taken too long to get out of 'COVID mode' and back into the 'new normal'. They add: "culture change demands behavioural change and strategic thinking".
- There was good evidence of strong collaborative working with the system, regulators and inter-agency partners. How can we strengthen and sustain this?

In particular, the Chair commented: "To bring about truly innovative change it all goes back to empowerment and culture".

## 1.4 Learning from our experience of Covid-19

The Trust continues to champion a culture of learning and continuous improvement and we carried out a series of reviews to evaluate the Trust's response to COVID-19. The objective of the reviews was to identify:

- Areas of good practice,
- Learning and recommendations for future response to business continuity critical events or further peaks in COVID-19 activity,
- Improvement actions required and raise awareness of the processes of response.

The review aimed to gain insight from a wide range of perspectives and experiences and was carried out with different groups of staff from across the organisation, including Executive and Non Executive Directors. In addition, a separate report was commissioned to review operational decision making during the COVID response period.

### 1.4.1 Summary of Key Learnings

There were many areas of good practice outlined within the reviews, with an overwhelming response relating to the way staff worked together, supported each other, and quickly adapting to different ways of working – the way our people worked and responded was felt to be exceptional by all groups.

Key learnings from the action reviews have resulted in a number of recommendations and actions being taken forward, including:

- A recognition that the existing REAP or CESP plans were not designed to operate under prolonged pandemic conditions, therefore the Trust has now introduced a COVID-19 Response Plan which has three escalation levels based on predefined triggers which allow the Trust to rapidly respond to changes in demand caused by COVID-19.
- The importance of having a clear command and control structure, with defined roles and responsibilities to ensuring escalation and decision making pathways are communicated and understood.
- The need to establish a system to centrally record and capture decisions made by different teams within the Command and Control structure with delegated authority, as a clear audit trail of actions
- Methods of communication such as Facebook Live and Microsoft Teams were seen as important and extremely useful additions/change to modified ways of working.
- Streamlining the mechanism for publishing and cascading communication will ensure essential information is targeted at the right groups in a timely manner
- An acknowledgement that the Trust need systems and processes in place to manage rapid onboarding of volunteers, and a method to coordinate redeployment of staff to support roles in the Trust.
- Strengthening arrangements for staff who are homeworking, to ensure they are provided the right level of support and able to function remotely
- Building resilience of the Logistics Supply Unit to enable responsive inventory management and supply chain processes able to meet elevated levels of demand, specifically relating to FIT testing and availability of PPE.

### 1.4.2 Operational Decision Making

It was acknowledged that the scale and impact of COVID-19 was not something the Trust had ever experienced, and the level and type of response required was unique. As a consequence, decisions and actions had to be undertaken rapidly. A report was commissioned to capture key activity and operational decisions recorded by Trust between the end of January and mid April 2020, in the context of:

- LAS performance and resource availability;
- Relevant external context – guidance issued, known key interactions with external stakeholders; and
- Recorded significant operational decisions made, together with the rationale for these (where recorded).

## 1.5 Responding to Patients

COVID-19 was a new virus about which little was known worldwide and for which there were no pre-existing guidelines for management of patients. The clinical course of the disease was not understood and London, being the first UK area to see high numbers of patients, led the way in developing many of the protocols and sharing learning. As the only pan-London acute Trust and provider of 40% of London's NHS 111 London Ambulance Service was the access point for many patients seeking urgent and emergency care.

The initial experience in February across London was that the majority of patients had mild symptoms without severe disease. These patients did not require an emergency ambulance or review in secondary care facilities, which were already under significant strain prior to this outbreak due to winter pressures.

As the Pandemic progressed through March and April the acuity of the patients increased and it was essential to identify those patients who were deteriorating and required an urgent face-to-face assessment and conveyance for critical definitive care - whilst continuing to manage those less unwell with clinical telephone assessment and advice.

Throughout the Pandemic our patients remained the primary focus and the following were implemented: to maintain safety:

### 1.5.1 Call handling and telephone assessment

- Both the 999 and NHS 111 call handling operations were redesigned to create additional COVID-19-specific call handling capability. Our ability to keep answering calls quickly was imperative for those patients who needed immediate assistance and early implementation of a specific triage protocol in EOC was critical.
- A specific pandemic triage protocol was implemented in London Ambulance Service ahead of the other English ambulance services to deliver a focused initial assessment
- Senior clinicians were utilised in all call handling areas (999 and 111) to provide support to non-clinical call handlers and undertake patient assessments using the latest clinical toolkits.

### 1.5.2 Responding to patients

- COVID specific clinical guidelines were developed and issued to all patient facing clinicians and this was updated as new guidance was released
- Daily attendance at the NHSE London Clinical Advisory Group ensured the LAS was aligned clinically to other health providers across London
- A dedicated Critical Care Transfer Service was designed and delivered to support the transfer of the most critically unwell patients both between hospitals and to Nightingale London.
- Bespoke clinical training was written and provided to the wide range of non clinical volunteers who were supporting us provide frontline care by working alongside an experienced ambulance clinician.
- Frontline crews had personal protective guidance throughout the pandemic to minimise the risk to posed to them and reduce community spread. The PPE protocols were regularly updated in line with the national guidance.

- A dedicated response to attend patients who had died in their own home was established in collaboration with the Metropolitan Police and NHSE London to ensure the patient's dignity was maintained and families and friends were well informed at a time when normal support mechanisms were necessarily restricted.

### 1.5.3 On-going learning and review

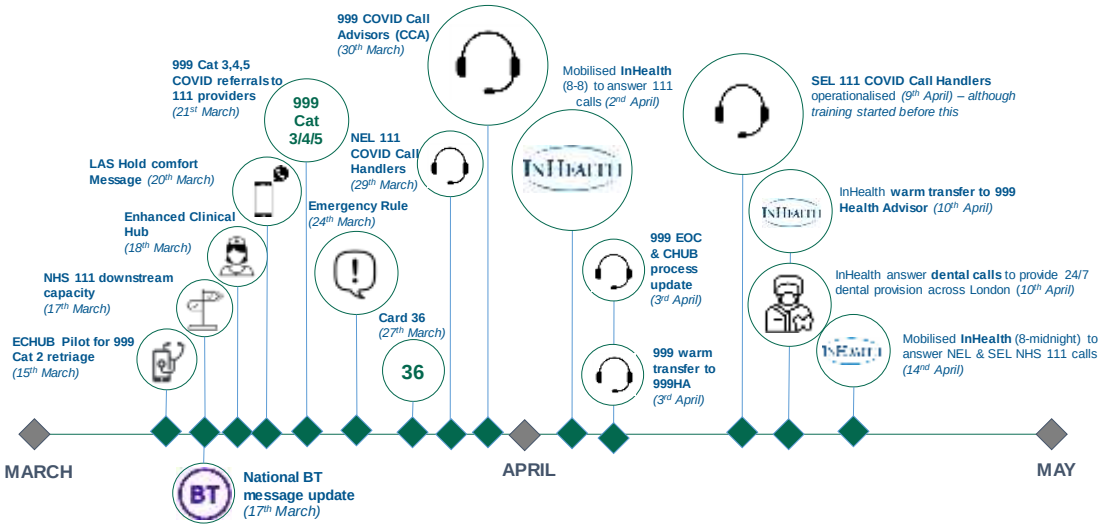
We recognised that we were managing a new disease that required new processes, guidance and systems to be implemented often at speed. On-going review was essential to provide assurance about safety, identify areas for improvement, share learning and further refine our guidance. We did this through maintaining our weekly serious incident review groups, weekly patient safety group to review and approve new guidance and processes, a continuous re-contact audit to review the care provided to patients who recalled 999 within 24 hours of a face-to-face assessment, a 2-stage structured judgment review of patients who had a delay in contacting LAS or the clinical response (by telephone or face-to-face) was delayed. Despite the unprecedented demands on the LAS, whilst the quality of care did not always meet the standards LAS expects to provide the systems and processes implemented were safe.

## 1.6 Our future ways of working

There are new processes and procedures introduced as part of our COVID response that has resulted in a positive effect on the organisation. The Trust intends to retain some of these enhancements as part of our operational delivery model or as part of resilience plans in the event of a future surge in demand

### 1.6.1 NHS 111 and 999 Emergency Operations

As NHS 111 services across London and 999 EOC began to receive a high numbers of calls relating to COVID symptoms, work was undertaken at pace to create a specific pathway and establishment of dedicated teams to manage COVID-related calls and to preserve capacity for NHS 111 and 999 to take emergency calls and ensure we attended to our sickest patients.

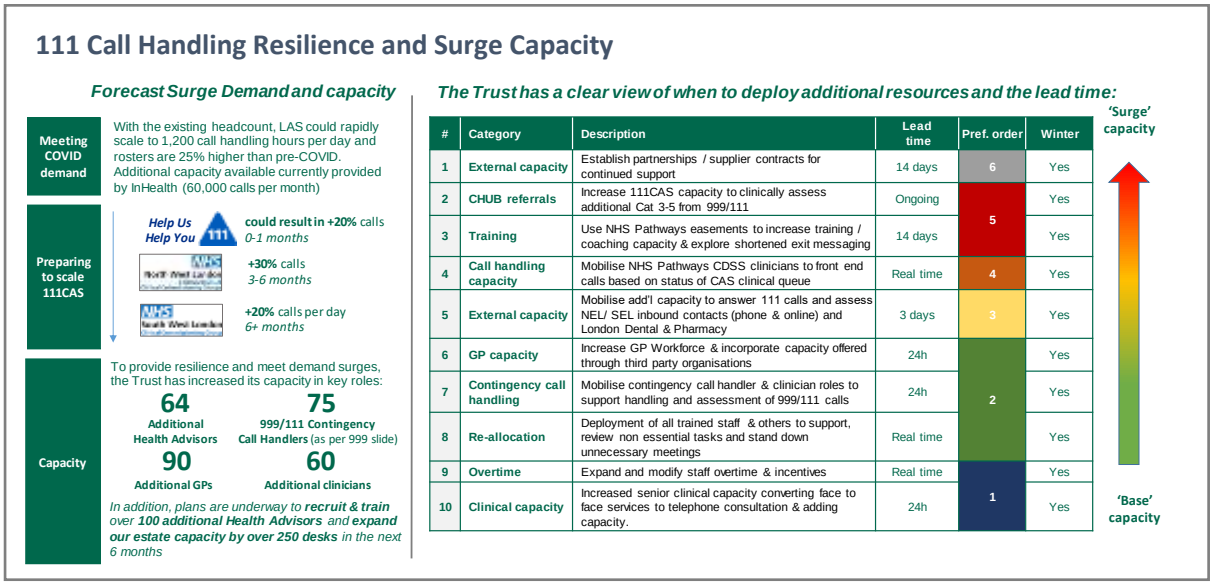



Legacy changes that have been retained as part of business as usual operations include:

- Electronic transfer of clinically appropriate 999 Category 3-5 activity to local 111CAS providers for assessment and onward referral
- Automated transfer of 999 activity to clinical queue for assessment
- Ability to warm transfer clinically appropriate 999 activity to a 111CAS Health Advisor for full assessment as part of blended operational model
- Access for electronic referrals to downstream services providers within each ICS
- Providing access for ambulance crews to seek clinical guidance or referrals for patients quickly through 111*5
- Utilising the contingency call handler pool to flexibly support initial 111 or 999 screening in order to protect fully trained call handlers who can undertake full assessment (Health Advisors & Emergency Call Handlers)
- Blending CAS & CHUB clinical workforce and operational processes
- ITK link enables interoperability with other ambulance services to support 999 call taking during periods of peak demand
- Ability to utilise external call handling capacity to provide added service resilience
- Access to GP clinical workforce through 3rd party agreements and partnerships with downstream service providers (e.g. GPOOH providers)
- Additional/separate 111CAS queue managed across multi sites
- Clinicians with a bespoke skill set to manage specific types of cases in multidisciplinary team
- Use of video technology to support clinical assessment

### 1.6.1.1 NHS 111 Resilience and Surge Plans

In the event there is a significant surge in NHS 111 call demand due to COVID-19, then up to 1,400 call handling hours per day would be required across NEL & SEL 111 sites meet 10,000 calls and ensure 95% of calls answered are answered in less than 60 secs. Answering the calls within 60 seconds is a both a clinical safety and quality measure as it is not possible to predict a patient's needs until the initial assessment has been made. Plans have been developed that describe our approach to manage demand and scale capacity including, more robust call triage, integrated capacity with the EOC and drawing on external support only when necessary.



**111 Call Handling Resilience and Surge Capacity**

***Forecast Surge Demand and capacity***

**Meeting COVID demand**

With the existing headcount, LAS could rapidly scale to 1,200 call handling hours per day and rosters are 25% higher than pre-COVID. Additional capacity available currently provided by InHealth (60,000 calls per month)

**Preparing to scale 111CAS**

***Help Us Help You*** **could result in +20%** calls *0-1 months*

**+30%** calls *3-6 months*

**+20%** calls per day *6+ months*

**Capacity**

To provide resilience and meet demand surges, the Trust has increased its capacity in key roles:

**64** Additional Health Advisors

**75** 999/111 Contingency Call Handlers (as per 999 slide)

**90** Additional GPs

**60** Additional clinicians

*In addition, plans are underway to* ***recruit & train*** *over* ***100 additional Health Advisors*** *and* ***expand our estate capacity by over 250 desks*** *in the next 6 months*

***The Trust has a clear view of when to deploy additional resources and the lead time:***

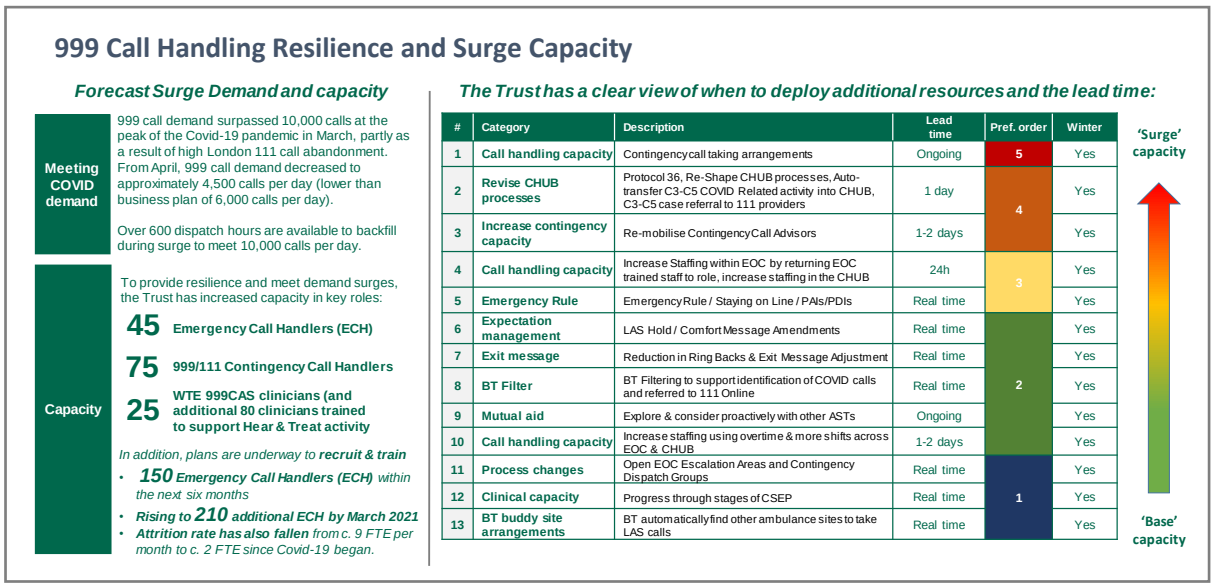
| # | Category | Description | Lead time | Pref. order | Winter |
|---|---|---|---|---|---|
| 1 | External capacity | Establish partnerships / supplier contracts for continued support | 14 days | 6 | Yes |
| 2 | CHUB referrals | Increase 111CAS capacity to clinically assess additional Cat 3-5 from 999/111 | Ongoing | 5 | Yes |
| 3 | Training | Use NHS Pathways easements to increase training / coaching capacity & explore shortened exit messaging | 14 days | | Yes |
| 4 | Call handling capacity | Mobilise NHS Pathways CDSS clinicians to front end calls based on status of CAS clinical queue | Real time | 4 | Yes |
| 5 | External capacity | Mobilise add'l capacity to answer 111 calls and assess NEL/ SEL inbound contacts (phone & online) and London Dental & Pharmacy | 3 days | 3 | Yes |
| 6 | GP capacity | Increase GP Workforce & incorporate capacity offered through third party organisations | 24h | 2 | Yes |
| 7 | Contingency call handling | Mobilise contingency call handler & clinician roles to support handling and assessment of 999/111 calls | 24h | | Yes |
| 8 | Re-allocation | Deployment of all trained staff & others to support, review non essential tasks and stand down unnecessary meetings | Real time | | Yes |
| 9 | Overtime | Expand and modify staff overtime & incentives | Real time | 1 | Yes |
| 10 | Clinical capacity | Increased senior clinical capacity converting face to face services to telephone consultation & adding capacity. | 24h | | Yes |

'Surge' capacity

'Base' capacity

### 1.6.1.2 999 Emergency Operations Centre (EOC) Surge and Resilience Plans

In the event of a significant surge in 999 call demand then 999 Emergency Operations Centre (EOC) would require up 1,900 call handling hours per day to meet 10,000 calls 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.



**999 Call Handling Resilience and Surge Capacity**

***Forecast Surge Demand and capacity***

**Meeting COVID demand**

999 call demand surpassed 10,000 calls at the peak of the Covid-19 pandemic in March, partly as a result of high London 111 call abandonment. From April, 999 call demand decreased to approximately 4,500 calls per day (lower than business plan of 6,000 calls per day).

Over 600 dispatch hours are available to backfill during surge to meet 10,000 calls per day.

**Capacity**

To provide resilience and meet demand surges, the Trust has increased capacity in key roles:

**45** Emergency Call Handlers (ECH)

**75** 999/111 Contingency Call Handlers

**25** WTE 999CAS clinicians (and additional 80 clinicians trained to support Hear & Treat activity

*In addition, plans are underway to* ***recruit & train***

- ***150*** ***Emergency Call Handlers (ECH)*** *within the next six months*
- ***Rising to 210 additional ECH by March 2021***
- ***Attrition rate has also fallen*** *from c. 9 FTE per month to c. 2 FTE since Covid-19 began.*

***The Trust has a clear view of when to deploy additional resources and the lead time:***

| # | Category | Description | Lead time | Pref. order | Winter |
|---|---|---|---|---|---|
| 1 | Call handling capacity | Contingency call taking arrangements | Ongoing | 5 | Yes |
| 2 | Revise CHUB processes | Protocol 36, Re-Shape CHUB processes, Auto-transfer C3-C5 COVID Related activity into CHUB, C3-C5 case referral to 111 providers | 1 day | 4 | Yes |
| 3 | Increase contingency capacity | Re-mobilise Contingency Call Advisors | 1-2 days | | Yes |
| 4 | Call handling capacity | Increase Staffing within EOC by returning EOC trained staff to role, increase staffing in the CHUB | 24h | 3 | Yes |
| 5 | Emergency Rule | Emergency Rule / Staying on Line / PAIs/PDIs | Real time | | Yes |
| 6 | Expectation management | LAS Hold / Comfort Message Amendments | Real time | 2 | Yes |
| 7 | Exit message | Reduction in Ring Backs & Exit Message Adjustment | Real time | | Yes |
| 8 | BT Filter | BT Filtering to support identification of COVID calls and referred to 111 Online | Real time | | Yes |
| 9 | Mutual aid | Explore & consider proactively with other ASTs | Ongoing | | Yes |
| 10 | Call handling capacity | Increase staffing using overtime & more shifts across EOC & CHUB | 1-2 days | | Yes |
| 11 | Process changes | Open EOC Escalation Areas and Contingency Dispatch Groups | Real time | 1 | Yes |
| 12 | Clinical capacity | Progress through stages of CSEP | Real time | | Yes |
| 13 | BT buddy site arrangements | BT automatically find other ambulance sites to take LAS calls | Real time | | Yes |

'Surge' capacity

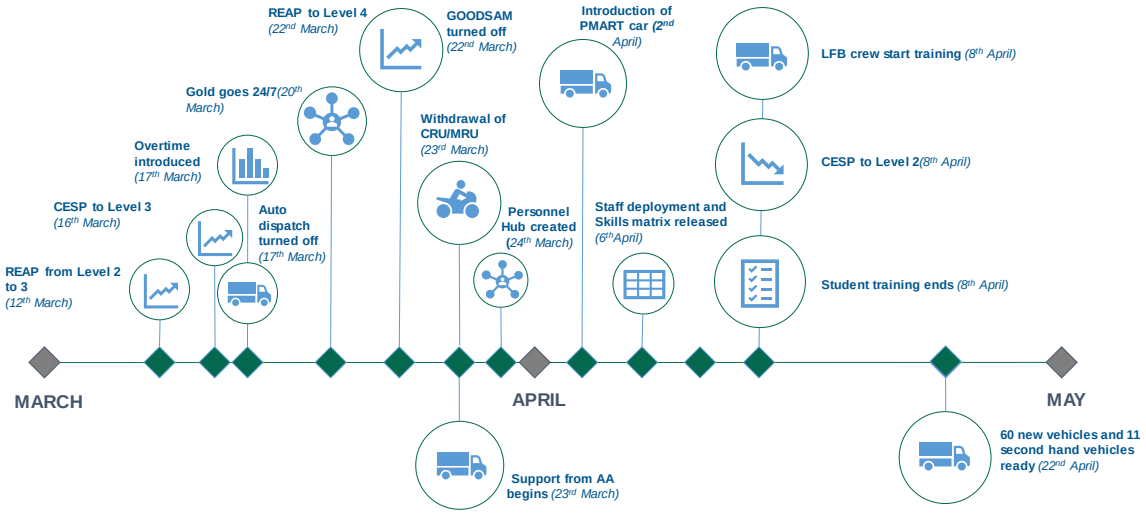
'Base' capacity

### *1.6.1.3 Clinical Assessment Surge and Resilience Plans*

IUC and EOC resilience actions to date have specifically targeted the role of clinical assessment and planned how the capacity will be sourced. 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 that 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.
Increased collaboration from staff training and improved processes has also allowed for more integration between the 111 and 999 teams.

## 1.6.2 Ambulance Operations

It was essential during the first peak of COVID that the Trust was able to deploy the maximum frontline response, therefore modifications to the deployment model was implemented to best utilise the skills of the staff and volunteer workforce, and maximum availability of our fleet.

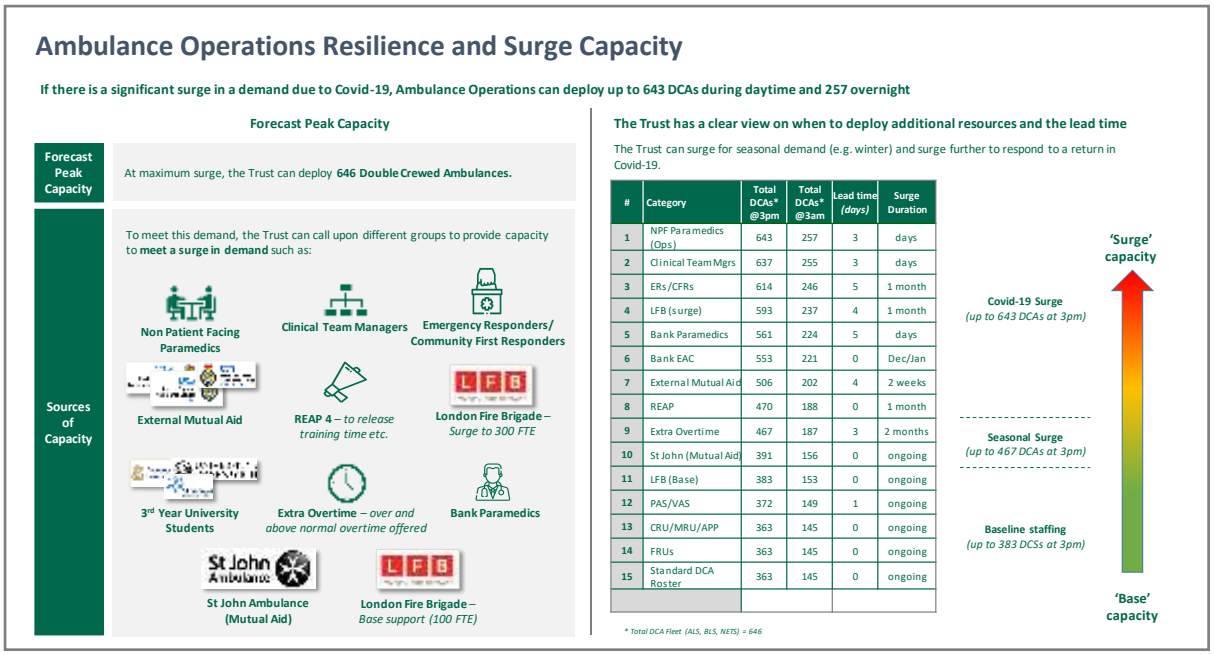



Legacy changes that have been retained as part of business as usual operations include:

- An ongoing commitment to a DCA led delivery model with proportionally fewer solo vehicles being regularly deployed will deliver a more resilient and flexible way of working
- Flexible capacity will continue in the vehicle prep and make ready functions to service the increased number of vehicles required and to increase vehicle capacity when necessary
- Circa 100 trained LFB (London Fire Brigade) staff members will continue to be utilised to support the core DCA roster. Further LFB capacity will be available during times of unusually high demand as part of our surge response.
- A deep dive of the Logistics supply unit and medicines packing function was undertaken. A number of recommendations were put forward to support the efficiency and resilience of logistics supply and improvements to medicines packing processes to ensure the Trust is MHRA compliant.
- PMART (Pandemic Multi Agency Response Team) will continue to ensure the most efficient use of LAS resources and maximise the number of staff ready to respond to an emergency case.
- Introduction of an Assistant Ambulance Practitioner (B4) building on our experience during Covid and the experience of other Trusts who have already introduced similar roles.
- Video conferencing pilot in collaboration with University College London NHS Trust to triage patients with stroke symptom providing access to quicker treatment.

### *1.6.2.1 Ambulance Operations Surge and Resilience Plans*

In the event there is a significant surge in a demand due to COVID-19, Ambulance Operations can deploy up to 643 DCAs during daytime and 257 overnight. To meet this demand, the Trust can call upon different groups to provide capacity to meet a surge in demand such as: paramedic students, Clinically trained managers, mutual Aid from other Trusts, LFB, Clinical Team Managers, St Johns Ambulance.




## 1.6.3 Consolidation of our Ambulance stations

Since the initial consolidation of Ambulance stations to 33 sites at the peak of the pandemic, several sites have re-opened. 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.

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

### 1.6.4 Other legacy changes made across the LAS

Areas of best practice from other areas of the organisation that we will continue to maintain in order to support:

- Establishment of the Wellbeing hub to provide all LAS staff members access to required health and wellbeing resources in times of both operational normality and demand surges
- Appointment of a **dedicated wellbeing lead**, and the development of Mental health and wellbeing resources to support staff and volunteers during COVID-19, either directly through LAS support or channels made available through wider NHS networks.
- Maintain the processes to **rapidly increase frontline staffing** resource in case of demand surge, via access to existing bank staff, external volunteers and utilising the redeployment of internal staff more effectively
- **Launch of LAS TV live** (previous Facebook live). This has allowed a much stronger and responsive communication channel to open between LAS senior leaders and other staff. It has been particularly effective as a channel because of guidance regarding social distancing and the accessibility to those in stations, at home or other locations. It is expected a version of LAS TV will continue as a regular feature.
- **Flexibility of remote working –** it has been very beneficial to be able to support staff the flexibility of working from remote locations, including home, through the deployment of better digital infrastructure – Also allowing the compliance with social distancing expectations for the working environment.
- **Covid Operational Leadership Team (COLT)** was launched to enable responsive decision-making and leadership capability, bringing together executives and other senior leaders from across the Trust. This has been effective in allowing rapid escalation and management of issue. It has recently morphed into a Daily senior leadership meeting (DSLT) using similar principles with less focus on Covid specific issues.

These changes, and more, are examples of how the Trust has adapted and continues to respond to national guidelines, staff expectations and good working practices accelerated by Covid-19. We will continue to listen to feedback and be responsive as other lessons are learnt and shared, supporting our teams to continue to develop and adapt as necessary. Through these changes we remain confident we will continue to deliver high quality care and support to our patients across London.

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Managing our Strategic Risks | | | |
| **Agenda item:** | 14.1 | | | |
| **Report Author(s):** | Frances Field, Internal 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:**

The purpose of this paper is to:

- Set out the Trust's approach to the management of strategic risk at Board level;
- Following a review by the Audit Committee, approve the new format of the Board Assurance Framework (BAF); and
- Provide an update to the Board on the status of current BAF risks:

  61 – COVID-19 Impact. No change to risk scores.

  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. This risk undergone a complete reviewed and update by the CIO with a change to the residual risk rating from 12 to 16 to reflect the increased risk of IT failure, which was approved by the Trust Board on 28 July 2020.

  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. The risk has been reviewed and updated by the Director of People and Culture and a proposal made to increase the residual rating from 12 to 16, as this has now become an area of significant concern.

  45 - A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. The content of this risk has been reviewed and updated since it was last presented to the Committee with no change to the residual rating.

  TO BE DISCUSSED: 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. This risk was reviewed

and updated in August 2020 with changes made to the controls and a notification that the action relating to the development of productivity measures which, includes scoping of a new automated productivity system that can extract information from the telephony has been paused with scoping/procurement to be resumed as part of Trust Covid recovery, as well as agreement of the metrics. No change to residual risk rating.

A discussion was held at the Quality, Assurance and Risk Committee about whether to remove BAF 54. The Executive recommendation is to remove this as the risk is not applicable at this time given that there is no contract in place. However, the Non-Executive members of the Committee requested that this is re-worded to reflect the financial risk elements.

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

The Trust Board is asked to:

1. Note the Strategic Risk framework set out in this report;

2. Approve the recommendation from the Audit Committee to adopt the new format of the BAF; and

3. Note the revisions to the BAF risks highlighted in red and approve the proposed increase in the residual risk rating of BAF risk 56 as well as discuss the approach to be taken for BAF 54.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | X | No | | CQO and Lisa Gibb |
| Finance | Yes | X | No | | CFO |
| Chief Operating Officer Directorates | Yes | X | No | | COO |
| Medical | Yes | X | No | | CMO |
| Communications & Engagement | Yes | X | No | | Director of Communications |
| Strategy | Yes | X | No | | Director of Strategy & Transformation |
| People & Culture | Yes | X | No | | Director of People and Culture |
| Corporate Governance | Yes | X | No | | Director of Corporate Governance |

# Managing our strategic risks

## 1.0. Purpose

1.1. The purpose of this paper is to:

- Set out the Trust's approach to the management of strategic risk at Board level;
- Propose a new format of the Board Assurance Framework (BAF).

## Managing Strategic Risk

## 2.0. Board responsibility and ownership

2.1. The organisation's approach to risk management should be more than a compliance mechanism. Risk management needs to be an integral part of the organisation's culture, strategy, and day-to-day business operations. Although the Board should not take a direct role in managing risks they need to maintain oversight of risk management and corporate issues that may impact on the organisation achieving the strategic objectives set out it its business plan.

2.2. The Trust's **Risk Management Strategy and Policy** describes the Board's responsibility for reviewing the effectiveness of its internal control through its assurance framework. The Board is required to seek assurance that it is doing its reasonable best to ensure the Trust meets its objectives and protects patients, staff, the public and other stakeholders against risk of all kinds. The Board is responsible for setting the strategic direction and objectives for the Trust. It discharges its function through a delegated structure designed to ensure effective risk management.

2.3. Assurance of achievement, weaknesses in delivery and key risks to the delivery of the Trust's objectives are reported through the Assurance Committees of the Board. They will receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with milestones and are responsible for providing assurance on the management of strategic risks to the Board at every other meeting.

2.4. Risk management oversight within the Trust falls under more than one committee; from the Risk Compliance and Assurance Group, Board assurance committees, up to the Trust Board. To effectively cover all areas of risk, committees need to be coordinated so that communication between them regarding risk occurs horizontally and vertically. Committees should report back to the Board regarding the adequacy of risk management measures so that the Board has confidence that management can support them.

2.5. **Non-Executive Directors** are responsible for receiving information presented to the Board and sub-committees on strategic risks (relevant to the committee's area of responsibility); for review of the impact on the achievement of the Trust's strategic objectives and to identify those that should be included on the BAF. The Board are responsible for the approval of BAF level risks which are submitted for addition to the BAF and for approving BAF risks proposed for de-escalation from the BAF or for closure. The Chair/s of the sub-committees can request further assurance from the Director/s responsible for strategic level risks in the event of unsatisfactory progress in the management of a risk. The Trust Board receives risk training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk

management at Board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed Regulations.

2.6. **Directors** are responsible for the identification of strategic risks within their individual areas of business; focussing on key themes of activity, linking the Trust's overarching commitments and strategic objectives outlined in our Organisational Business Plan and enabling strategies. Directors are required to carry out detailed assessments on 'strategic' risk within their area and should work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change, identifying risks that may prevent the organisation from achieving its objectives. They will be required to report strategic risks to relevant Board sub-committees for review and where appropriate to be signed off by the Trust Board for addition to the BAF.

2.7. The review and update of BAF level risks will remain the responsibility of the nominated Director until the risk is approved for removal from the BAF by the Trust Board. Directors will be expected to present their updated BAF risks at every other meeting to Trust Board and sub-committees, to provide assurance that the risks are being managed appropriately in line with the Trust's risk appetite.

2.8. Board Horizon scanning and reviewing the Board Risk Appetite Statement

Once a year at a Board development session, the Board will undertake a horizon scanning session with regard to its strategic risks while also reviewing its strategic risk appetite statement.

### 3.0. Strategic and Corporate Risk Management Framework

3.1. The Trust's Risk Management Strategy and Policy describes the definition of strategic and corporate (Trust wide) risk as follows:

- **The Board Assurance Framework (BAF)** sets out the strategic risks of The Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF can be used to drive the Board agenda.
- It is the "main tool that the [Board] uses in discharging its overall responsibility for internal control" and a key source of evidence for the Annual Governance Statement (NHS Audit Committee Handbook, HFMA, Fourth edition). The Director of Corporate Governance is responsible for overseeing the process for the management of the BAF; including the reporting of the BAF to the Trust's assurance committees and the Trust Board. The BAF is currently presented to the assurance committees and the Trust Board bi-monthly. **The Corporate (Trust Wide) Risk Register C (TW) RR** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. The Corporate (Trust Wide) Risk Register is a high level operational risk register that contains all risks that have been identified as affecting more than one Sector/Department/Directorate or is unable to be mitigated by the them and may need a Trust wide approach.
- Corporate (Trust Wide) risks are generally owned by the executive team who delegate their management to either a nominated individual, designated committee or a time limited project group who will monitor actions and plans against them. The C (TW) RR is reviewed by the Risk Compliance and Assurance Group on behalf of the Executive Committee and the Trust Board. The C (TW) RR is currently reported to the Trust Board bi-monthly.

  **The Risk Compliance and Assurance Group (RCAG)** which is chaired by the Chief Quality Officer, with the Director of Corporate Governance as the Deputy Chair, manages and monitors all risk management processes and activities with the Trust. The Group meets monthly and is responsible for the delivery of a systematic and action-oriented approach to the management of all known and foreseeable risks within the Trust to enable the Executive Committee to provide assurance to the Audit Committee and the Trust Board that the Trust's

Risk Management Framework is operating effectively. The RCAG currently receives the BAF each time it meets.

The RCAG oversees the management of risks rated 15 and over and receives the BAF on a monthly basis for noting and discussion. Linkages between Corporate (Trust Wide) and BAF risks are discussed by the group thereby identifying emerging themes and risks that may potentially require inclusion on the BAF. These risks are escalated to the appropriate sub-committee or through the key issues report to the Executive Committee.

## Proposed changes to the framework

### 3.1. New BAF format

NHS Providers held a session in June 2020 which highlighted a number of key areas in the management and reporting of risk and the importance of driving appropriate conversations, which focus on the provision of assurance that we are managing our risks.

Part of the presentation focussed on a recommended template for the BAF which was deemed best practice by industry standards. Following this session we have reviewed our current BAF format and redrafted it to include those best practice elements (attached new BAF – Appendix 1).

### 3.2. Audit Committee feedback

The Audit Committee received the report and the proposed new BAF at its meeting on the 3rd September 2020. Members agreed to recommend to the Board the new format of the BAF but also advised on the following considerations:

- An Assurance Framework is developed in due course in line with HM Treasury guidance;
- The Audit Committee to consider holding 'Audit and Risk clinics' with the executive leadership team;
- Trust to consider the wider system of risk identification and ownership and gain assurance that the process for reporting, escalating and mitigating risks is embedded into the culture particularly led by the first line of defence; and to
- Consider the boundary between "strategic" and "operational" risks.

### 3.3 Conclusion

**The Trust Board is asked to:**

- Note the Strategic Risk framework set out in this report;
- Approve the recommendation from the Audit Committee to adopt the new format of the BAF; and
- Note the revisions to the BAF risks highlighted in red and approve the proposed increase in the residual risk rating of BAF risk 56 as well as discuss the approach to be taken for BAF 54.

**Appendix 1**

## Board Assurance Framework: August 2020

**Purpose**

The purpose of the Board Assurance Framework (BAF) is to present the Trust's risk assurance framework in the context of the strategic objectives based on the Goals and deliverables set out in the Strategic Plan 2018 – 2023.

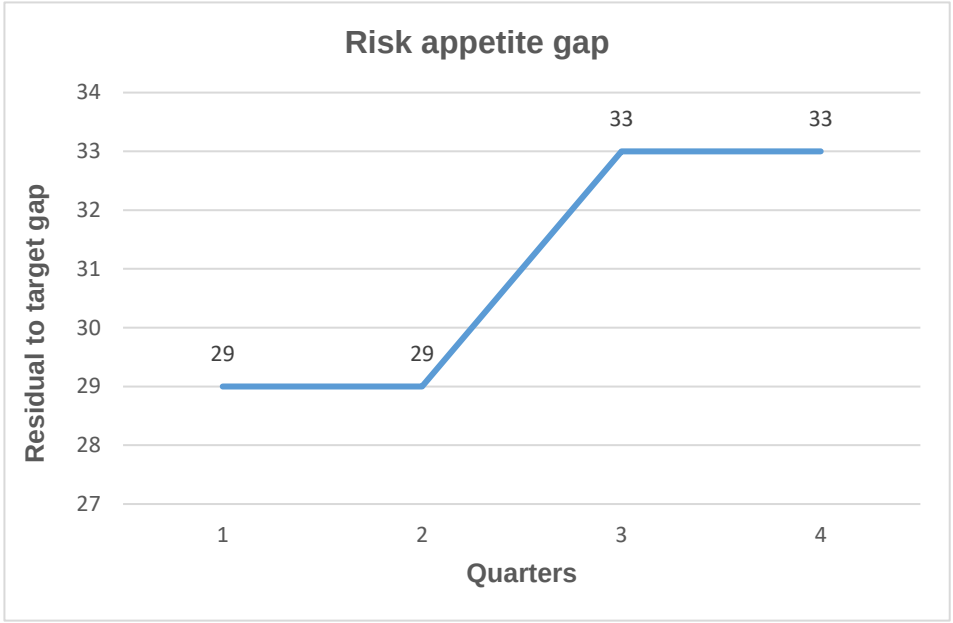
**The Board is asked to note the changes highlighted in red and in particular the risks exceeding the Board tolerance scores as shown in the table below.**

**Summary of current position**

| Strategic Risk | Initial Risk Score | Residual Risk Score | Risk Tolerance | Risk exceeding tolerance? | Change in risk score |
|---|---|---|---|---|---|
| COVID-19 Impact | 20 | 16 | Low (6-10) | Yes | ⟷ |
| 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 | 16 | 16 | Low (6-10) | Yes | ↑ |
| A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. | 20 | 15 | Low (6-10) | Yes | ⟷ |
| 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. | 16 | 12 | Low (6-10) | Yes | ⟷ |
| 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. | 16 | ~~12~~ 16 | Low (6-10) | Yes | ↑ |

## BAF Risk reporting Trend 2020

| | Target | Residual | | | |
|---|---|---|---|---|---|
| | | Jan | April | July | Oct |
| **BAF 61 COVID 19** | 8 | 16 | 16 | 16 | 16 |
| **BAF 58 IT failure** | 4 | 12 | 12 | 16 | 16 |
| **BAF 45 Cyber attack** | 10 | 15 | 15 | 15 | 15 |
| **BAF 54 111/IUC KPI's** | 8 | 12 | 12 | 12 | 12 |
| **BAF 56 Recruitment/Retention** | 8 | 12 | 12 | 12 | 12 |
| **Total risk score** | 38 | 67 | 67 | 71 | 71 |
| **Residual to target gap** | 38 | 29 | 29 | 33 | 33 |



| STRATEGIC GOAL 1: Providing outstanding care for our patients | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Executive Lead** Chief Executive Officer | | **Assuring Committee:** Board | | | | | | |
| **No. and Risk description** | | **Initial risk score** | **Key controls and assurances** | **Residual risk score** | **Action plan** | **Timescale** | **Risk tolerance** | **Board update** |
| **61** | **COVID-19 Impact** | **20**<br>26.05.20 | **Controls**<br>1. Strategic Recovery Group to work with each directorate to develop action plans for future resilience and sustainability.<br>2. Pandemic business continuity plans being developed, incorporating lessons learned and preparing for any potential peaks in future.<br>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.<br>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<br>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<br>6. Australian recruitment programme regularly reviewed and approach updated as necessary.<br>7. Appointment of dedicated COVID Wellbeing lead with remit for creating the Trust's COVID staff wellbeing | **16**<br>26.05.20 | 1. COVID-19 decision making review underway.<br>2. To review and assess the Trust's Strategy and strategic risks following COVID<br>3. The organisation has been asked to set out its position including funding to deliver health care at system level. | | **6-10** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | delivery plan and working with internal and external partners to deliver the plan<br>8. Interim Head of Wellbeing has been appointed and the Wellbeing Hub has been set up to provide one point of entry for all staff covering their health and wellbeing needs<br>9. 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 (this has been stood down with the reduction of demand, however there are plans to reinstate it as required).<br>10. Working with CQC and NHSI to agree SI process meet whilst recognising the scale of investigations required to meet LfD regulatory requirements.<br>11. 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.<br>12. 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<br>13. 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.<br>14. 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<br>15. 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.<br>16. We have agreed with NW London assumptions in line with our month 3 forecast for the basis of our 20/21 financial plan submission for the 7th September 2020.<br>17. Secured capital of £50M to support the capital programme for transformation requirements in 20/21.<br>18. The Trust is developing an efficiency programme to deliver savings equal to additional revenue investment agreed with NW London to drive the transformation programme<br><br>**Assurances**<br>19. Reports are provided to the Board Assurance Committees on COVID-19 related activities.<br>20. Reports provided to Executive Committee who sign off strategic risks and actions.<br>21. Status reports provided to the Trust Board via weekly NED calls and monthly Trust Board meetings. | | | | |

| STRATEGIC GOAL 2 : | Be a first class employer, valuing and developing the skills, diversity and quality of life or our people | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Executive Lead** | **Director of People & Culture** | | **Assuring Committee** | **People and Culture Committee** | | | | |
| **No. and Risk description** | | **Initial risk score** | **Key controls and assurances** | **Residual risk score** | **Action plan** | **Timescale** | **Risk tolerance** | **Board update** |
| 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 | **16**<br><br>23.05.19 | Controls<br>1. The Trust has historically built strong pipelines for paramedic recruitment overseas which will allow it to respond to an under supply in the UK market. These activities are currently on hold due to Government restrictions and internal challenges.<br>2. 20/21 UK Graduate recruitment in place - a proposal to bulk recruit 96 UK Partner Paramedic students.<br>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. (This Group has not met for 10 months and is under review, however there are 4 other Groups running which are focussing on operational resourcing for this year; Third Year Student Working Group, Non-Patient Facing Clinicians Working Group, Recruitment Working Group and the LFB Working Group to support the Ambulance Ops Sustainability Plan (eg. sustainability over winter and to support a second peak) | ~~**12**~~ **16**<br><br>29.09.20 | **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.**<br>1. Determine skill mix to support patient requirements and operational delivery within the financial budget available.<br>2. Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers.<br>3. Develop and agree Design and Operating Model for Ambulance Services.<br>Develop Trust plan for 999 and 111 integration across call handling and telephony based clinical services. | Actions 1-2: Ongoing<br><br>Action 3: 3 March 21 | **6-10** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 4. Engagement in national workforce planning group to influence debate on challenges of English Ambulance Trusts with funded paramedic places<br>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~~ (Recruitment team now in place at Waterloo)<br>6. The Trust has developed a paramedic apprenticeship to attract and retain local employees<br>7. The Trust is developing accessible career pathways for non-registered clinical roles. Introduced new Band 4 role (Assistant Ambulance Practitioner) There will be two cohorts, one will be operational in Feb 21 and the second cohort in April 21.<br>8. We are working on a new Band 5 TEAC / Future Paramedic programme at Band 5. ~~(currently on hold due to social distancing)~~ The LAS academy is coming to an end and we will move to the partnership with Cumbria for an apprenticeship programme which provides a level 5 qualification<br>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 | | | | | |

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| | | | is working on agreeing the curriculum with the chosen supplier. The target course start date is October 2020.<br>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.<br>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.<br>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.<br>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.<br>14. Covid bank to LAS Bank - procedure now in place to help support front-line resourcing.<br>15. Work is currently underway to develop an Ambulance Ops Sustainability Plan. | | | | |

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| | | | 16. Introduced new Band 4 role (Assistant Ambulance Practitioner) New cohort will be operational in October 2020.<br>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.<br><br>Assurances<br>1. The International recruitment campaign is ongoing via skype interviews for 2020/21.<br>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<br>3. Skills Mix Matrix is the subject of ongoing executive meetings. Strategic Workforce Group will own this on behalf of ExCo. | | | | | |

| STRATEGIC GOAL 3 : Partner with the wider NHS and public sector to optimise healthcare and emergency services provision across London | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Executive Lead** Chief Operating Officer **Assuring Committee** Quality Assurance Committee | | | | | | | | |
| **No. and Risk description** | | **Initial risk score** | **Key controls and assurances** | **Residual risk score** | **Action plan** | **Timescale** | **Risk tolerance** | **Board update** |
| 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. | **16**<br><br>26.3.19 | **Controls**<br>1. Daily monitoring of metrics including safety.<br>2. Clinical escalation plan developed and implemented<br>3. Executive oversight – direct reports meetings.<br>4. Thematic review of incidents and complaints weekly reflected in monthly quality report.<br>5. Improvement plan developed and being delivered using agile techniques.<br>6. Revised forecast and planning modelling to improve resource productivity and capacity particularly at weekends.<br>7. Scrutiny through both internal and external committees, QOG, QAG, CQRG.<br>~~8. Baseline inspection and review against CQC KLOE's which have informed a comprehensive action plan.~~<br>9. Action plans put in place following CQC inspection report published January 2020<br>~~10. Agile approach to the mitigation of risks in place.~~<br>~~11. Phased approach to implementation of SEL based on learning identified during the NEL mobilisation~~.<br>12. Joint governance meetings and arrangements to ensure learning is shared between NEL and SEL<br>12. Secured the support of regulators and commissioners in identifying further | **12**<br><br>26.3.19 | 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.)<br>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. | Oct 2020<br><br>Complete | **6-10** | |

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| | | | potential sources to recruit and retain medical staff within the CAS.<br>Additional capacity and capability engaged to assist in the delivery of the improvement plan.<br>**Assurances**<br>1. Daily performance report published to executives / commissioners.<br>2. Plan signed off by Medical Director.<br>3. IUC delivery, standard agenda item at ExCo meetings.<br>4. Evidence of completed actions stored on x drive.<br>5. Minuted meetings<br>6. 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.<br>7. We are monitoring agency costs overspend aiming to have permanent staff where possible and maintaining focus on KPI delivery. | | | | | |

| STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Executive Lead** Chief Information Officer | | | **Assuring Committee** Logistics and Infrastructure Committee | | | | | |
| **No. and Risk description** | | **Initial risk score** | **Key controls and assurances** | **Residual risk score** | **Action plan** | **Timescale** | **Risk tolerance** | **Board update** |
| 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 | **16**<br><br>28.7.20 | **Controls**<br>1. Completed a review of CAD infrastructure, vulnerabilities and weakness, Report provided to COLT and LIC and recommendations accepted<br>2. Report on telephony system in EOCs completed and submitted to COLT and LIC and recommendations accepted<br>3. Contract set up with Northrop Grumman to carry out daily checks on the CAD database put in place<br>4. Regular monitoring of CAD performance in place and ongoing<br>5. New generator provided at HQ prior to lockdown<br>6. ITK links established with all English Trusts and the Trust now receiving updates from all.<br>7. Contractor appointed to oversee UPS implementation – plan developed.<br>8. CAD system replicated across both sites – site switchover in the last 12 months<br>9. Significant internal knowledge of systems<br>**Assurances**<br>1. Regular reporting to committees, sub committees and groups.<br>2. IT Delivery Board established with Terms of Reference<br>3. Draft roadmap developed and is being socialised with operations<br>4. Commissioned independent reports.<br>5. Routine planned maintenance. | **16**<br><br>28.7.20 | 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<br>2. Avaya CM7 programme for EOCs to be restarted<br>3. Define and agree remediation plan for UPS.<br>4. Complete project review and lessons learnt for UPS programme.<br>5. Roll out and update of the CM7 Avaya telephony system (version 7) Due to go live end of August / September.<br>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.<br>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~~ | 31/10/20 - 01/04/21<br><br>01/08/21<br><br>31/10/20<br><br>Subject to project review<br><br>30/09/20<br><br>30/09/20<br><br>Complete | **6-10** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 6. Outline business cases.<br>7. Project boards established for replacement of critical systems<br>8. Capital allocation of funds for corrective actions.<br>9. D999 Programme Board established and overseeing key projects<br>10. Issues with systems discussed at all levels of the Trust | | ~~due date to be reported in August 2020.~~<br>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.~~<br>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).<br>10. CAD Essentials board to be restarted and control room risks will be an agenda item<br>11. Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place<br>12. Audits of telephony system<br>13. CAD dashboard to be implemented and reviewed at CAD essentials board<br>14. Cyber to be moved to ICT and a clear roadmap developed to resolve outstanding issues including patch management<br>15. Completion of build of new hardware platform for existing CommandPoint to be completed at Crown Hosting Centres | 30/05/21<br><br>31/10/20<br><br>31/10/20<br><br>31/10/20<br><br>31/10/20<br>31/10/20<br><br>Complete<br><br>Complete | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 16. IT Priorities reassessed and focused on key areas<br>17. IT Structure to be reviewed and areas of capacity and capability identified and corrected | Complete<br><br>Complete | | |

| STRATEGIC GOAL 4 : Provide the best possible value for the tax paying public, who pay for what we do | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Executive Lead** Chief Information Officer | | **Assuring Committee** Logistics and Infrastructure Committee | | | | | | |
| **No. and Risk description** | | **Initial risk score** | **Key controls and assurances** | **Residual risk score** | **Action plan** | **Timescale** | **Risk tolerance** | **Board update** |
| 45 | A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. | **20**<br><br>14.12.17 | **Controls**<br>1. Technical cyber protection, detection and remediation solutions are deployed but require review.<br>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.<br>3. Auditable set of documents covering people, processes, procedures and technical controls; reviewed by NHSD and third parties at least twice a year<br>4. Broad set of real-time security reporting and alerting with ability to take immediate action<br>5. NHS specific intelligence feed from NHS Digital implemented in technical controls and cyber responses<br>**Assurances**<br>1. Compliance-based cyber security KRIs/KPIs (reported to IM&T SMT and monthly CEO performance review)<br>2. Performance reporting to L&IC through IM&T<br>3. Internal Audit and independent audit against DSPT<br>4. Additional NHSD assurance support through CORS programme<br>5. CareCert notifications performance measured and reported as part of the | **15**<br><br>15.1.18<br>⟺ | 1. Deliver technical control/assurance projects:<br>a. Network segregation and access control (Cisco ISE and TrustSec)<br>b. Hardening of internet-facing systems (configuration and improved access control)<br>c. N365 – IG Compliance monitoring and data loss prevention (potential requirement for license upgrade)<br>d. SolarWinds Logging solution and Security Information & Event Management (SIEM)<br>2. Leverage NHSD funded opportunities:<br>a. Cyber Risk Framework workshops to enable enterpise integrated cyber risk management<br>b. CORS Support – Supplier cyber management process, training needs analysis, basleine secuirty architecture patterns, cyber cultural vision statement<br>c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised quals.<br>3. Recruitment of substantive IG and Information Security resource at 2nd line of defence. | CIO<br>Aug 2020<br><br>CIO<br>Nov 2020<br><br>Dir of Corp Gov | **6-10** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | IM&T's KPIs,reported to IM&T SMT & ExCo monthly | | | Nov 2020 | | |

## Appendix 2

### Risk Appetite Statement (Under Review)

The London Ambulance Service NHS Trust (LAS) recognises that it delivers an integral part of the National Health Service (NHS) in London by ensuring patients get the right emergency care at the right time and as such operates in a high risk environment. Its long term sustainability depends upon the delivery of its strategic ambitions and its relationships with its patients, people, public and partners. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to all safety and compliance objectives, including public and patient harm and employee health and safety. The Trust has a moderate risk appetite for the pursuit of its operational objectives, including reputational risks and financial risks involving value for money. The Trust has a higher risk appetite when seeking opportunities for innovation (clinical and financial) within the constraints of the regulatory environment.

**Risk appetite score matrix**

| Risk Appetite | Score |
|---|---|
| Low | 1 - 10 |
| Moderate | 12 – 16 |
| High | 20 - 25 |

### 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<br>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<br>Our People | LAS has a HIGH risk appetite for innovation that does not compromise quality of care. | 20-25 |

| | | | |
|---|---|---|---|
| **Financial/VFM** | Partners<br>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<br>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 |

# 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 (APP no longer in the HUB as no longer required, but will be reviewed in the event of a further peak)
- Increased senior clinical support in EOC to provide guidance on cardiac arrest care and decision making (senior clinical support no longer in EOC as no longer required, but will be reviewed in the event of a further peak)
- 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. (Senior Clinical Leadership no longer running, but will be reviewed in the event of a further peak)
- 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. (This service has been suspended with the stand down of the Nightingale Hospital).
- 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 (The Serious incident panel now meets fornightly)
- 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

***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 August 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 September 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 London HCP to agree income for 20/21 income.
   - We have agreed with NW London assumptions in line with our month 3 forecast for the basis of our 20/21 financial plan submission for the 7th September 2020.
   - The Trust is developing an efficiency programme to deliver savings equal to additional revenue investment agreed with NW London to drive the transformation programme

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 £50M 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 review senior finance and procurement in light of transformation timeline and post COVID.
- Revenue bridge for ICS CFO agreement has been presented w/c 17 August
- 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 01 September 2020 by Chief Finance Officer – 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 respond 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 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
- Winter planning is undertaken by the trust to cover the response to demand expected during November 2020 to March 2021. The plan will cover: Lessons learned from previous winters, forecast of demand and response times across the 999 and 111 services, demand management strategies, capacity management strategies including overtime/incentives, business continuity plans and key risks and mitigations.
- Winter planning group to be stood up to support planning and oversight over the winter period.
- 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 to respond to additional peaks combined with winter pressures.
- The Trust has set up a Strategic Incident Room (COVID 19 cell) this has been 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 ongoing 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 review of performance and the impact of the various actions undertaken through a response for Covid-19. 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 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 worst case 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, retained the capability and systems to increase the number of volunteers if required by demand.
- 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 24 August 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 | 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
   - National contact tracing arrangements in place for crew members and co-workers
   - Covid bank to LAS Bank - procedure now in place will allow for 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 to help support front-line resourcing.
   - A new band 4 role is being recruited to fill the gaps identified by the Ambulance Ops Sustainability Plan.
   - 111 and EOC have been increasing their staffing levels to meet the anticipation of increased demand.
   - Partnership arrangements with LFB are under discussion to provide business as usual and surge support as needed.

2. **Limited welfare and wellbeing support to meet staff's physical, emotional and mental wellbeing requirements.**

   **Key activities and actions to mitigate risks:**

   - Interim Head of Wellbeing has been appointed and the Wellbeing Hub has been set up to provide one point of entry for all staff covering their health and wellbeing needs.
   - 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.
   - Introduction of the 'How are you Doing Survey' provided a base line of staff morale so that initiatives can be identified to respond to staff needs.

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: (reflected in BAF risk 56)**

- 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.
- Training identified for international paramedics for inbound Australian paramedics when they are able to enter the UK.
- 96 UK graduates joined the LAS in August 2020 and are now operational as newly qualified paramedics.

**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 rolled 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, Daily Senior Leadership Team (DSLT) 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:**

- 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 (now back to BAU Staff Council held every other month, weekly OPF, hearings now taking place)
- Resolution framework recommended is being implemented to provide swift resolution of staff issues supported by external mediation resource.
- National reporting for WRES, WDES and staff survey has recommenced

**Risk reviewed on 4 September 2020 – proposal to reduce residual risk rating from major (4) x likely (3) = 12 to a major (4) x unlikely (2) = 8 due to the mitigations in place**

# 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 13 August 2020**

- COVID19 risk register was developed and those ongoing risks have now been embedded into BAU processes)
- 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~~ – now back to producing bi-monthly 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) – now embedded into BAU processes
- Minutes of direct reports meetings
- Daily monitoring of Datix (COVID19 and non-COVID19) by corporate teams and weekly gathering of soft intelligence via QGAMs (this has become a BAU processes)
- 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 creation of an information library (now become a BAU process)
- All quality assurance systems assessed to maintain oversight whilst reducing pressure on operational staff – i.e. audits , serious incidents (now back to BAU processes)
- Working with national leads for safeguarding, coroners to maintain oversight whilst reducing operational pressures.

# COVID-19 Sub-category Strategic Risk Assessments

- **Risk Score reviewed 13 August 2020 – risk score remains the same**

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Corporate (Trust Wide) Risk Register | | | |
| **Agenda item:** | For Information | | | |
| **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 6th August 2020.**

## New Risk

- Risk ID 1131 – There is risk that the management of medicines could be severely compromised due to the contract for Kitprep, which is due to expire on 31/10/20, either not being renewed or renewal with restricted terms by the supplier or LAS not renewing the contract which would cause prolonged use of the business continuity arrangements and therefore failure to comply with legal and regulatory requirements and damage to the reputation of the Trust if not properly managed.

  The group were informed that the lead time for a new product could be 8-12 months and the CIO would be seeking a definitive answer from the supplier on the future of Kitprep. The risk was approved for inclusion in the C(TW)RR and the score agreed.

- Risk ID 1133 - There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers.

The Group were informed that there have been incidents reported and an increase to job cycle times. EOC have also noted evidence of this issue and concern was raised that some schemes will remain in place post the COVID response. The risk was approved for inclusion in the C(TW)RR and the score agreed.

## Current Risk

- 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 an external company would be delivering a programme of general immunisations and that this was separate from the winter flu programme. The risk and score remains unchanged.

- 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 the packing app was being rolled out but this had led to the data being less assured. A supplier meeting was held and agreed to provide a resolution within 7 days. The risk and score remains unchanged.

- 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.

  The Group noted that there is currently no evidence to support this risk due to the recent performance data and the group would like to consider the scoring of the risk after linking in with Operations.

- 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 although incidents have decreased there would be a review across ambulance services to assess what additional security measures are required. Mystery shopper report is due at the end of August. The risk and score remains unchanged.

- Risk ID 1032 – There is a risk that EOL hardware is unsupported due to a lack of funding. 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 but the risk and score remains unchanged until such time as projects to address this have been completed.

- 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 noted that this would link into the current asset tracking project (digital vehicle programme). The risk and score remains unchanged.

- Risk ID 1081 - There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed.

  The Group were updated that the Trust will be able to apply for a licence once the new drug packing unit is operational and has the appropriate registered staff in post. The risk and score remains unchanged but risk was moved from the local risk register to C(TW)RR.

- 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 IM&T will upgrade each phone to enable the call handler to set themselves to available after each call to avoid a phone being unmanned. A quality impact assessment will be carried out to review the impact this may have on call performance. The risk and score remains unchanged.

**Closed Risk**

- 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 there had been no further issues reported and agreed to close the risk.

## 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 | | RCAG |
| Finance | Yes | | No | | |
| Chief Operating Officer Directorates | Yes | | No | | |
| Medical | Yes | | No | | |
| Communications & Engagement | Yes | | No | | |
| Strategy | Yes | | No | | |
| People & Culture | Yes | | No | | |

| ID | Sector / Department | Description | Risk level (current) | Controls in place | Risk Lead | Risk Owner | Last review date | Assurance | Risk level (Target) |
|---|---|---|---|---|---|---|---|---|---|
| 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. | 16 | 1. PAM monthly performance review meetings with Account Manager (LAS representatives, Nicola Bullen and Julia Crossey, Sharon Edgell, H&S)<br>2. KPI Dashboard provided by PAM, monthly<br>3. Monthly CEO Performance meetings including progress update and on Imms progress<br>4. Formal letter to PAM setting out concerns of performance against contract<br>5. Monthly immunisation report provided by PAM to track progress<br>6. As needed meetings with recruitment as the major user of OH service | Layne-Smith, Ali | Layne-Smith, Ali | 06/08/2020 | 1. Ongoing engagement direct with employees via various channels to get direct feedback on service (Nicola Bullen)<br>2. PAM survey of customer experience (PAM Account Manager). To be included in contract meeting<br>3. Follow up meeting with PAM Managing Director and Account Manager (December 2018)<br>4. PAM nurse to provide update on outstanding imms<br>5. Active management of OH issues escalated and future action identified to clarify and resolve | 8 |
| 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. | 16 | The Trust has conducted its assessment of the risks faced by the Trust in the event of a worst case<br>departure from the EU on 31 October 2019, in line with the framework mandated by the Department<br>of Health and Social Care.<br>2. The Trust's standing orders allow for urgent decisions to be taken when necessary.<br>3. The Trust has business continuity plans in place which are being tested in the context of hypothetical<br>EU exit scenarios.<br>4. The Trust has mapped the supply chain for medical consumables and all the Trust's suppliers have a<br>UK depot. Four key suppliers would hold 3 months' worth of stock on UK soil.<br>5. Fuel stocks confirmed which address the civil contingency act requirement to supply 20 days' supply.<br>6. A fuel monitoring system is installed and working to protect fuel stocks.<br>7. Fuel management plan in place-<br>(continuity) aligned to the national arrangement for fuel distribution<br>co-ordinated by NARU – NACC<br>8. Local business continuity plans reviewed | Bewes, Lorraine | Meer, Khadir | 22/04/2020 | Exit from the EU to be a standing item on the Executive Committee<br>agenda going forward.<br>2. A focus group is in place which is meeting fortnightly providing<br>feedback to the Executive Committee on the actions being taken to<br>manage any risks identified with standing reports on logistics, fleet<br>parts and fuel, procurement, drugs supplies including Frimley Park,<br>communications and EPRR and Business Continuity.<br>3. The Trust has identified a Director to be the Senior Officer<br>responsible for the Trust's preparedness for the UK's exit from the<br>EU.<br>4. The Trust has been advised they are considered a priority service<br>by the government for the supply of fuel in the event of a shortage.<br>5. IUC/111 clinicians in the CAS are receiving increased requests for<br>longer prescriptions which is being mitigated through a medicines<br>bulletin being sent to staff.<br>6. Internal audit review noted significant | 8 |
| 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. | 15 | Daily drug audit (Perfect Ward)<br>Manual updates to system to rectify errors (incident reports submitted for all discrepancies and flagged to IM&T) | Mooney, Mr Gavin | Brade, James | 12/08/2020 | Discussed at medicines management group bimonthly and included in the MSO report<br>Reported at performance review | 6 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 967 | Organisational Development | There is a risk that patient experience will be adversly 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. | 16 | Use of supplementary roster to aim to provide additional staffing<br>Use of overtime<br>OPC rostering with high focus on weekend provision<br>PAS/VAS commission | Layne-Smith, Ali | Layne-Smith, Ali | 06/08/2020 | Performance data | 8 |
| 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. | 15 | 1.Security Management Policy implemented.<br>2.Organisational procedure on station duties in place and communicated to staff.<br>3.Incident reporting system in place to enable the prompt reporting, investigation and management of incidents.<br>4.Security surveys being carried out on vulnerable sites.<br>5.Support available from the Metropolitan Police where acts of theft, damage, vandalism are reported.<br>6.Security awareness training incorporated into H&S training delivered across the Trust.<br>7.Engagement of security guards at sites where delays in garage door/shutter repairs are outstanding | Finch, Stephen | Wand, Justin | 06/08/2020 | 1. Incidents reported on Datix.<br>2. Monitoring of Incident reports by Corporate Health & Safety Committee.<br>3. Regular review of incidents by Trust LSMS. | 4 |
| 1032 | Information Management & Technology (IM&T) | There is a risk that EOL hardware is unsupported due to a lack of funding. 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. | 16 | A replication infrastructure is in place at the secondary site however some of the hardware are EOL as well. | Brade, James | Thurston, Barry | 06/08/2020 | No assurance can be given due to no funds were made available for two consecutive finance years | 8 |
| 1050 | Fleet and Logistics | There is a risk that critical pieces of equipment needed for patient assessment or interventions will be missing from the vehicle or primary response bags due to errors by Vehicle Preparation Team or being misplaced by staff during the treatment of patients which could lead to failure or delays in patient care. | 16 | Staff should check bag at start of each shift.<br>VP are replacing all missing pieces of equipment and will place a note in the bag if any supply chain issues. | Green, Mandy | Wand, Justin | 06/08/2020 | QA checks on completion of packing and at VP hubs on delivery by LGMs, quartermasters and project team.<br>Staff sign the tag on each sealed bag to state who has packed bag for audit trail<br>Project group are receiving data regarding incidents. | 4 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1081 | Fleet and Logistics | There is a risk of the inability for the Trust to store, pack and supply medicines to frontline clinicians due to the legal requirement for organisations that supply medicines to staff, to have a Whole Sale Dealers Licence; which may lead to the inability for LAS staff to treat patients if not properly managed. | 16 | A review is underway, which was commissioned by the COO.<br>Chief Pharmacist has carried out a detailed review of the medicines packing function in line with Good Distribution Practice criteria. | Wand, Justin | Wand, Justin | 12/08/2020 | Chief Pharmacist has carried out an initial assessment. | 2 |
| 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. | 16 | 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.<br>All patients whose calls have been missed and not noted to have recontacted the service will be called back | Hobson, Neil | Goldie, Jon | 06/08/2020 | Incidents are raised on Datix to document when phones are left unmanned but logged in.<br>All patients whose calls have been missed and not noted to have recontacted the service will be called back | 4 |
| 1131 | Medical Directorate | There is risk that the management of medicines could be severely compromised due to the contract for Kitprep, which is due to expire on 31/10/20, either not being renewed or renewal with restricted terms by the supplier or LAS not renewing the contract which would cause prolonged use of the business continuity arrangements and therefore failure to comply with legal and regulatory requirements and damage to the reputation of the Trust if not properly managed. | 16 | Paper system as part of business continuity if Kitprep were to fail. Alan Bristow has had a contract review meeting with the supplier Perfect Ward. Specification for system has been agreed. | Mooney, Mr Gavin | Wrigley, Fenella | 11/08/2020 | Business continuity plan in place if Kitprep fails but not long term solution. | 8 |
| 1133 | South East Sector | There is a risk that crews will be delayed attending calls, conveying patients to hospital or accessing properties due to the introduction of road closures, reduced lane capacity causing congestion, parking restrictions and other traffic calming schemes with limited/minimal consultation as a result of a pan London response to COVID by TfL and local authorities to enhance cycling and walking schemes. The aim is to increase capacity to assist with social distancing requirements and the reduced public transport capacity capabilities and local authorities developing schemes to support the reopening of the hospitality sector, provide safe spaces near schools and provide traffic safe neighbourhood zones. This could lead to increased job cycle times which could lead to an adverse impact on patient care/patient safety due to delayed response, members of the public at risk of accident in pedestrian zones, acute site impact and impact on wider NHS providers. | 15 | Bulletin circulated to crews<br>Return CRU to certain areas of London<br>Emergency Services Group established and meeting monthly with LAS, LFB, MPS, sub director of streets and TfL head of traffic flow.<br>LAS COO has formally written to TfL and Local Authorities to express concern (LFB has also formally written) and PFD notice from Leeds City Council shared<br>LAS consistently objecting to calming measure that put physical barrier in place (planters or lockable bollards) | ORourke, Darren | Meer, Khadir | 13/08/2020 | Review of performance and impact on job cycle times<br>Monitor incidents via Datix | 5 |

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | IPC Framework | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Dr Fenella Wrigley, Chief Medical Officer, Director Infection Prevention and Control (DIPC) | | | |
| **Presented by:** | Dr Fenella Wrigley, Chief Medical Officer<br>Dr Trisha Bain, Chief Quality Officer | | | |
| **History:** | Quality Assurance Committee 8 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

On the 4 May 2020, NHS England/Improvement published the new guidance on Infection Prevention and Control (IPC) and alongside this, they published the IPC Board Assurance framework. This was presented to the Trust Board in May – prior to submission to CQC.

On 31st July CQC provided additional questions in preparation for a telephone interview with the DIPC and CQO on 11th August after which their assessment was shared.

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

The Trust Board are presented this paper for assurance and are asked to note the content.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | X | No | | Dr Trisha Bain |
| Finance | Yes | | No | | |
| Chief Operating Officer Directorates | Yes | | No | | |
| Medical | Yes | X | No | | Claire Brown, Head of IPC |
| Communications & Engagement | Yes | | No | | |
| Strategy | Yes | | No | | |
| People & Culture | Yes | | No | | |
| Corporate Governance | Yes | | No | | |

London Ambulance Service NHS Trust

**Infection Prevention & Control Board Assurance Framework**

On the 4 May 2020, NHS England/Improvement published the new guidance on Infection Prevention and Control (IPC) and alongside this, they published the IPC Board Assurance framework. This was presented to the Trust Board in May – prior to submission to CQC.

On 31st July CQC provided additional questions in preparation for a telephone interview with the DIPC and CQO on 11th August after which their assessment was shared.

The framework was intended to help providers assess themselves against the new IPC guidance, as a source of internal assurance that quality standards are being met. It is underpinned by the legislative framework including the Health and Safety at work 1974, IPC code of practice and the CQC key lines of enquiry.

**The framework covers the following 10 Key Lines Of Enquiry (KLOE) all of which have specific subheadings;**

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users - Green
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections Amber
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance Green
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion Green
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people Green
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection Green
7. Provide or secure adequate isolation facilities (Not applicable to the Trust)
8. Secure adequate access to laboratory support as appropriate (Not applicable to the Trust)
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections Amber
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection Amber

In response to the framework, the Clinical Directorate reviewed the Trust's current IPC systems and process against the above key lines of enquiry and concluded that current IPC systems and processes provide assurance that the expected standards are being met and are responsive in terms of the current pandemic. **However, six specific sub headings under KLOEs 2, 9 & 10, were identified for further work due to gaps in assurance.**

**The below table outlines the specific areas where LAS rated themselves amber and provides an update on actions was taken to further improve the identified gaps in assurance.**

**The CQC report has now been received and is attached as assurance.**

| Areas requiring further work | Gaps in assurance | Mitigating action (May 2020) | Updated on further actions being taken (June 2020) |
|---|---|---|---|
| Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. (This is under KLOE 2) | Contract variations due to increase in Peak Vehicle Requirement (PVR). | The external contractor who provides the cleaning service to LAS NHS Trust. Under section 13.3 & Appendix cleaning teams' training is recorded.<br><br>Guidance within the Trust policies for Vehicle Cleaning and Station Cleaning cover further requirements. | The external contractor (Interserve), are contracted to daily clean and make ready 95% of available ambulances and also to deep clean. Under section 13.3 the SOP for the decontamination clean is highlighted & contains details of the cleaning teams' training records. |
| Increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance (This is under KLOE 2) | COSHH risk assessments have been undertaken by H&S where alternative disinfectant wipes have been procured due to shortages in supply due to increased frequency. | Cleaning frequency of premises increased as per contract, including touch points (door handles, stair rails) for corporate locations, call handling and consolidated stations. Provision of cleaning wipes, hand sanitiser at entry points to the building.<br><br>Deep Cleaning at hubs for vehicles with confirmed contact with COVID and AGPs, as per the manual attached. This is audited at the hospitals by the Vehicle Preparation Contracts Manager. | Risk assessments have been carried out in regards to alternative cleaning such as the use of chlorine solution in vehicles and high risk areas such as toilets and kitchens.<br><br>Operational sites have had a COVID secure assessment against national guidance and assurance visits were underway at the time of writing this report. Early indications show that local management actions including cleanliness of premises and working environment have been completed and visited premises are compliant.<br><br>With regards to DCA vehicles, 6 designated super hubs Decontaminated vehicles after every patient identified with COVID19. At the peak, up to 64 vehicles a day were going through the decontamination process with some vehicles being seen more than twice a day. All fleet numbers were recorded and numbers of cleans reported each day to the Trust. The attached ambulance COVID clean list daily report spreadsheet evidences all vehicles going through this process. The manual confirms procedures followed in line with IP&C guidance. Regular Deep cleans are every 6 weeks and continue in line with contract KPIs. |

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| Staff are supported in adhering to all IPC policies, including those for other alert organisms (KLOE 9) | Risk assessments at education centres to recommence training | Monitored through the IPC champions at the IPC committee meetings. Corporate H&S, QOG and RCAG, COLT, internally. Externally regional director of IPC, NASME, QGARD, NASIPCG<br><br>Additionally monitored by line managers through compliance of Statutory Mandatory Training. There has been a reduction in Statutory Mandatory Training during COVID. Risk assessments with regards to social isolation. | CSR, IPC Link practitioner training by IPC team, A&E audits undertaken by IPC team which enables areas for improvement and good practice to be addressed/ commended in real time; Clinical ride out audits undertaken by IPC team- real time feedback, OWR process undertaken by QGAM's and CTM's |
| All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance (This is under KLOE 9) | Risks on register<br><br>ID 1036 and ID 719 | Waste management provided by Tradebe, in line with Waste Management Policy TP057, which includes disposal of Infectious healthcare waste (clinical waste). As per guidance, Category B (UN3291) waste is regularly packaged, handled, transported and disposed of by the outsourced contractors. Waste produced by suspected or confirmed 2019-nCoV patients is placed in a single UN approved orange sack and placed in a tagged, yellow, clinical 770l bin for a collection with the other clinical waste in the usual manner. This waste is processed at the contractors' sites, which are validated at STATT Level III – more than sufficient to render the waste safe. | Additional clinical waste collections have been arranged through a sub-contractor called Albus which was provided and managed by Tradebe. As the current provider did not have capacity to provide extra visits to all operational sites. Due to the consolidated sites and increased staff numbers, we were initially visiting hubs daily, this has been reduced to three times per week and all other operational stations twice weekly. The frequency of visits is being reviewed once collection volumes are confirmed each month. |

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| PPE stock is appropriately stored and accessible to staff who require it (under KLOE 9) | PPE security – new risk declared. | Additional warehouse space secured in unit 12 LSU, with regular deliveries to hub (orderwise). Bronze logistics mangers have been in post at our deployment hubs since lockdown to support crews and ensure they have the correct PPE and stocks are monitored. | • PPE is stored in a clean and well run warehouse. Off the floor and on safe racking<br>• PPE is distributed daily to every VP hub<br>• PPE is stored within stores on stations and overseen by the vehicle preparation team and QM<br>• PPE is distributed to staff daily by the Bronze Logistics team<br>• PPE numbers and usage is monitored by a stock inventory team<br>• PPE is stored within bags in the ambulance to keep it clean and free from exposure |
| Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported (This is under KLOE 10) | FOM risk assessment being undertaken with BAME staff at present | Papers discussed at COLT 15/04/2020<br>• P&C Bulletins<br>• FAQs<br>• Covid-19 Personal Plan<br>• NHSE Mental health hotline<br>• Webinars | Risk assessments for the majority of staff in "at-risk" group have been undertaken and in some cases still ongoing. Actions resulting from these risk assessments are monitored by local management teams with oversight at COLT.<br><br>There are PPE advocate for BAME staff in each sector to ensure that any issues relating to access to PPE for this group of staff who are in the "at risk" category are picked up and addressed in a timely manner. The Chief Executive has written to all manager to emphasise the importance of risk assessments and this work continues to be monitored closely at Trust level. |

**CQC additional questions and summary of evidence provided:**

| Questions | Yes/No/NA | Evidence/documentation |
|---|---|---|
| 1. Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / vehicles and facilities? | Yes | COVID secure assessments undertaken<br>Increased cleaning (4hrly implemented in EOC, 111 hub following assessment undertaken by IPC);<br><br>In addition, where stocks were challenged clear IPC guidance was provided about how to maintain safety<br><br>• Green Clinell wipes should not be removed from EOC's or 111 centres, as they are high risk a critical function.<br><br>• The Top Tips for staying well is available on the Pulse (see below).<br><br>• IPC have worked with EOC and 111 centres over the past 2 winter periods to advise on safe systems of work and IPC have visited Croydon and Barking last week to support .<br><br>• With regards to cleaning and disinfection of EOC and 111 centres, IPC would advise a 24 hour function to ensure toilets, mess rooms and kitchen areas are cleaned on a frequency of minimum 6 times in a 24 hour period, using Actichlor plus or Chlorclean at 1000ppm dilution.<br><br>o Cleaning staff must ensure they change their gloves between each cleaning activity ( room) and clean their hands before and after glove removal.<br>o If the cleaners are using microfibre cloths they should be adopting the correct procedure i.e. of folding and the 8 quarter technique. The microfibre cloths must be appropriately laundered . Cloths that are not used appropriately in line with national cleaning guidelines, can be a reservoir for the virus and have potential to spread across the environment.<br>o Disposable cloths could be used as a safe system of work, but must be changed between activities, i.e. Mess room, Kitchen, Toilets, Hand wash sinks. The principle of cleaning from clean to dirty areas should be in place and |

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| | | top to bottom ( high to low) . Carpeted areas should be vacuumed daily , ensuring the appliance has a HEPA filter.<br><br>• With regards to ventilation in the EOC's and 111 centres, the national guidance is: "*Call centres are supplied with ventilation systems which encourage the flow of air around the rooms. These ventilation systems are often set to provide an 80/20 fresh to recirculate air as this increases efficiency in terms of power utilisation of the unit. It is recommended that during this time the ventilation units are set to provide 100% fresh air circulation therefore not recirculating 'used' air at this time – if this is possible. Advise can be sought from Estates/Engineer as to if this can be achieved".*<br><br>**Vehicles** – increased cleaning regimes in line with PHE guidance Compliance is 92% |
| 2. Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them? | Yes | IPCC/ monthly quality reports/ Board assurance reports. VP, A&E hand hygiene audits.<br>DATIX data- reporting to IPCC/QOG monthly.<br><br>LAS COVID-19 guidance patient facing staff- risk assessment;<br><br>• Identification of COVID-19 disease<br>• On Scene-Clinician Precautions/PPE<br><br>An agreed specification for the cleaning of Trust vehicles and premises is adhered to when employing sub-contractors for any cleaning related work. The Trust will offer advice and guidance in respect of infection preventions and control arrangements where appropriate and monitor that the LAS standards are complied with. All current products are detailed in the IPC Handbook (2017) and staff should comply with Control of Substances Hazardous to Health (COSHH) regulations in terms of chemical management. |
| 3. Are there systems in place to provide and maintain a clean and appropriate environment in vehicles, facilitating the prevention and control of infections? | Yes | Make ready service provided by Interserve aligned to LAS IPC/National Cleaning Specification/PHE IPC national guidance<br>• LAS COVID-19 guidance (Appendix 7)<br>Post conveyance decontamination. |

| | | |
|---|---|---|
| | | • Decontamination of vehicles undertaken. VP daily, 6 weekly deep cleans<br>• VP audits undertaken, reported electronically via my assure app. IPCC/ monthly quality reports/ Board assurance reports |
| 4. Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance? | ? Not best placed to answer this | The IUC antibiotic information is on the original submission – this is audited routinely<br>Paramedics only administer antibiotics for meningococcal disease<br>We have a microbiologist provide expert input into development of guidelines for IUC and advanced paramedics |
| 5. Does the trust provide suitable accurate information on infections, in a timely fashion, to service users and any person concerned with providing further support or nursing/ medical care? | Yes | • Hand over to acute services by ambulance clinicians and where necessary will not enter the hospital until an isolation room identified<br>• Increased management of less unwell patients with telephone assessment to support the patient being managed at home rather than conveying to the emergency department reducing the risk of spread of infection<br>111 assessments are recorded on adastra. The GP gets a PEM in real-time, which will include the reason for the call, pathways chosen, all NHS pathways chosen and CAS consultation notes and disposition. This goes into the patient records. |
| 6. Is there a system in place that ensures prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people? | Yes, EOC will alert crew? Potential COVID-19 –alerting staff to use appropriate PPE reduce transmission.<br>?appropriate assessment for | EOC will alert crew if infection likely so appropriate PPE is donned<br>Paramedic on scene risk assessment.<br>Risk assessment for this can be found in COVID-19 LAS guidance and general learning in their IPC workbook<br><br>**For staff:**<br><br>Clear PPE guidance which is updated in line with<br>Guidance on shielding and protecting themselves |

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| | | Risk assessments for vulnerable staff, BAME, and all staff risk assessment.<br><br>Owned by OH and Health and well-being hub undertaken by line managers<br>Wellbeing hub –<br>  |
| 7. Are there systems in place to ensure that all workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection? | Yes | COVID-19 Guidance for all patient facing staff<br><br>Risk assessment for all staff<br><br>Top tips for reducing the spread of COVID-19 in the work place<br><br>Contractors- Lakethorne + Interserve – aligned to LAS IPC guidance for PPE +Cleaning –SOPs in place. Daily Cleaning checklists in place;<br><br>An agreed specification for the cleaning of Trust vehicles and premises is adhered to when employing sub-contractors for any cleaning related work. The Trust will offer advice and guidance in respect of infection preventions and control arrangements where appropriate and monitor that the LAS standards are complied with. All current products are detailed in the IPC Handbook (2017) and staff should comply with Control of Substances Hazardous to Health (COSHH) regulations in terms of chemical management. |

| | | |
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| | | Infection Control Handbook (see above)<br><br>LAS Infection Prevention and Control Policy<br><br>Communication routes –RIB/Pulse/ media platforms / LAS Live / daily frontline briefings |
| 8. Is there secure or adequate isolation of patients who may be contagious? (Vehicle transportation) | Yes | HART team- provider of transport to High Consequence Infectious Diseases (HCID) confirmed or suspected cases.<br><br>Ambulance – door shut between cab and patient area to provide an isolation environment within the ambulance; all occupants wear a mask<br><br>Cleaning post-conveyance for any possible infectious patients as per PHE guidance |
| 9. Is there adequate access to laboratory support? (Appreciate this may not apply) | N/a<br>? OH laboratory support for staff | LAS do not swab/screen/test patients.<br>We have been supported by NHSE with regards to staff testing and swabbing |
| 11. Does the trust have a system to manage the occupational health needs of staff, regarding infection? | N/A for IPCT- OH will be best placed to answer | Workforce immunisation Policy<br><br>Guidance for managers- supporting staff returning to work from shielding (See above)<br><br>PHE guidance followed/implemented for track and trace and returning travellers |

# Infection Prevention and Control Assessment

# Engagement call

# Summary Record

**London Ambulance Service NHS Trust**

| Provider address | Date |
|---|---|
| 220 Waterloo Road<br><br>London<br>SE1 8SD | 14/08/2020 |

Dear London Ambulance Service NHS Trust

The Care Quality Commission is not routinely inspecting services during the pandemic period and recovery phase, although we will be carrying out some focused inspections. We are maintaining contact with providers through our usual engagement calls and by monitoring arrangements such as those for infection prevention and control.

This Summary Record outlines what we found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs.

We have found that the board is assured that the trust has effective infection prevention and control measures in place. The overall summary outlines key findings from our assessment, including any innovative practice or areas for improvement.

This assessment and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

# Infection Prevention and Control – Assessment areas

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|---|---|
| **1. *Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / isolation facilities?*** | |
| **Yes** | The Board had received/undertaken a clear and comprehensive assessment of Infection Prevention and Control across all services including an assessment of the estate and isolation facilities. |

| | |
|---|---|
| **2. *Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?*** | |
| **Yes** | There are systems in place in manage and monitor the prevention and control of infection. |

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|---|---|
| **3. *Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?*** | |
| **Yes** | There are systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections. |

| | |
|---|---|
| **4. *Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?*** | |
| **Yes** | There is appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. |

| | |
|---|---|
| **5. *Does the trust provide suitable accurate information on infections, in a timely fashion, to service users, their visitors and any person concerned with providing further support or nursing/ medical care?*** | |
| **Yes** | The trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion. |

| **6. *Is there a system in place that ensures prompt identification of people who have or are at risk of developing an infection, so that they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people?*** | |
|---|---|
| **Yes** | The trust has systems to identify promptly people who have an infection, or who are at risk of developing an infection so that they receive timely and appropriate treatment. |

| **7. *Are there systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection?*** | |
|---|---|
| **Yes** | There are systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process or preventing and controlling infection. |

| **8. *Are there secure or adequate isolation facilities?*** | |
|---|---|
| **Yes** | The trust has effective process in place to manage the isolation of patients appropriately. |

| ***9. Is there adequate access to laboratory support?*** | |
|---|---|
| **Yes** | There is adequate and responsive access to laboratory support. |

| **10. *Is there evidence that the trust has policies designed for the individual's care which will help prevent and control infections?*** | |
|---|---|
| **Yes** | The trust has effective policies designed for the individual's care which will help prevent and control infections. |

| **11. *Does the trust have a system to manage the occupational health needs of staff, regarding infection?*** | |
|---|---|
| **Yes** | The trust has a system to manage the occupational health needs of staff regarding infection. |

## Overall summary record

The Trust provided a copy of the Infection Prevention and Control (IPC) risk rated IPC board assurance and supporting information in advance of the assessment meeting. CQC reviewed this information along with Trust Board minutes and the annual report for 2019/20.
The assessment call and was attended by the following Trust representatives: Dr Fenella Wrigley, Dr Patricia Bain, Jeni Mubaze.
CQC representatives: Stella Franklin supported by Jane Brown.

An update was provided on the IPC assurance framework, including progress on the mitigating actions. The Trust Board had approved the IPC assurance framework in May 2020. Updates were provided to the Trust Board through various governance committees and Board meetings.
The Trust has undertaken a thorough assessment of all areas of the service in relation to IPC and put in place measures to address and manage risks. The Trust has an appropriate system to promptly identify people within the organisation who have or are at risk of developing an infection.
The Trust continues to provide information for carers and the wider public through their website and social media. Triaging processes have increased and calls triggering the likelihood of COVID-19 have an enhanced assessment, which may result in a link through to their GP. Community testing was set up and made available for clinicians.
The Trust continues to ensure the health needs of staff are met, and the occupational health team have been providing both welfare and mental health support to staff. This is a supportive and holistic approach, which considers both the physical and psychological needs of staff. Where necessary, staff have been enabled to continue to work whilst protecting their families through the provision of alternative accommodation. The Trust reported that risk assessments for BAME staff were at a completion rate of 96%. Risk assessments for all other vulnerable staff, the rate of completion was at 82%.
There have been sufficient staff to enable the service to respond to the pandemic, with external agency support and returning ex-colleagues, as well as internal movements. All staff, volunteers and external contractors, are given sufficient information to ensure they are aware of and discharge their responsibilities in preventing and controlling infection.
Staff have been provided with IPC training and continue to receive updates or additional training, in line with national guidelines. Training has included donning and doffing PPE, and front door risk assessments. Staff have had access to IPC policies and revised guidance and monitoring of staff compliance with expected IPC

standards has continued. However, there was acknowledgement that the Trust Board were not currently provided with the level of detail on this.
The Trust reported they had coped with the changing guidance related to PPE. They have ensured staff have been provided with appropriate PPE and that suitable fit testing has been undertaken. A task and finish group complete daily checks on PPE. A daily leadership team meeting is used to share information on failure and pass rates, which are then sent to the senior leadership team.
The Trust responded to the pandemic by reviewing its infrastructure and resources. Ambulance stations were re-configured to enable improved IPC equipment management through the Bronze logistics role. There was acknowledgement of three sites which are not fully compliant with shower arrangements, which is being dealt with. Vehicle and ambulance station cleaning regimes have been enhanced and there is an agreed process for decontamination of vehicles used by known COVID positive patients.
There are sector engagement managers at each trust as a point of contact and named people within each trust for direct contact. Ambulance personnel have been using the emergency care boards at each Trust, which has enabled them to keep up with the red green and blue IPC related systems within each trust.

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Quality Priorities report | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Jeni Deborah Mwebaze, Head of Quality & Assurance Systems | | | |
| **Presented by:** | Trisha Bain, Chief Operating Officer | | | |
| **History:** | Quality Oversight Group<br>8 September 2020 Quality Assurance Committee | | | |
| **Purpose:** | ☒ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

The Trust Identified and agreed a total of 18 quality priorities. These priorities are monitored by the Quality Governance & Assurance team to ensure they remain on track to achieve by the end of the financial year. The purpose of this paper is to update QOG on progress against the quality priorities as at end of July 2020.

There is good progress on 17 out of the 18 priorities. The only exception in the report is the quality priority relating to the roll out of tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients. The roll out started in March but due to COVID 19, MRU and CRU services were taken off the road and still remain off the road. There is no date set for these services resuming at the current time and as such the COO has requested that this is stepped down as a priority.

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

Trust Board is asked to note the exception presented in the report.

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | x | No | | Chief Quality Officer |
| 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 | | |

NHS
London Ambulance Service
NHS Trust

# London Ambulance Service – Quality Priorities Report August 2020 Update

Author – Jeni Mwebaze, Head of Quality Assurance Systems
Amy Pitcher, Quality Compliance Manager

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| **Safe** | *The administration of thrombolysis by APP – Critical Care for patients in cardiac arrest with pulmonary embolus* | ● | The administration of thrombolysis by APP will be reported on a monthly basis along with ROSC rate for drug from this month (July 2020), however outcome data will only be available on a quarterly basis. | **<u>June & July data</u>**<br><br>2x administrations of thrombolytic treatment<br><br>ROSC rate = 0<br><br>Both cases confirmed as massive pulmonary embolus at hospital |
| | *Pilot of non-medical prescribing for paramedics in conjunction with HEE.* | ● | Pilot of non-medical prescribing for paramedics has started, however due to Covid-19 there has been limited progression. Four staff members are currently enrolled on the training, which takes approx. 6 months to completed, once staff have passed, outcome will be monitored. The next intake for the course will be approx. September 2020. | COVID-19 has significantly disrupted progress of student non-medical prescribers. This has resulted in unplanned on-line delivery of teaching and assessments as well as a temporary reduction in the availability of clinical placements. Designated DMPs (supervisors) have needed to be changed due to staff redeployment to other non-clinical areas. All students in the current cohort have elected to continue with written assessments through this period. Revised dates for submission of NMP clinical portfolios have been agreed with the relevant Universities and all staff have now resumed placement activity.<br><br>Candidates have been selected for a second cohort of student NMPS and are in the process of applying to their nominated Universities. A Trust non-medical prescribing policy has been authored which will support the roll-out of prescribing for paramedics in the ambulance operational environment alongside a range of practitioners in a variety of other settings within the Trust. |

# Quality Priorities

Priority area on or ahead of target | Domain area on track
Priority area off target but no escalation | Domain area off target but no escalation
Priority area off target escalation required | Domain area escalation required

London Ambulance Service NHS Trust

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| Safe | *Implement the Patient Safety Incident Response Framework (PSIRF) and be a pioneer in the new process for other Ambulance Trusts.* | | Due to COVID19, the National Patient Safety Team put the PSIRF on hold which will last until potentially Autumn. There are a number of outstanding documents from NHSE that are required before we can move towards being approved as ready to implement. | The National Patient Safety team recommenced the PSRIF programme in July 2020 with an adjusted project plan and timescales. The new plan will sees early adopters switching from SIF to PSIRF between September and December. All required document templates have also been made available.<br>The LAS fortnightly task group ( currently consisting of Legal, PED, a QGAM and the quality improvement and learning team) has re-started work to complete the PSIRP and various other processes/documentation required from NHSE and aim to have them completed by September 2020 to meet the new national timescales. |
| | *Ongoing testing of Trust security measures to ensure continuous improvement Trust arrangements to secure vehicles stations and equipment.* | | The Security Mystery Shopper visits continue, with the current round of visits due to be completed by end of Q1. No data is currently available. | My Assure app has now started to be used in the Security Mystery Shopper visits to provide real time information. The Health, Safety & Security Department have struggled to complete the previous round of Mystery Shopping visits due to the pressures of Covid-19.<br><br>• 20 audits were completed in July<br>• 89.57% average Trust score<br>• 1 site non compliant<br>• 7 sites partially compliant<br>• 12 sites fully compliant (achieving >90%)<br><br>There are still issues around doors not being closed and vehicles not being locked on site.<br><br>A new round of visits will commence in August and be completed by the end of September. |
| | *Completion of the medicine management room project to ensure medicines are correctly stored.* | | 12 rooms have been constructed, 1 is due to finish by the end of June and the final 2 rooms will start construction in June. Out of the 12 constructed 1 is fully operational. The other rooms are waiting for IM&T to complete their work re: CCTV, iPads & Abloy keys. The previous 25 rooms will be required to have retrofitting to ensure they meet the say specification as the new rooms. | 14/15 rooms have been constructed. The final room will be complete by the end of August. 1/14 is fully operational - The other rooms are waiting for IM&T to complete their work re: CCTV, iPads & Abloy keys. This is in progress.<br>The previous 25 rooms from phase 1 will be required to have retrofitting to ensure they meet the same specification as the new rooms. Work is in progress to identify the scope of work required to achieve this. |

# Quality Priorities

Priority area on or ahead of target | Domain area on track
Priority area off target but no escalation | Domain area off target but no escalation
Priority area off target escalation required | Domain area escalation required

London Ambulance Service NHS Trust

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| Effective | *Continue with efforts to achieve the IUC service's staff rota to ensure comprehensive covers at all times.* | | A new data warehouse roll out became available at the end of November from which data will be able to be drawn. Action was put on hold due to Covid-19. | Staffing plan had been increased to accommodate an increase in demand on IUC services, with focused overtime opportunities ensuring comprehensive cover at peak periods. Both services returned performance levels above the 95% KPI for June and July for calls answered within 60 seconds and below the 5% abandonment rate KPI. |
| | *Assess the use of the IUC service's escalation plan triggers to ensure key factors are being considered.* | | CAS Escalation policy has been reviewed internally by LAS. Audit will be created this month (June) using My Assurance to review appropriateness of escalation. 5 days per month, per site - 2 hours per day. | Neither NEL nor SEL IUC CAS services has required escalation out of BAU during June or July. The CAS queue has remained well managed throughout and therefore audit of escalation triggers and actions is not applicable for this time period. Audit scores: N/A |
| | *Roll out tempus monitors for MRU and CRU to enable full assessments to take place when they attend patients* | | All Tempus Pro Monitors were rolled out across MRU and CRU on the 3rd March. Due to Covid-19 ALL MRU and CRU were removed from front line duties on the 21st of March. – the bikes have been stored and the monitors used to assist the Nightingale Critical Transfer System. Only having the monitors in use for under 3 weeks no impact evaluation has been carried out. | MRU and CRU services are still off the road. There is no date set for these services resuming at the current time. |

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| Caring | *Invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.* | | The single point of access wellbeing hub has been created and will be going live at the end of June. The hub will be able to signpost to the most appropriate services and give advice to staff. The opportunities to be part of the hub will be open to all staff. | The Hub is now fully operational via phone and email. Analysis of the first month of contacts will take place in August to identify any gaps and trends. |
| | *Reduction in Violence & Aggression* | | V&A standards have not yet been published by NHSE/I. A gap analysis has been completed based on the draft standards and an action plan will be created based on this information. Once the standards have been released, we will review our gap analysis & action plan accordingly. | NHSE/I still has not yet finalised the Violence Reduction Standards. An initial gap analysis of the current draft Standards indicates that an overall rag rating of each section:<br><br>Plan - Red;<br>Do - Red;<br>Check - Amber;<br>Act - Amber.<br><br>A Violence Reduction Standards Group is being formed to monitor and review workstreams to enable compliance with the Standards. The first piece of work has been the production of a Violence Reduction Policy which has been presented to the Corporate Health, Safety & Wellbeing Committee for final comment. |
| | *Develop the stress policy in relation to wellbeing of staff. Ensure this is implemented effectively.* | | A new Well-Being Strategy Group has been set up in June 2020, and an interim Head of Well-Being has been appointed to lead on the Health & Well-Being Strategy. Stress and Mental Health training is being mandated for all staff and is a target on the delivery plan to the strategy. A significant amount of work is taking place to support staff more widely on well-being, and the direction of travel update on the position of the stress policy has been tabled for discussion at the next Well-Being Strategy Group to be held on 16/06/20. | The implementation of the Stress Management Policy development has been discussed at both the Wellbeing Steering Group (29/07/20) and the Corporate Health, Safety & Wellbeing Committee (30/07/20) and has been updated. It has been sent for comment to Trust Union H&S colleagues prior to approval. Comments should be returned to H&S by 31/08/20. |

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| Responsive | *Undertake a deep dive review into delays (2x90th centile) to patients due to recent high demand and COVID19* | 🟡 | The QI&L team are reviewing the long delay SIs declared in 2019/20 to identify key themes and learning. This will feed into the COVID19 review which is also looking at long delays. This review will identify learning and actions for implementation to support surges in demand in the future. | The long delays (2x90th Centile) SIs review has been completed which was presented including key learning at QOG in June 2020. The COVID19 review has also been completed and all 248 cases undergoing an Structured Judgment Review. The methodology and the initial findings were also presented at QOG in June 2020. The review has seen three formal SIs being declared. A SMART action plan is being developed (finalising in the next 2 weeks) on the key findings to be implemented within the next 3 months which will be monitored through SIALG. |
| | *Integrating the 999 and 111/IUC CAS systems to provide seamless care for patients regardless of access point* | 🟢 | The integration work was somewhat stalled by COVID. However a number of steps have been taken in the right direction with regard to integration because of COVID. Over winter, the service started a piece of work transferring some Cat5 calls into the CAS downstream providers. This stalled, but, during COVID, this was in fact expanded out into a wider range of calls in an attempt (and successfully so) to increase capacity within the 9s. This is now continuing, to a lesser extent, but is available for peaks in demand and forms part of the sustainability plan.<br><br>During COVID the service utilised some additional staff who were passed very specific cohorts of patients, to be triaged through an NHS Pathways option, and not through MPDS. This saw low priority patients, calling with COVID symptoms to be triaged using a different triage platform, and with access to downstream providers for referral. Again, this was the first time a 999 call had been triaged through NHSP – whilst not in full NHSP, it's certainly a step in terms of integration.<br><br>The service is working on a number of technology and estates programmes at the moment. Whilst some of this relates to ability to sustain current performance and outputs; elements of it will also enable better integration moving forward. | The service has continued to build on the integration pathways which were implemented to support the Trust's response to the COVID pandemic and the ability to flex workforce across 111/999 based on demand is a key action for future service sustainability.<br><br>Integrating 111/999CAS systems has been identified as a London requirement as part of the wider system U&EC Restoration Board and Think NHS 111 First programme (London-wide system response to COVID. LAS has committed to 3 key priorities as part of this programme: optimise 111CAS outcomes, increase 999 Hear & Treat rate and optimize See, Treat & Refer outcomes.<br><br>The Trust has most recently engaged in multi-provider discussions with NWL ICS to design and deliver an enhanced IUC model in Q2 20/21 which will provide the foundation for future 111/999CAS integration.<br><br>The Trust has also submitted an Expression of Interest to participate in a national C3/C4 clinical validation pilot from 17/08/2020, which will identify learning to support 999 referrals to local 111CAS providers for clinical assessment. |

| | Quality Priorities from Quality Account | | June Update | August Update |
|---|---|---|---|---|
| **Responsive** | *Clinical development of ePCR and a new CAD system to capture clinical care of patients.* |  | **CAD** - technical workshops have begun with Cleric and significant progress made on defining the HLD, ahead of server purchase. A 'show and tell' test system will be available in late June to enable system functionality review to commence.<br><br>**ePCR** - server builds are complete, with configuration change workshops scheduled to sign off functional build during June. ePCR is on track for formal SAT and SIT testing in July and pre-live testing in mid-Aug. Decision to revert to ePCR training via CSR significantly simplifies the rollout targeted for Sep – Nov 20. | **CAD** – The project remains on track for delivery May 2021. Cleric have provided the TEST database which has been applied to the LAS TEST system. System configurations will be completed w/c 03/08 prior to scheduling a number of 'show and tell' sessions.<br><br>The technical builds (live systems) are well underway at ARK Datacentres, work is due for completion end of August, Cleric will then review the system builds. Site visits to EEAST and SECAMB are now scheduled. 8 x Working groups have been setup and will be working through Cleric configuration. Cleric have commenced system interface development activities.<br><br>Draft test strategy has been completed and is ready for review. Planning for staff training remains an on-going activity<br><br>**ePCR** - SAT, SIT and UAT testing are all going well with only a few minor issues being identified.<br><br>Reporting and BI workstreams continue to review system test data to support pre-live testing. Hospital engagement has been going well.<br><br>We have a go/no go board planned for 13th Aug which will give us the mandate to start pre-live entry of live patient data by 150 staff. Full live is still on track for the end of Sept 20. |

| | Quality Priorities from Quality Account | | June Update | August 2020 |
|---|---|---|---|---|
| **Well led** | *Develop Quality Improvement Hubs for sharing best practice through a formalised operations & management structure* |  | A Trust wide approach to Quality Improvements hubs was being developed prior to COVID19 which was aligned with the staff innovation work being undertaken by the strategy team. The QI hubs were also linked into the PSIRF work and included in the Trust's PSIRF model. The Head of QI&L is a member of the education and learning group providing a link between this group and SIALG. The QI hubs will collaborate on clinical education needs identified through these routes for consideration on future operational education programmes. | The work on the QI hubs has restarted following COVID19 which continues to aim for QI hubs to be in place by the end of the financial year. There has been collaboration with other ambulance Trusts through the wider Ambulance Q network (which is attended by all ambulance Trusts) to share ideas and JDs for roles where similar models have been successfully launched. The next step is to pilot the QI hub in one sector alongside a sector quality hub. |
| | *A continuous focus on improving the Staff Survey results particularly around B&H culture.* |  | Head of Staff Engagement started in June 2020 who will be leading on the staff survey. Currently in the process of setting up a sentiment analysis with Picker, where an action plan will be derived from. New survey planned for Autumn '20. | An action plan was initially started earlier this year, however this was put on hold due to COVID19. We have received the sentiment analysis from Picker and are reviewing the detailed analysis. Some issues that were highlighted in the staff survey from 19/20 have been addressed inadvertently throughout the COVID19 period. For example: improving communications, improving health and wellbeing of staff, However given the short timeframe between now and the 20/21 staff survey in September/October, we are limited in formalising an action plan based on the 19/20 data. We are therefore focusing as a team to prepare and plan for the next staff survey, including preparations for the next action plan. A staff survey working group is in the process of being set up which will help ensure improvements are made following the next survey. |

| | Quality Priorities from Quality Account | | June Update | August 2020 |
|---|---|---|---|---|
| **Well led** | *Explore and develop the paramedics in Primary Care Network (PCN) proposal to provide a broader training opportunity for paramedics.* |  | The project was paused due to Covid19 in March, however work has restarted in the last couple of weeks. The working group will be working with Merton Health to trial paramedics in the PCN for 6 months (6 FTE). Working group meetings continue to progress the trial. | The Merton Trial has been agreed at Programme Management Board (4th August). Work will now progress to finalise and confirm implementation details. There is no formal implementation date, however we are aiming to start early September. We continue to attend the pan-London Workforce Delivery Group (WDG) and the next stage will be consideration of, and a business case for pan-London delivery. |
| | *Ensuring that the Trust adopts and maintains the optimal health and wellbeing strategies and culture for both existing LAS staff and the expanded workforce during and after the COVID-19 pandemic.* |  | There is a well-being strategy that has been drafted. The delivery plan will be monitored by newly formed wellbeing steering group. Full programme of resilience work is to start by the end of June to provide a “check in” with all staff post first covid peak. A Sheilder’s group was created and who meets virtually on a regular basis. The swabbing line and antibody testing is now live. | The staff testing team is still active, and by the end of July 2020 more than 6000 antibody tests had taken place. The shielding mess room is still active and there is also a virtual canteen once a week that is aimed at staff working from home. There is now focus on how the Trust can deliver overdue immunisations and get a high uptake of flu vaccinations. We have expanded our Covid staff risk assessments from BAME staff to all staff. We have also identified a well being lead for the estates strategy. |

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Serious Incidents (SIs) and SI Thematic Reviews | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Helen Woolford, Head of Quality Improvement and Learning<br>April Wrangles, Senior Quality Governance Manager | | | |
| **Presented by:** | Dr Trisha Bain, Chief Quality Officer | | | |
| **History:** | Update on SIs closed by CCG and quarterly thematic report | | | |
| **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 and includes:

- There were 4 Serious Incident Investigations in June and 9 in May 2020 all of which were closed by the Clinical Commissioning Group
- 27 Serious Incident Investigations were declared in Q1 of 20/21. Of those declared, 13 were declared Level 2 comprehensive investigations and 14 were declared Level 1's concise investigations.
- The CCG closed 12 SI reports in Q1. In this quarter, there had been an increased number of call handling errors and an increased number of SIs declared where patients were not conveyed to hospital. This is largely expected considering the demand that was placed upon the call handlers, the increase in call volume, and the desire to reduce the pressure in hospitals during the height of the COVID-19 pandemic.
- The 999 COVID19 has been completed and the draft report outlines the methodology, reviews and actions identified as a result.
- The COVID19 review has identified a number of themes including care/nursing homes not always accesses the ambulance service appropriately and the need to review welfare ring backs at times of high demand. An action plan has been developed which will address this issues and be monitored through the Safety Investigations Assurance and Learning Group (SIALG).

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

The Trust Board is asked to note the information provided within the report, and provide feedback to the Head of Quality Improvement and Learning.

| Routing of Paper – Impacts of recommendation considered and reviewed by: | | | | | |
|---|---|---|---|---|---|
| **Directorate** | **Agreed** | | | | **Relevant reviewer [name]** |
| Quality | Yes | x | No | | Chief Quality Officer |
| 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 | | |

# Serious Incident (SI) Thematic Report
## Quarter 1 – 2020/21

## 1. Introduction and Background

1.1. This paper provides an overview of the Serious Incidents (SI's) reported and declared to the Clinical Commissioning Groups (CCGs) as well as a thematic review of those SI's which were closed by the CCGs in Quarter 1 (Q1) of 2020/21. This thematic review specifically focuses on SI's by category and key contributory factors.

## 2. Context

2.1 During Q1, a total of 1,422 patient safety incidents were reported on the Trust's Risk Management system, Datix. Of these, 27 incidents (1.9%) were declared as SI's following review at the Serious Incident Group (SIG). Of those declared, 13 were declared Level 2 comprehensive investigations and 14 were declared Level 1's concise investigations.

2.2 Due to the COVID-19 pandemic, the 60 day timeframe for submitting an SI report to the CCGs was suspended. Proactively, and as part of the Business Continuity Plan for COVID-19, the Trust set a target timeframe of 85 working days to ensure investigations were still progressed. The Trust resumed to the 60 working days from the 20th May although nationally timeframes are currently suspended. Compliance against these respective timeframes in Q1 was 100%.

2.3 Also during Q1, the CCGs approved and closed 12 SI reports.

## 3. Serious Incidents Declared in Q1

3.1. This section considers the SI's declared in Q1, 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 Q1**

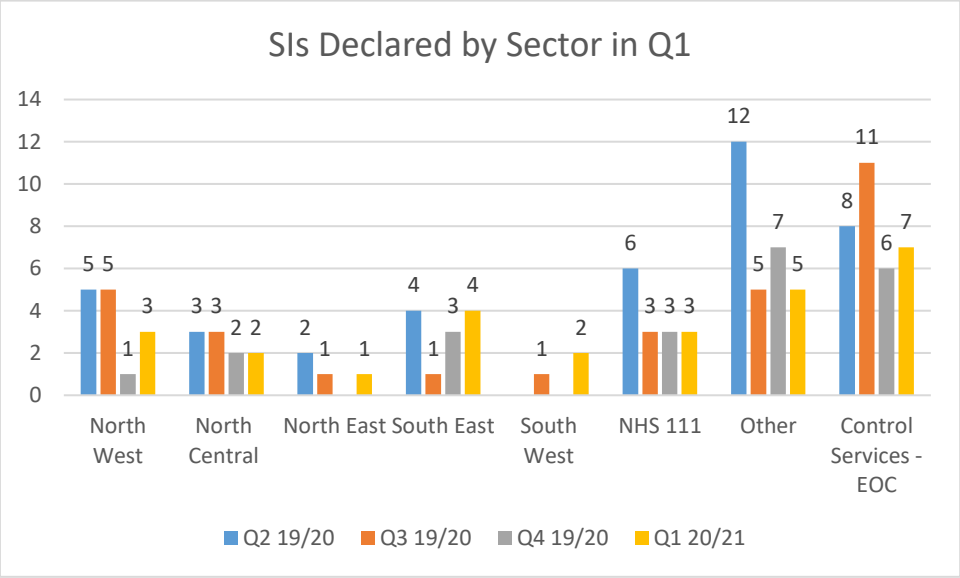



Figure 1

| | Q2 | Q3 | Q4 | Q1 |
|---|---|---|---|---|
| Trust Total | 40 | 30 | 22 | 27 |

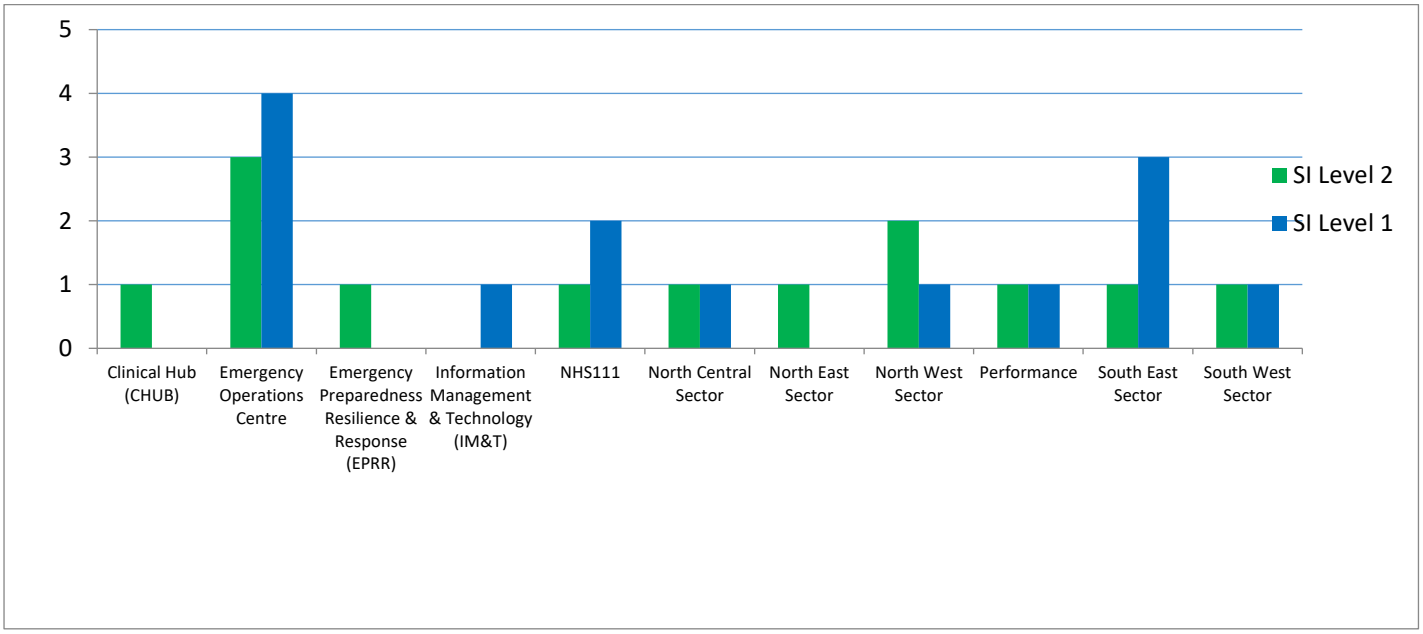
3.2. Graph 1: The overall number of SIs declared in Q1 of 20/21 was 27.

3.3. There has been an increase in the number of SIs declared in Q1 across Sectors (North West, South East, South West and EOC).

3.4. There has been a slight decrease in the number of SIs reported under "Other" when compared to Q4. "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) and Emergency Preparedness Resilience & Response (EPRR) 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.

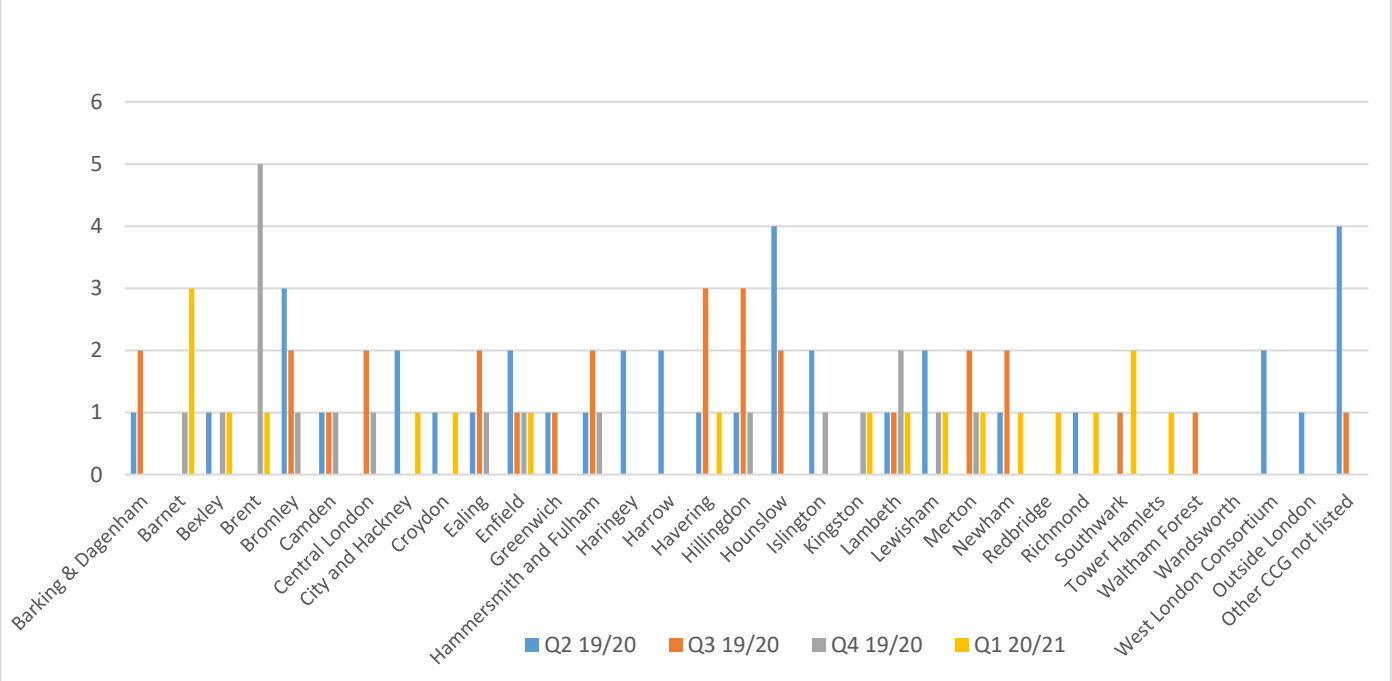
3.5. These categories and numbers are monitored by the central team and the Safety Investigation Assurance and Learning Group (SIALG).

**Graph 2. SI's Declared by Department/Area in Q1 – Levels 1 and 2 breakdown**

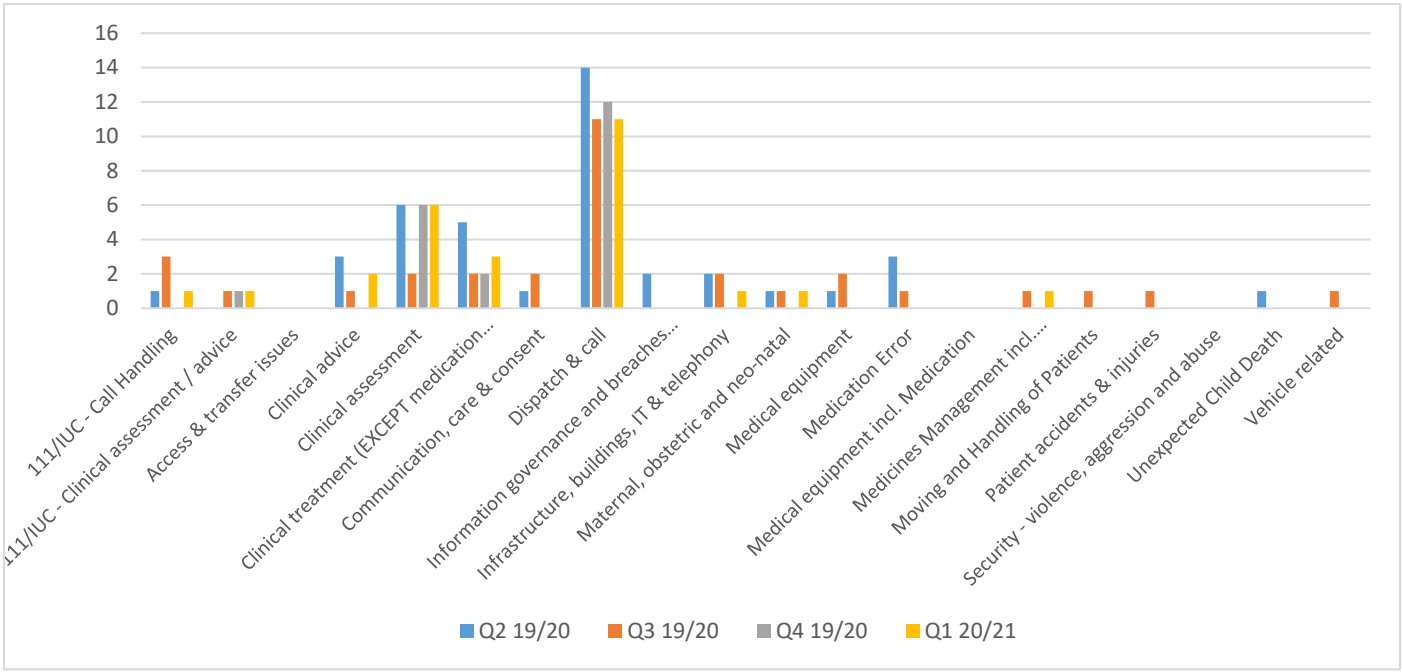



3.6. Graph 2 shows the breakdown of both Level 1 and Level 2 investigations declared in Q1 with the expansion of the "other" category from graph 1.

**Graph 3. SI's Declared by CCG distribution**

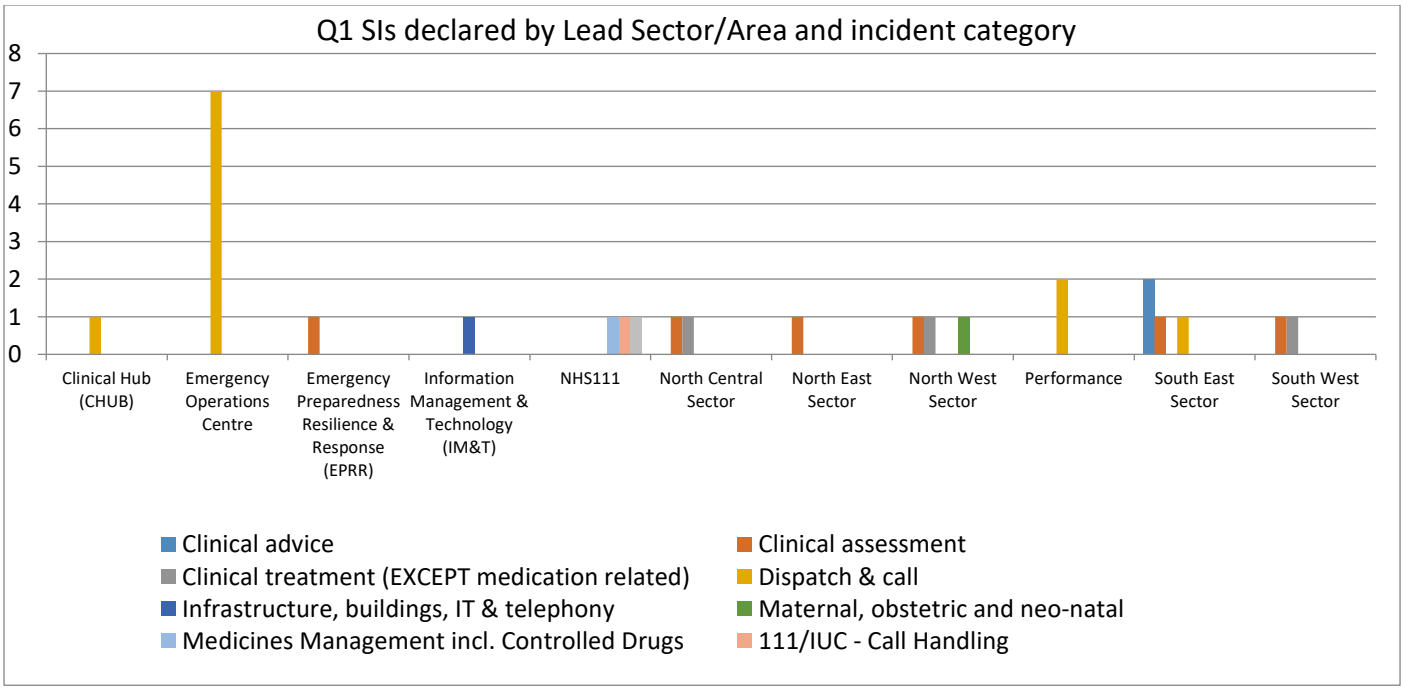


**Graph 4. SI Categories**




3.7. 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 Q1 – Category Breakdown**



3.7 Types of the SIs declared in each Department/Area for Q1

There were 3 SIs declared in the ***North West*** in Q1:

- Maternity: 25 weeks pregnant patient conveyed under emergency conditions to the nearest hospital; advising of a still birth with no active resuscitation in progress.
- Quality Alert received from the hospital who identified that the patient was floppy, with agonal breathing and had not been administered oxygen by the crew.
- A 9 year old was not conveyed after experiencing a fainting episode. 4 weeks later the patient suffered a cardiac arrest and was successfully resuscitated.

There were 2 SIs declared in the ***North Central*** in Q1:

- A patient had reportedly been tasered whilst on the wall and had fallen approximately 5 foot. The patient's C-spine was palpated prior to attempting to get the patient to stand. The patient was loaded onto a scoop stretcher and conveyed under emergency conditions to a Major Trauma Centre where they were identified as having life changing spinal injuries.
- A patient was conveyed to an ED STEMI under normal road conditions.

There were 4 SIs declared in the ***South East*** in Q1:

- 3 incidents involved calls where patients were assessed and left at home. The patients were then conveyed to hospital after further assessment.
- Airway management during a cardiac arrest.

There were 2 SIs declared in the ***South West*** in Q1:

- A patient with lower back pain and breathing problems was assessed and not conveyed. A further call was received reporting that the chest pain was back. The patient was then conveyed under emergency conditions to the nearest ED where it is reported that the patient died the same day.
- A patient having breathing problems and a heart attack was found to be in cardiac arrest with no CPR in progress.

There was 1 SI declared in the ***North East*** in Q1:

- An ambulance attended and did not convey a patient who was presenting with a mental health crisis. A second call was received reporting that the same patient had fallen from the third floor. A pre alert call was placed to a Major Trauma Centre (MTC). Whilst travelling to the hospital the patient deteriorated into cardiac arrest and was reported to have died at the hospital.

There were 2 SIs declared regarding ***Performance*** in Q1:

- These 2 incidents involved delayed response, with the Trust breaching its target response time for a Category 2 and 3 priority calls.

There were 3 Serious Incidents declared in the ***111/IUC*** in Q1:

- A data error entry meant that the patient was incorrectly placed as a P3 as oppose to a P2. The patient was conveyed under emergency conditions to ED.
- A clinical assessment was undertaken for a patient with the outcome of home management advice being obtained. The audit of the call identified that home management advice was not appropriate as the patient was immunosuppressed.
- An agency Advanced Clinical Practitioner (ACP) member of staff (registered pharmacist by background had allegedly been accused of carrying out private business transactions.

There were 7 Serious Incidents declared in the ***Control Services - EOC*** in Q1:

- The 7 incidents involved:
  - 'missed' NoC trigger phrase for ineffective breathing
  - Incompleted NoC assessment prior to transferring the call to the Covid Call Centre

There were 3 Serious Incidents declared in the '***Other Category'*** in Q1

- A call was received electronically from CARE UK reporting that a patient had a fever and a cough. The call was assessed by the CHUB and home management advice was provided. 29 hours later a second 999 call was received into the EOC reporting that the patient was in cardiac arrest.
- A Mutual Aid vehicle attended and did not convey a female with abdominal pain. 23 hours later a second call was received reporting that the patient was deceased and beyond help.
- A 111 national failure of telephony: Engineers fixing the issues with the CHUB and EBS Avaya system, inadvertently switched an unmanned CM7 telephone line on.

Identified Themes in Q1:

3.8. Q1 has seen an increased number of call handling errors and an increased number of SIs declared where patients have been not conveyed to hospital.

This is largely expected considering the demand that was placed upon the call handlers, the increase in call volume, and the desire to reduce the pressure in hospitals during the height of the COVID-19 pandemic.

COVID-19 Review

3.9. In addition to the 27 declared SIs, the Trust identified 246 patient safety incidents which, outside of the circumstances of the pandemic, may have triggered an SI investigation due to either the delayed response time or the delay in answering the 999 call. These incidents occurred between the 9th March and the 5th April and were identified through either incidents reported for the purpose of contact tracing or from applying a set of filters to data which was obtained from Business Intelligence.

3.10. These 246 incidents formed the COVID-19 Review and were all the subject of a Structured Judgement Review (SJR) which was developed by the QI&L team to identify whether probably harm was caused by the delayed attendance/delayed 999 call answering. The SJR also identified if there were any other factors involved in the incident which may require further investigation in the form of a second review or an SI investigation.

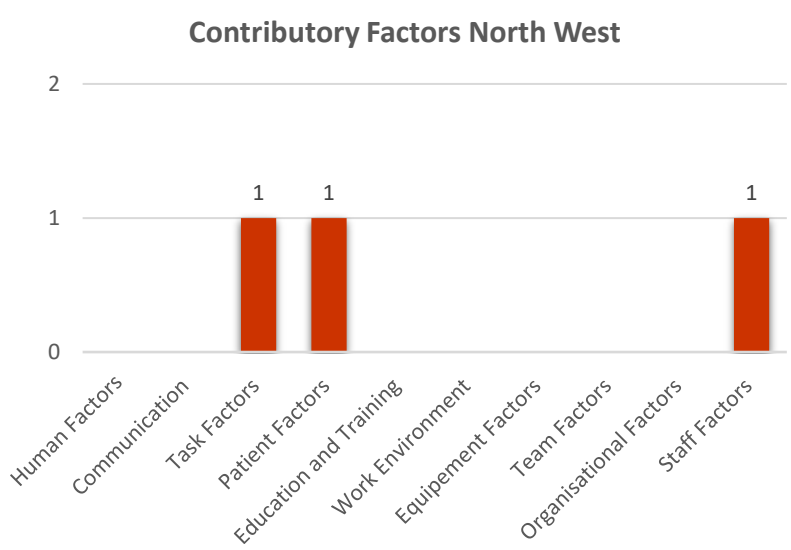
3.11. Of the 246 incidents, 22 were the subject of a second review and 3 were declared as SIs.

3.12. The QI&L are currently in the final stages of completing the report and ensuring that recommendations are shared with all appropriate teams so that actions can be implemented prior to a potential second ‘peak’.

# 4. Thematic Review of closed SI's in Q1.

4.1. The following provides information on the outcome and contributory factors identified in completed investigations

## North West



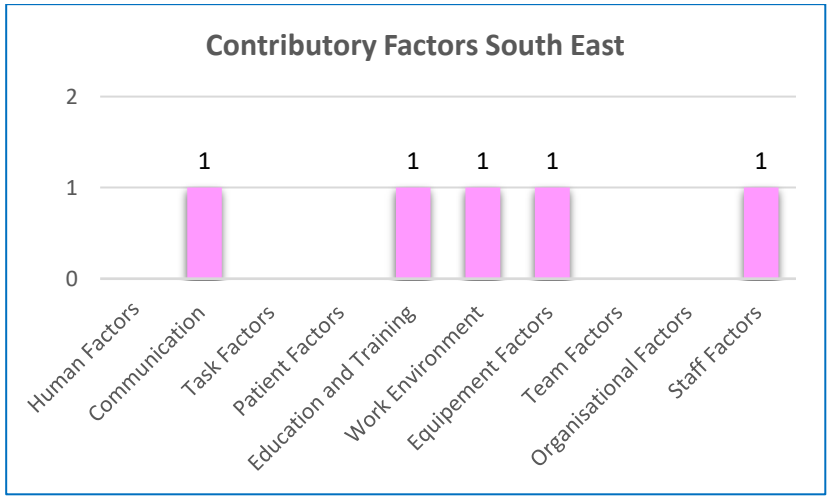

There was 1 Serious Incident closed by the CCG for the North West sector during Q1. Key contributory factors identified from the SI report included:

Task: The documentation on the Patient Report Form (PRF) did not fully reflect the assessment and discussion had with the patient.
Patient: The patient declined a 12 lead ECG due to her improving condition in the presence of her family. This was accepted in line with the crews working diagnosis of a hypoglycemic episode.
Staff: The patient made a conscious and informed decision to decline conveyance to hospital.

***Key learning and actions taken across the SIs in relation to these contributory factors included:***

- The LAS have continued to run "Perfect PRF" workshops in order maintain a high standard of documentations.
- A Trust wide guidance issued regarding accuracy of PRF's
- The SI report shared with the staff involved.

## South East



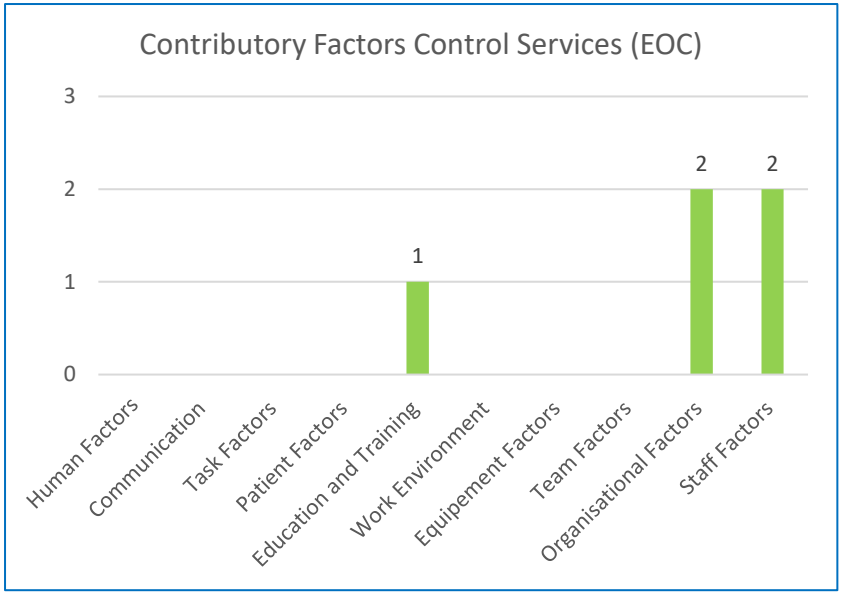

There was 1 Serious Incident closed by the CCG for the South East sector during Q1. Key contributory factors identified from the SI report included:

Communication: The crew did not accurately record the information they provided to the patient in order to make an informed decision on conveyance.
Education: Lack of knowledge and understanding: in relation to the "special risks" outlined in the "known hypoglycaemic referral flowchart".
Environment: A conflicting relationship between the wife and patient led to a loud and disruptive scene. This external factor could have contributed to a disjointed thought process for the clinicians.
Environment: Patient referral tool V2" does not specifically refer the user to the "known hypoglycaemic referral flowchart".
Staff: The mentor made an assumption that the referral would not be accepted based on a previous experience

***Key learning and actions taken across the SIs in relation to these contributory factors included:***

- The Education and Development Team will consider the topic of Hypoglycaemia on future mandatory training.
- The Know Diabetic Hypoglycaemic Referral Flowchart to be reviewed and made available to all staff.

## Control Services (EOC)




There were 2 Serious Incidents closed by the CCG for Control Services in Q1. Key contributory factors identified from the SI reports included:

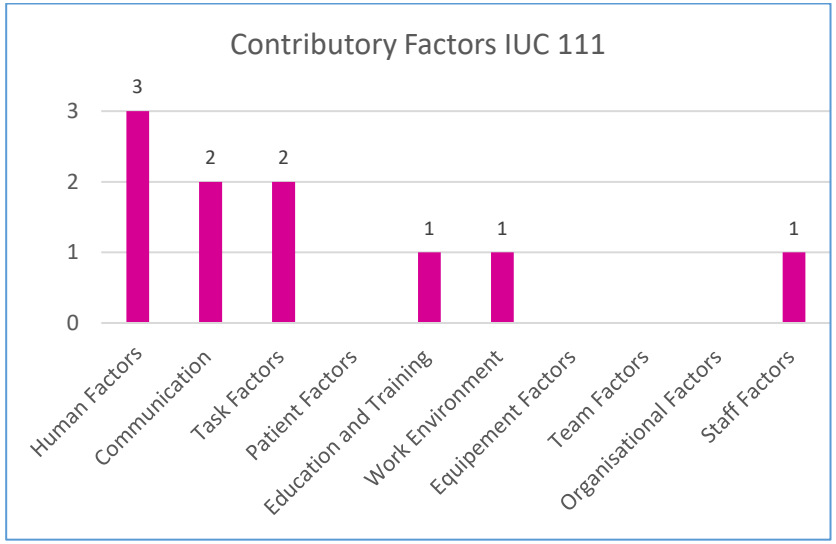
Organisational: The effect of shift change over contributed to the lack of oversight by the Clinical Hub. The current MPDS triage system does not give high priority to community alarm calls and makes no allowance for losing voice contact with a patient.

Staff: ERD did not contact the MPS immediately as per procedure based on an assumption that a DCA should be dispatched first. ECH did not provide any Post-Dispatch Information (PDI's) as in their view that as the caller was on a care line, not with the patient, hence providing the PDI's were not appropriate or relevant.

***Key learning and actions taken across the SIs in relation to these contributory factors included:***

- Request 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.
- Call taking staff fully made aware of updated guidelines within OP60 regarding the management of 3rd and 4th party calls.
- There is a plan in place for the Trust to undertake a review of the current position with regards to shift change over in the Clinical Hub.

## NHS 111/IUC Services




There were 3 Serious Incidents closed by the CCG for 111/IUC in Q1. Key contributory factors identified from the SI report included:

Human: The Health Advisor (HA) was given conflicting answers to the same clinical question which then resulted in selecting a negative answer. GP's approach to telephone triage was to focus solely on the declared concern of the caller and did not involve a full systems review of patients.

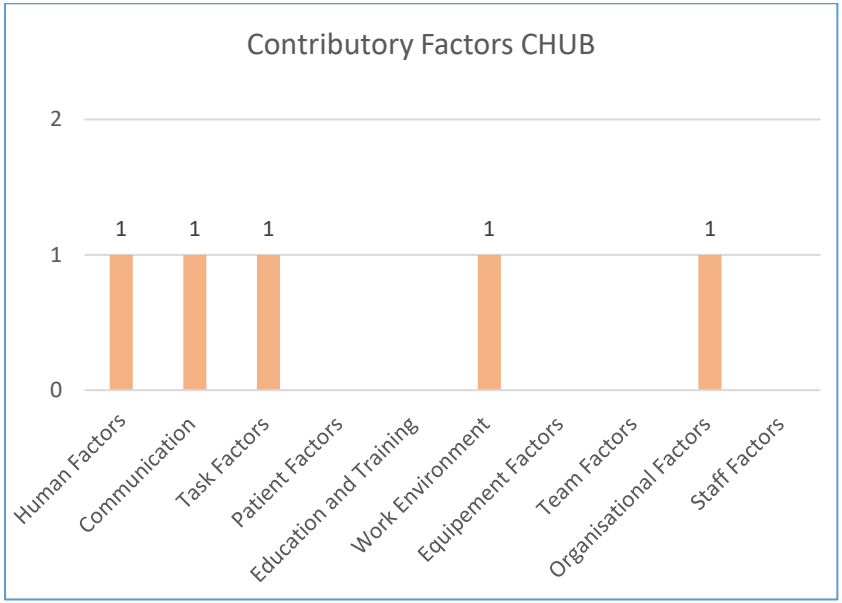
Communication: The amount of time HA spent unsuccessfully in attempting to understand the history and events leading up to the first call meant that HA was reluctant to probe into the situation surrounding the patient's second contact to the service.

Task: GP did not follow Clinical Assessment Template nor the NICE guidelines in relation to the treatment of fever. No clear guidance on what action to take if a reassessment results in a lower disposition than the original one reached.

***Key learning and actions taken across the SIs in relation to these contributory factors included***

- HA met with the CTM for review of the report and complete a reflective exercise including, seeking clinical advice when uncertain of significance of symptoms or conflicting responses
- Review the advanced practitioner audit tool to ensure there is an appropriate place to capture if the Clinician Assessment Template was used.
- Revise the Procedure for the Management of Calls SOP to provide clear guidance for staff in the event of a re-triage triage resulting in a lower acuity outcome than previous assessments.

## CHUB



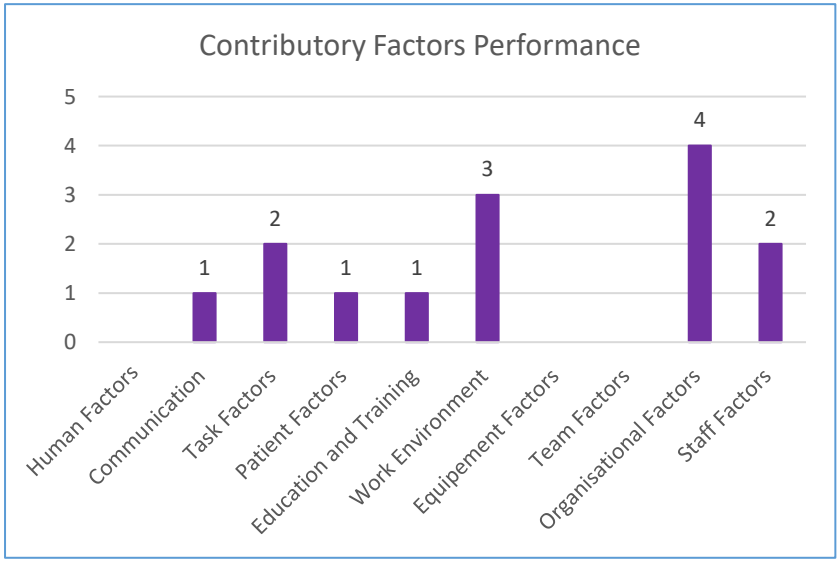

There was 1 Serious Incident closed by the CCG for CHUB in Q1: Key contributory factors identified from the SI report included:

Human: Clinical practitioners missed or not acting upon vital information due multi-tasking and experiencing difficulties with communication during stressful situation.
Communication: Clinical practitioners found patient's son to be difficult to communicate with and obtaining pertinent information was a challenge.
Organisational: 4th party callers - Careline providers are regular callers into EOC and are therefore familiar with the information is required by an ambulance service. ECH did not question the accuracy of the information passed during the call and so did not ring the patient directly to confirm his details.
Environment: The EOC control room was extremely busy with incoming and held emergency calls. The staffing levels were slightly reduced in the Clinical Hub on this day, resulting in a large workload for all staff.
Task: Clinical practitioners had to enter or correct data due to missing important demographics of the patient.

***Key learning and actions taken across the SIs in relation to these contributory factors included:***

- The Trust had reviewed the electronic referral pathway between Clinical Hub and IUC.
- Investigation findings shared to appropriate persons.

## Performance




There were 4 serious incidents closed by the CCG for Performance in Q1. Key contributory factors identified from the SI reports included:

Environment: The number of DCAs required to attend Category 2 calls outweighed the Trusts capacity to provide the resources.
Organisational: Long handover wait times at EDs: Ongoing significant waits to handover patients from ambulance to EDs. Waiting at EDs for extended periods of time meant that the number of crews on the road was impacted severely.
Task: There was no guidance which advises Emergency Resource Dispatchers (ERDs) how to manage a call where the patient has left scene and represented to the LAS via a different route. Current Trust guidance does not include DX0112 when considering dispatching an FRU to an uncovered Category 2 call of set determinants.
Staff: delayed in getting to the patient due to statutory vehicle checks.

***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.

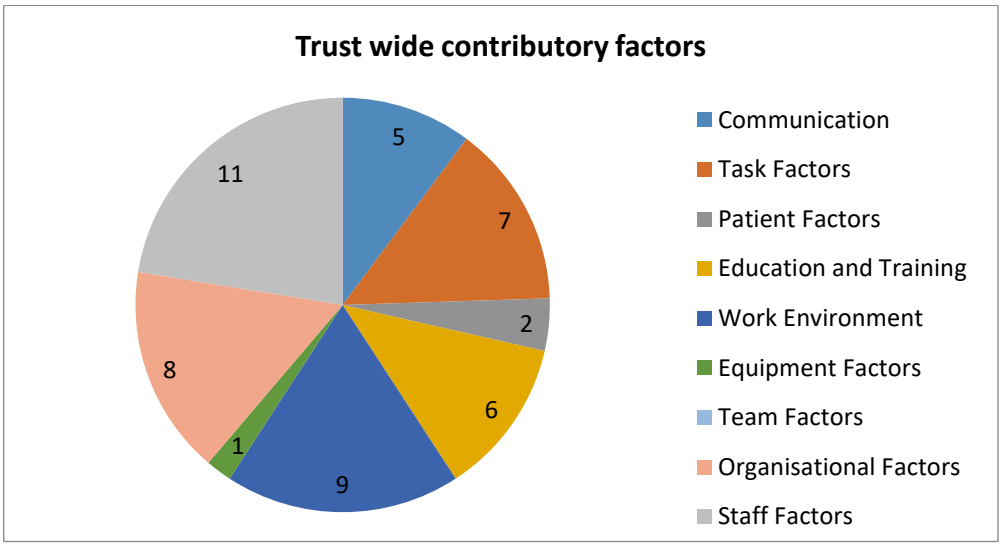
## Contributory Factors – Zero Serious incident report closed by the CCG

There were 0 Serious Incident closed by the CCG in Q1 for the following sectors;

- North Central Sector
- North East Sector
- South West Sector

4.2. Trust wide contributory factor themes

**Graph 6. Trust-wide Contributory Factors**




4.3. There were 12 SIs closed by the CCG in Q1, which is a reduction of 36 compared to the 48 SIs that were closed in Q4. The CCG closed an extremely high number of SIs in Q4 which is believed to be due to COVID-19.

4.4. Staff factors (psychological and cognitive) continue to be the highest occurring contributory factor accounting for 22% of factors in Q1 compared to 16% in Q4. The number of staff factors has continued to increase as the SI lead investigators and the Trust continue to gain a better understanding of the impact that human factors can have during an incident.

4.5. Work environment factors accounted for 18% of the contributory factors in Q1 with the reports identifying shift related fatigue, a high workload and too many tasks to perform at once. This is an increase of 1% compared to Q4 and will account for the challenges faced during the management of the pandemic.

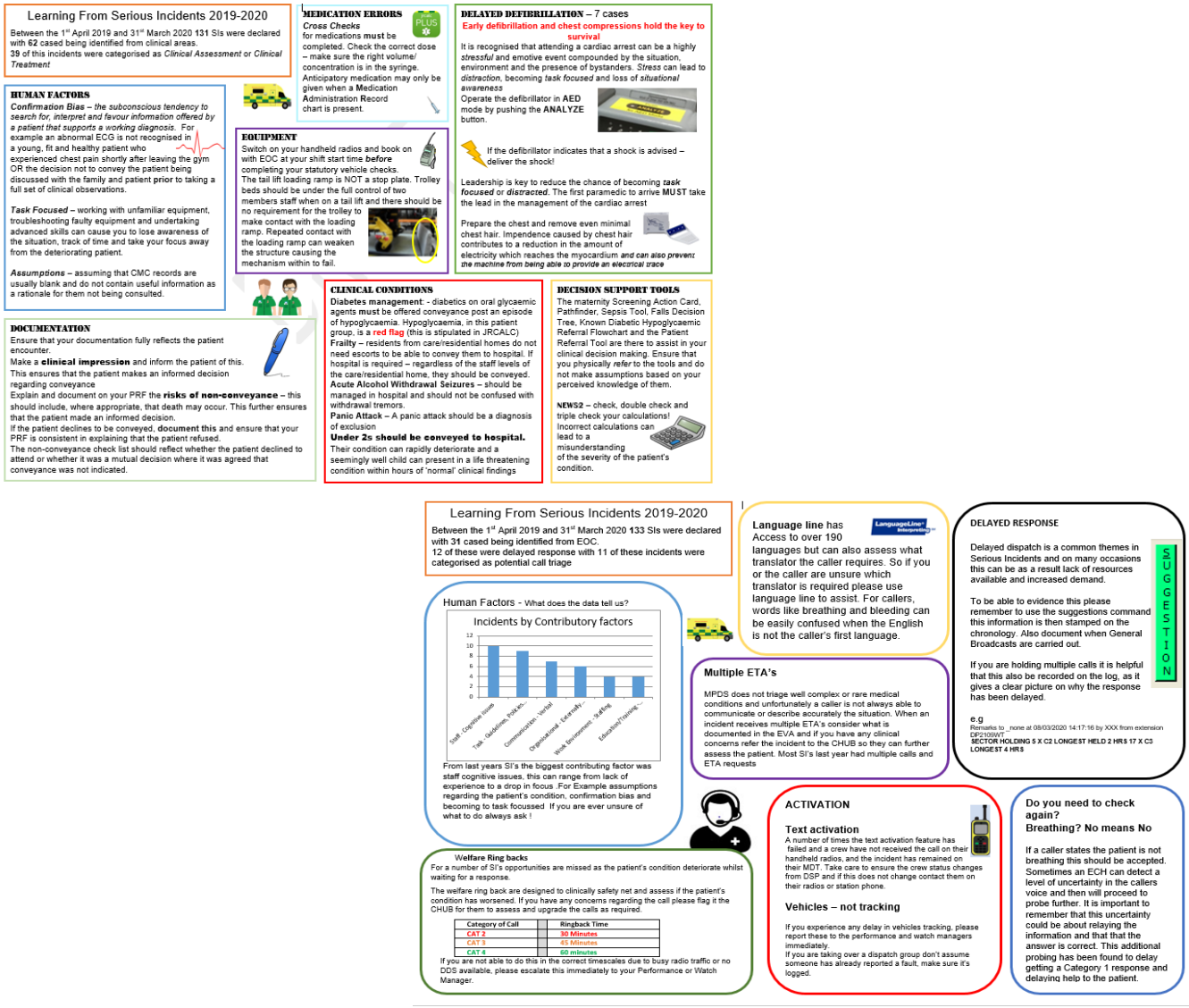
4.6. The use of organisational factors has increased from 12% in Q4 to 16% in Q1 due to the consideration of the impact of delayed handovers at emergency department and LAS resource availability.

# 5. Organisational Learning.

5.1 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.

5.2 The Trust also ensures that those involved in SIs 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.

5.3 Sharing the learning from incidents has been challenging during Q1 due to actions associated with the Trust being at REAP 4. Additionally the Trusts response to COVID-19 was fast paced and evolving daily and required an extensive amount of information relayed to front line staff. The QI&L team therefore have collated the key learning themes from SIs and developed them into a one page summary document for EOC and Operational staff depicting key learning messages.



5.4 The next SI case review evening is scheduled for August 2020. Additionally in August, the first 'SI briefing' will be held which is initially targeted at Clinical Team Managers (CTM) to provide them with a monthly overview of the Trusts position with regards to SI investigations and it also will be a mode for sharing learning messages. Once this is an established process, other management groups will be invited to attend.

## 6. Conclusion

6.1. 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 Safety Investigation 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**

London Ambulance Service NHS Trust

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|---|---|---|---|---|
| **Report to:** | **Trust Board** | | | |
| **Date of meeting:** | 28 September 2020 | | | |
| **Report title:** | Annual Caldicott Report | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Dr Fenella Wrigley, Chief Medical Officer and LAS Caldicott Guardian | | | |
| **Presented by:** | Dr Fenella Wrigley | | | |
| **History:** | IGG Committee, 10 September 2020<br>Executive Committee, 16 September 2020 | | | |
| **Purpose:** | ☒ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☐ | Noting |

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

The Caldicott Guardian has responsibility for ensuring that their organisation satisfies the highest practical standards for handling person identifiable information. Their main concern is information relating to patients, service users and their care, but the need for confidentiality extends to other individuals, including their relatives, staff and others.

This report gives assurance from the Caldicott Guardian (CG) to the Trust Board that the organisation complies with its statutory requirements and proactively manages the protection of patient identifiable information.

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

The Trust Board is asked to:
• Accept this annual report and the assurance it offers
• Acknowledge the areas for on-going review and improvement
• Continue to support the role of the CG and the Information Governance Team to sustain the excellent performance and highest standards within LAS

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

| Directorate | Agreed | | | | Relevant reviewer [name] |
|---|---|---|---|---|---|
| Quality | Yes | x | No | | Chief Quality Officer |
| Finance | Yes | x | No | | Chief Finance Officer |
| Chief Operating Officer Directorates | Yes | x | No | | Chief Operating Officer |
| Medical | Yes | x | No | | Chief Medical Officer |
| Communications & Engagement | Yes | x | No | | Director of Communications and Engagement |
| Strategy | Yes | x | No | | Director of Strategy and Transformation |
| People & Culture | Yes | x | No | | Director of people and Culture |
| Corporate Governance | Yes | x | No | | Director of Corporate Governance |

# London Ambulance Service
# Caldicott Guardian Annual Report

# September 2020

**Background:**

The Caldicott Report on patient-identifiable information (1997) made a number of recommendations for regulating the use and transfer of patient identifiable information between NHS organisation in England and to non-NHS bodies. The role of the Caldicott Guardian is a statutory requirement of NHS organisations. This is the first CG Annual Report, a new initiative that demonstrates the openness, maturity and accountability of LAS with specific regard to protecting patient identifiable information. Every single member of LAS staff has a responsibility to follow the Caldicott Principles and the Data Protection Act irrespective of whether they are clinical or not. It is a serious offence to breach patient / data confidentiality, which might lead to investigation by the Information Commission and potential sanctions

**Senior Information Risk Owner (SIRO) vs Caldicott Guardian (CG)**

Information is a valuable resource: its loss can damage services and reputations, and its misuse can damage individuals and organisations. In line with the NHS information governance framework LAS has appointed Directors as the Caldicott Guardian (CG) and the Senior Information Risk Owner (SIRO).

These two roles are distinct but complementary roles. Whilst Caldicott Guardians were introduced to the NHS in 1998 and to social services in 2002, the SIRO role was not mandated for the NHS until June 2008. Caldicott Guardians are primarily responsible for maintaining the confidentiality of personal information; SIROs have responsibility for understanding how the strategic business goals of the organisation may be impacted by any information risks, and for taking steps to mitigate them.

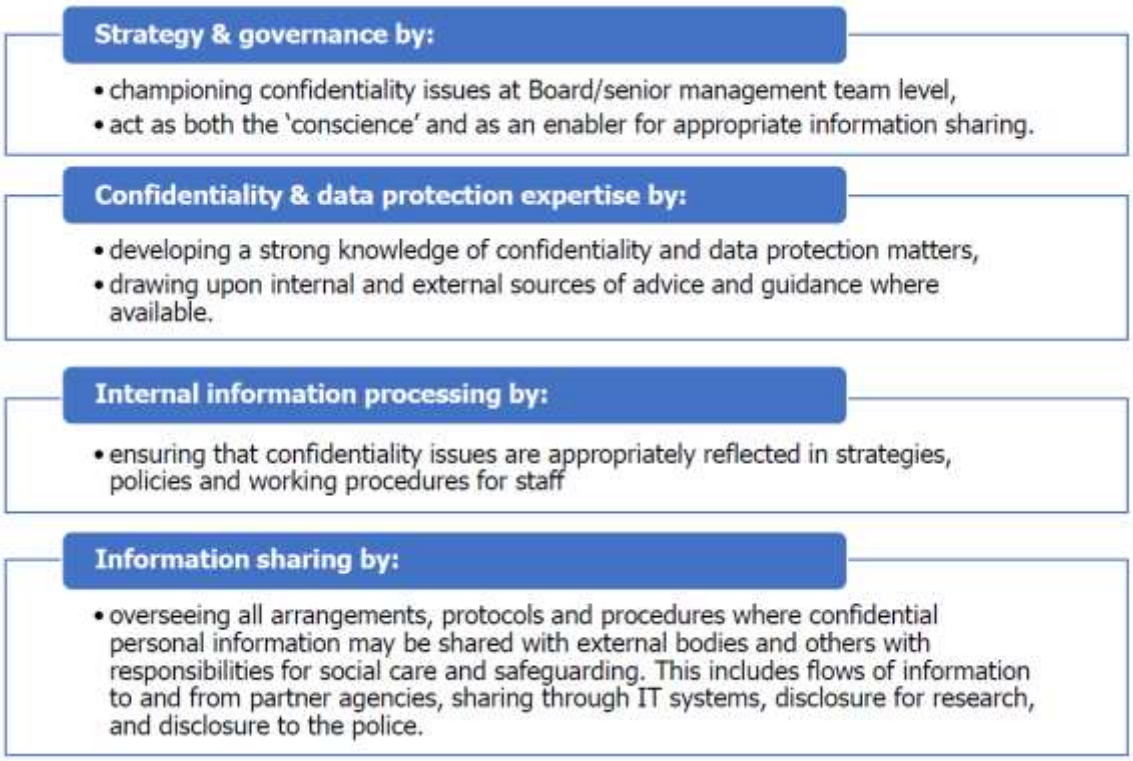
Caldicott Guardians' activities are particularly concerned with the seven Caldicott principles and the common law duty of confidentiality, whilst the SIRO is mainly involved in ensuring compliance with the Data Protection Act and other relevant legislation. It is important to stress however that these are not absolute distinctions: there is much overlap and close working and partnership between the two is essential.


**The Caldicott Guardian?**

The Caldicott Guardian (CG) is a senior member of an organisation with key responsibility to champion confidentiality and data protection issues of patients and clinical services and to act as both the 'conscience' of the organisation as well as an 'enabler' for appropriate information sharing, advising on options for lawful and ethical processing of information. Their main CG

concern is information relating to patients, service users and their care, but the need for confidentiality extends to other individuals, including their relatives, staff and others.

Ensuring compliance with the data protection standards is not simply an issue of operating within the law; it is also about the effective handling of personal information and respecting the interests of individual data subjects.




**What are the Caldicott Principles?**

The Caldicott Principles were developed in 1997 following a review of how patient information was handled across the NHS. The Review Panel was chaired by Dame Fiona Caldicott and it set out six Principles that organisations should follow to ensure that information that can identify a patient is protected and only used when it is appropriate to do so. Since then, when deciding whether they needed to use information that would identify an individual, an organisation should use the Principles as a test. The Principles were extended to adult social care records in 2000.

The Caldicott Principles are fundamentals that organisations should follow to protect any information that could identify a patient, such as their name and their records. They also ensure that this information is only used and shared when it is appropriate to do so.

A seventh principle in April 2013 following her second review of information governance.

**The 7 Caldicott principles are:**

- **Principle 1: Justify the purpose for using confidential information**

Every proposed use or transfer of personally identifiable information, either within or from an organisation, should be clearly defined and scrutinised. Its continuing uses should be regularly reviewed by an appropriate guardian.

- **Principle 2: Don't use personal confidential data unless absolutely necessary**

Identifiable information should not be used unless it's essential for the specified purposes. The need for this information should be considered at each stage of the process.

- **Principle 3: Use the minimum necessary personal confidential data**

Where the use of personally identifiable information is essential, each individual item should be considered and justified. This is so the minimum amount of data is shared and the likelihood of identifiability is minimal.

- **Principle 4: Access to personal confidential data should be on a strict need-to-know basis**

Only those who need access to personal confidential data should have access to it. They should also only have access to the data items that they need.

- **Principle 5: Everyone with access to personal confidential data should be aware of their responsibilities**

Action should be taken to ensure that those handling personally identifiable information are aware of their responsibilities and their obligation to respect patient and client confidentiality.

- **Principle 6: Understand and comply with the law**

Every use of personally identifiable data must be lawful. Organisations that handle confidential data must have someone responsible for ensuring that the organisation complies with legal requirements.

In April 2013, Dame Fiona Caldicott reported on her second review of information governance, her report "Information: To Share Or Not To Share? The Information Governance Review", informally known as the Caldicott2 Review, introduced a new 7th Caldicott Principle

- **Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality**

Health and social care professionals should have the confidence to share information in the best interests of their patients and within the framework set out by these principles. They should also be supported by the policies of their employers, regulators, and professional bodies.

**Caldicott Principle revisions out to consultation:**

On the 30 April 2020 Dame Fiona Caldicott, the National Data Guardian (NDG) for Health and Social Care (NDG), launched a public consultation seeking views on:

- Proposed revisions to the seven existing Caldicott Principles;
- Proposed extension of the Caldicott Principles through the introduction of an additional principle which makes clear that patients' and service users' expectations must be considered and informed when confidential information is used;
- The proposal that the NDG uses her statutory power to issue guidance about organisations appointing Caldicott Guardians to uphold the Caldicott Principles.

https://www.gov.uk/government/consultations/caldicott-principles-a-consultation-about-revising-expanding-and-upholding-the-principles

The Consultation ends on 3rd September 2020.

LAS has responded to the consultation supporting the proposals, in line with other UK Ambulance Services.

## Data Sharing Agreements in LAS

LAS have a number of data sharing agreements in place that are held by the Corporate Governance Team. For LAS Data Sharing Agreements are overseen by the IG manager and have particularly applied to COVID research projects**.** These are needed for both 999 and IUC and are important to understand the whole patient journey and help to achieve better patient outcomes.

During COVID-19 evidence where our experience as a service of dealing with the pandemic will be fundamental to our ongoing management of these patients and for the future planning for similar public health emergencies.

All projects that collected or stored data to support the service delivery and improvement, such as GoodSAM of the UCLH Stroke Face Time project, had a DPIA process to ensure that any data transmitted complied with Caldicott principles, and EU GDPR requirements, as per TP059 DPIA Policy Procedure.

LAS is working closely with NHSE London to look at pan-London data sharing agreements.

### Data Sharing during COVID 19

Health and care information is, and will continue to be, vital in our response to COVID 19 and the ongoing work around the lesson learnt during the pandemic.

The Secretary of State has issued 4 notices under the Health Service Control of Patient Information Regulations 2002. These notices require that data is shared for purposes of coronavirus (COVID-19), and give health organisations and local authorities the security and confidence to share the data they need to respond to coronavirus (COVID-19). This is limited to Covid-19 purposes, for a time-limited period (initially to 30 September, with scope to extend) and requires organisations to keep records of all data processed.

This response has been supported by the National Data Guardian, who provided a joint statement with Dame Fiona Caldicott that ‘Information sharing must be done differently to support the fight against COVID-19 and to protect citizens compared to ordinary times’.

## Requests for Information

As the only pan-London acute NHS Trust, with over 2 million patient contacts per year, LAS frequently receives requests for information. These increased during the pandemic. Requests for information enter the organisation via a number of routes including through to the Communications Department and via Freedom of Information Requests. Of particular relevance to this report the requests for information may include information on patients, processes and staff.

## Subject Access Request - SAR

Everyone has the right to ask an organisation whether or not they are using or storing your personal information. This is called the right of access and is commonly known as making a subject access request or SAR. SARs entitle individuals to the right to find out what personal data is held about them by an organisation(‘data controller’), why the organisation is holding it and who their information is disclosed to by that organisation

Individuals ('data subjects') have the right to gain access to their personal data held by the organisation

- what personal information an organisation holds about you;
- how they are using it;
- who they are sharing it with; and
- where they got your data from

These requests can come through to anyone in your organisation and Individuals may make a SAR using Facebook or Twitter

Where necessary, assistance should be given to applicants to help frame the request and the response should be sent within 30 days of receiving such requests.
Within LAS SAR requests are received from 8 main sources

*a) Patients/relatives/advocates*

These are requests for the records the Trust holds about a specific incident(s). The patient experiences team support these requests utilising a variety of methods in line with the Ombudsman's guidance on 'early resolution as it has been identified some SAR requests are better managed through other processes for example the NHS complaint procedure. The Trust also receives some SARs for this purpose via the FOI route, but generally accommodates such request when the DPA/GDR obligations are met.

*b) Historical Records*

Patients asking from "all the records held" about them often going back many years

c*) Other Agencies*

These include clinicians responsible for a patient's ongoing care, Health & Safety Executive, the Independent Office of Police Conduct, Prison & Probation Ombudsman.

d) *Solicitor Requests*

Requests from solicitors

*e) Employees*

These are requests from current or former employees about specific material or "all the data held" – these are passed to People & Culture team.

f*) Safe Guarding*

Request from social workers pertaining to Safeguarding related matters – these are managed by the Safeguarding team.

*g) Police*

Requests from the police – these are managed by the Operational Information and Archives Department (OIAD).

For requests from media or other non-medical bodies the following guidance is within the DHSC publication "Confidentiality: NHS Code of Practice (Nov 2003) *Non-medical purposes - To the Media*"

The Number of Subject Access Requests Received

| Source | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Solicitors SAR requests | 136 | 170 | 156 | 164 | 132 | 151 | 189 | 164 | 124 | 161 | 150 | 173 | 71 | 85 | 117 | 2143 |
| SAR PALS | 59 | 41 | 52 | 76 | 61 | 52 | 45 | 52 | 35 | 62 | 61 | 66 | 69 | 86 | 98 | 915 |
| Total | 195 | 211 | 208 | 240 | 193 | 203 | 234 | 216 | 159 | 223 | 211 | 239 | 140 | 171 | 215 | 3058 |

Requests for the records held after a complaint have been made at the outset have historically not been included in the data set.

As it stands, the data does not differentiate between instances where the request was met or not or the reason thereof as there are not any sub-subject categorisations available within the case management system. Similarly, we cannot currently differentiate between the type of applicant nor nature of the request.

Where there is any doubt about the release of information for a SAR, media request or Freedom of Information the request is validated by the Caldicott Guardian to ensure compliance against the Caldicott principles

## Social Media

Like many NHS organisations social media is a regularly used channel for communicating within LAS.

The LiA Facebook group has over 3,000 members and was set up as part of the Listening into Action programme. The purpose of the LiA Facebook group is to engage and communicate directly with a large part of the workforce, as well as to gather staff views and feelings.

The LiA Facebook group is a closed group, so it is possible to discuss work related issues and incidents that cannot be discussed on a public page.

There is a code of conduct associated with LiA and volunteer peer moderators take a proactive role in supporting LAS staff and volunteers to post appropriate messages.

The communications team scan external social media channels and will highlight any posts where the Caldicott principles may have been breached and support the removal and feedback.

## Cyber Risk Framework

In July 2020 the LAS was engaged in a workshop to contribute to the overall development of a Cyber Risk Framework (CRF), which is comprised of a defined risk assessment process, systemic risks, and a risk profile. The aim of the workshop was to produce an updated risk profile, draft action plans and how agree a plan of how to embed the CRF into our existing risk management process.

The Caldicott guardian attended the workshop to review the safety of patients' personal information and risks across the Trust if a Cyber attack were to happen. It also ensured that the Caldicott Guardian seven principles were being aligned against the cyber risk profile developed and the resulting actions.

Ultimately the CRF will provide us with a risk framework with an aim to reduce the risk of a cyber-security threat by providing clear, concise actions.

## National Data Opt-Out Programme

On 25 May 2018, NHS Digital launched the national data opt-out programme, a tool that allows patients to choose to opt out of their data being shared outside of the NHS. The new system is based on a recommendation by the NDG, Dame Fiona Caldicott, in the 2016 Review of Data Security, Consent and OptOuts. The review was launched following the suspension of the national Care.data programme, due to concerns over the opt-out system in place and over patient confidentiality.

This is an online system, but a non-digital alternative is provided for patients who cannot or do not want to use an online system. Unlike its predecessor, Care.data, there is a single opt-out point applied across the system, and a mechanism for people to register their choice.

Although the opt-out tool was launched on 25 May 2018, health and care organisations were not expected to comply until March 2020. Due to the Covid-19 outbreak, the compliance deadline has been extended to 30 September 2020, at which point the position will be reviewed. NHS Digital have said that "organisations that are already compliant should continue as appropriate"[i]

The Government's response to the NDG review confirmed that the national data opt-out programme would not apply to information anonymised in line with the Information Commissioner's Office Code of Practice on Anonymisation.

The Trust, through the Health Informatics Oversight Group (HIOG), has begun work on implementing the National Data Opt-Out Programme led by the Head of Data Quality Assurance and the Information Governance Manager.

[1] NHS Digital, 'National data opt-out' ; NHS Digital and NHSX to NHS England, 19 March 2020

## NHSmail

The nhs.net email address change was due to be delivered in April 2020, but due to COVID has not yet been delivered by the NHS.net Project Team, in the Digital Change team.

NHSmail is delivered in partnership between NHS Digital, NHS Scotland and Accenture, is used by 1.3million people across the Nhs already. NHSmail support team also use sophisticated mechanisms to identify and block spam emails containing phishing website links Additional benefits in moving across to a nationally recognised system, is the added Information Security for transmission of patient identifiable data and encryption across all mobile devices. This is particularly important for the Caldicott Principles, as patient identifiable data will have a level of security previously undelivered by the lond-amb.nhs.uk email server.

## Information Governance Training

Principle 5 of the Caldicott Principles states that everyone with access to personal confidential data should be aware of their responsibilities. The Information Governance Statutory Mandatory Training covers this responsibility, and at the time of writing, compliance is at 91.18%. Comparatively, last year the compliance stood at 88.88%, which suggests that staff are more aware of their responsibilities.

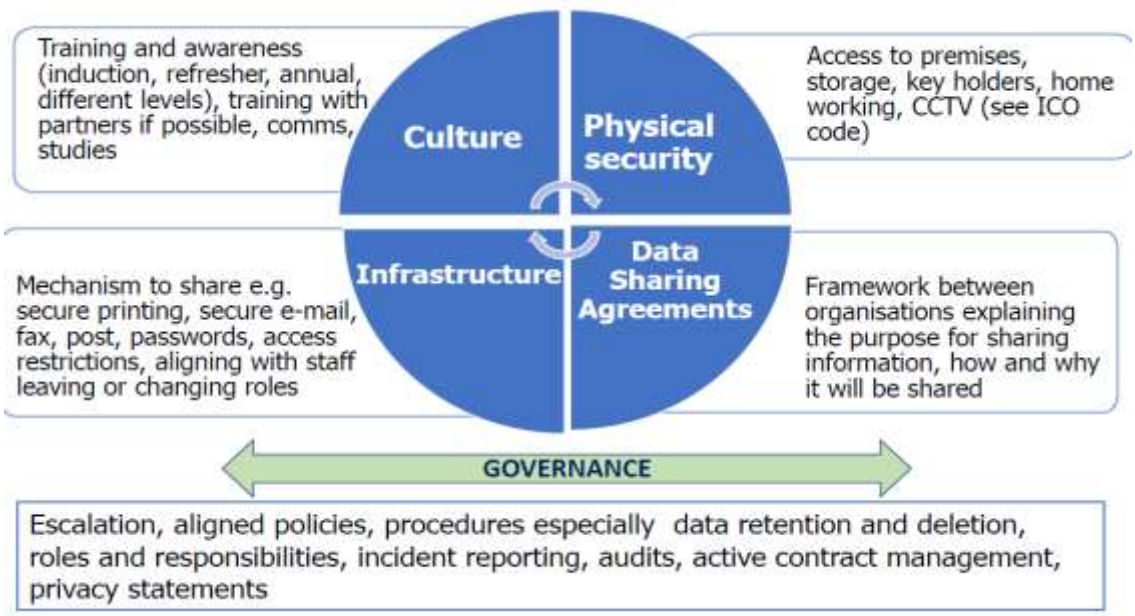
The Caldicott Guardian has attended a Caldicott Guardian refresher course and advanced course to maintain their knowledge and skills. In addition, the LAS Caldicott Guardian is the representative for UK Ambulance Services on the UK Caldicott Guardian Council.

## Information Governance incidents

The Information Governance breaches are reported via the Trust Incident Management System (Datix) and then investigated according to the potential severity.

The diagram below shows the baseline required to share data effectively and also highlights where breaches could occur.

**Baseline required to share data effectively**




The tables below provides an overview of the incident types and an indication of the level of harm caused to individuals as a result of those reported incidents.

Between June 2019 and May 2020 there were 271 information governance incidents reported of which, when reviewed, 96% were classified as no harm.

**Learning and actions taken following information governance incidents:**

1. The implementation of Electronic Patient Care Records will enable accurate, up-to-date, and complete information about patients at the point of care, rapid access to patient records for a more coordinated, efficient care and a safer, more secure way of sharing information minimising the risk of misplacement.
2. Further work is needed to improve accuracy of reporting Information Governance incidents for example the categorisation of 'other IG incidents';
3. To consider implementing a deadline within which all incidents investigations must be complete and approved by the respective managers;
4. To devise a method of accurately identifying the directorate where the incident happened. This will ensure that the Lessons Learned from incidents are widely disseminated in the areas affected by the incidents.

## Information Commissioner Office referral

On Thursday 22nd August 2019, a serious Information Governance breach occurred, when a small number of student paramedics were able to access personnel folders containing the confidential information of staff members on a Network Drive. Immediate risk mitigation took place, and access to the Network Drive was restricted following an assessment of the clinical and operational risk. An internal communication was sent on 27th August 2019 informing all members of staff of the change in access.

HR processes were commenced against the staff who we believe have made inappropriate access to the personnel folders in question, and support was provided to the staff members that needed it.

The Trust's Chief Information Officer (SIRO) and Director of Corporate Governance (DPO), head of information security and information governance manager met to commence investigations and assess risks from this incident. Consequently, a Level 2 Serious Incident Investigation was completed on 77/11/2019 (STEIS reference: 2019/19689) and the Lead Investigator was Paul Woodrow. The Incident was discussed at the Information Governance Meeting in October 2019, with a recommendation that the Information Commissioners Office was informed.

## Summary and work for on-going improvement and assurance

It is essential that the Caldicott Guardian knows what the current condition and status of patient identifiable information is within the organisation. It is equally important that we balance the compliance with legislation with the benefits and duty to share.


**Proposed Work-plan:**

The very minimum requirements for the Improvement Plan are

1. Working with internal communications to promote the understanding of the Caldicott Guardian and SIRO including the introduction of a CG decision log.
2. Further IG audit - an overall assessment of the current position including:

    i. adherence to existing Code of Conduct;
    ii. induction processes;
    iii. training needs

iv. IM&T risk management
v. Operational and Environmental Security
vi. Quality of Information supplied to the Public

3. Support the implementation of the actions and learning from the incident reporting (as above)
4. A review of existing flows of patient identifiable information
5. Conclusion of the review of database construction and management where patient identifiable information is stored
6. A review of procedures for handling patient identifiable information collected by or transferred to the and of the procedures for disclosing information to other organisation
7. Ensure compliance against Erasure Request to ensure that where personal data information has been disclosed to third parties it should be erased unless there is a legitimate reason to keep it.
8. The Trust implements a system able to measure the Trust's performance on a key GDPR requirement of providing SAR information within 30 days of receiving such requests.
9. The Trust should consider publishing detailed guidance about the type of information we hold, the conditions of release and directional information about how to apply on the Trust website.

Much of the work will link closely between the CCIO, SIRO and IG manager but as some of the audits have not been done before it will be a considerable undertaking but one which is essential to establish where the organisation stands and to help to establish a Caldicott score and improvement plan. Once the framework is in place for such an audit the task in succeeding years becomes easier but it remains necessary to revisit these aspects of the governance agenda each year.

While the actual work may well be done by others, the Caldicott Guardian and SIRO should ensure they fulfil a quality assurance role and are kept aware of progress/problems.

*Dr Fenella Wrigley*
*Chief Medical Officer and Caldicott Guardian*
*September 2020*

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Use of the seal | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Victoria Moore, Corporate Governance 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:**

The Board have a duty to report each use of the Trust Seal.
The Seal has been used once during the reporting period and appropriate details are provided.

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

The Board is asked to note the use of the Trust Seal in line with its Standing Orders.

**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 | x | No | | Chief Medical Officer |
| Communications & Engagement | Yes | | No | | |
| Strategy | Yes | | No | | |
| People & Culture | Yes | | No | | |
| Corporate Governance | Yes | x | No | | Director of Corporate Governance |

London Ambulance Service NHS Trust

# 2020/21 Register of the Seal

| Number | Date of sealing | Description of Document Sealed | Name of Persons attesting sealing |
|---|---|---|---|
| 02 | 27 August 2020 | Picton UK Real Estate Trust (property) No. 2 Limited<br>and<br>London Ambulance Service NHS Trust<br><br>Licence to alter for the secure drugs room in Cody Road, London. | Fenella Wrigley, Chief Medical Officer<br>and<br>Syma Dawson, Director of Corporate Governance |

London Ambulance Service
NHS Trust

| Report to: | Trust Board | | | |
|---|---|---|---|---|
| **Date of meeting:** | 29 September 2020 | | | |
| **Report title:** | Action Log, Training response | | | |
| **Agenda item:** | For Information | | | |
| **Report Author(s):** | Fenella Wrigley, Chief Medical Officer<br>Khadir Meer, Chief Operating Officer | | | |
| **Presented by:** | Fenella Wrigley, Chief Medical Officer<br>Khadir Meer, Chief Operating Officer | | | |
| **History:** | N/A | | | |
| **Purpose:** | ☐ | Assurance | ☐ | Approval |
| | ☐ | Discussion | ☒ | Noting |

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

The Trust Board action log contains two actions in respect of training this paper provides members with the action responses.

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

The Board is asked to receive the action updates

| **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 | x | No | | Chief Medical Officer |
| Communications & Engagement | Yes | | No | | |
| Strategy | Yes | | No | | |
| People & Culture | Yes | | No | | |
| Corporate Governance | Yes | | No | | |

1. What is the total abstraction for training (in patient facing hours) remembering 24 hours are CSR

| Abstractions associated with the delivery of clinical education by CES aligned to the 2020/21 workforce plan | | | | |
|---|---|---|---|---|
| **CES clinical training** | **Abstractions** | **Number of staff** | **Cost (£)** | **Notes** |
| NQP UK | 0 | 162 | 1,074,960 | New starters, fallow time. |
| NQP International | 0 | 121 | 788,583 | New starters, fallow time. |
| TEAC / AAP | 0 | 231 | 2,720,811 | New starters, fallow time. |
| CSR | 0 | All clinical staff | | 24 hr individual learning account per learner. |
| TEAC | 432 | 231 | 45,200 | 2 days per learner at the end of the course. |
| Academy | 3,500 | 100 | 435,000 | 7 weeks per learner. |

2. What is the finite cost of CES services, and we can help define how much abstraction is needed for our programs

| CES budget (2020/21) | |
|---|---|
| **CES account type** | **Full year budget (£)** |
| Non pay expenditure* | 2,516,235 |
| Pay expenditure* | 11,666,785 |

*Subject to change due to the new AAP programme and departmental growth aligned to Trust's clinical education strategy.