London Ambulance Service
NHS Trust

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

Thursday 23 September 2021 at 10am – 12.45pm
at Newham Dockside, 1000 Dockside Road, London, E16 2QU and via video-conference.

Please note: The Trust's Annual Public Meeting will take place from 5.30pm.

Agenda: Public session

Timing	Item		Owner		Status
10.00	1.	Welcome and apologies	HL	Verbal	
	2.	Declarations of interest	All	Verbal	
	3.	Minutes of the public meeting held 27 July 2021	HL	Enclosed	*Approval*
	4.	Action log and Matters arising	HL	Enclosed	
10.05	5.	**Report from the Chair**	HL	Enclosed	*Information*
10.15	6.	**Report from the Chief Executive**	DE	Enclosed	*Assurance*
10.25	7.	**Report from the Chief Operating Officer**	KM	Enclosed	*Assurance*
Director and Board Committee Assurance Reports					
	8.	**Integrated Performance Report**	LB	Enclosed	*Information*
10.35		**8.1. Quality and Clinical Care** • Quality Accounts & Quality Priorities - biannual report • Directors Report (Quality) • Directors Report (Clinical Care)	JM JM FW	Enclosed Enclosed Enclosed	*Assurance*
11.10		**8.2. People and Culture** • Directors Report	DMG	Enclosed	*Assurance*
11.20		**8.3. Finance & Audit** • Directors Report • M4 Finance Report • Finance & Investment Committee • Audit Committee	LB LB BA RP	To Follow Enclosed Enclosed Verbal	*Assurance*

Timing	Item		Owner		Status
11.50		**8.4. Logistics and Infrastructure** • Logistics and Infrastructure Committee	SD	Enclosed	*Assurance*
Patient and Public Engagement					
12.00	9	**LAS Patient and Public Council**	AT/CB	Enclosed	*Assurance*
Governance					
12.10	10	**Board Assurance Committee Terms of Reference and Memberships 2021/22**	DS	Enclosed	*Approval*
12.15	11	**Trust Policy Approvals:** • **Procedural Documents** • **Fit and Proper Persons** • **Managing Conflicts of Interest**	DS	Enclosed	*Approval*
12.25	12	**Board Assurance Framework and Corporate Risk Register**	DS	Enclosed	*Approval*
Concluding Matters					
12.35	13	Any other business	HL	Verbal	*Information*
12.45	**Meeting close** The Chair shall bring the meeting to a close and exclude representatives of the press and other members of the public having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).				

Additional reports, circulated for information only:

- Quality Report
- Use of the Seal

London Ambulance Service
NHS Trust

TRUST BOARD: Public meeting – Tuesday 27 July 2021

DRAFT Minutes of the public meeting of the Board held on 27July 2021 at 9.30am, at County Hall, London and via Video Conference

Present		
Name	**Initials**	**Role**
Heather Lawrence	HL	Chair
Lorraine Bewes	LB	Chief Finance Officer
Sheila Doyle	SD	Non-Executive Director
Garrett Emmerson	GE	Chief Executive Officer (CEO)
Amit Khutti	AK	Non-Executive Director
John Martin	JMa	Chief Paramedic and Quality Officer
Khadir Meer	KM	Chief Operating Officer
Rommel Pereira	RP	Non-Executive Director (vc)
Anne Rainsberry	AR	Non-Executive Director
Mark Spencer	MS	Non-Executive Director (vc)
Fenella Wrigley	FW	Chief Medical Officer
In attendance		
Jill Anderson	JA	Associate Non- Executive Director (vc)
Trisha Bain	TB	Interim Director of Corporate Affairs
Dame Christine Beasley	CB	Chair of the Public and Patients Forum
Line De Decker	LDL	Associate Non-Executive Director (vc)
Damian McGuinness	KN	Director of People and Culture
Diane Scott	DS	Interim Director of Corporate Affairs
Antony Tiernan	AT	Director of Communications and Engagement
James Stanton	JS	Head of Corporate Governance (Minute taker) (vc)
Victoria Moore	VM	Corporate Governance Manager
Sam Matthews	SM	Communications
Apologies		
Karim Brohi	KB	Non-Executive Director

(vc) – via video conference

Welcome and apologies

1. The Chair welcomed those present, in person and via video link, to the meeting and extended a welcome to the public watching online. Apologies were noted as set out above.

2. The Chair introduced Line De Decker, Associate Non-Executive Director, Damian McGuinness, Director of People and Culture and Diane Scott, Interim Director of

Corporate Affairs, and welcomed them to their first Trust Board meeting. The Chair also welcomed Dame Christine Beasley, who was attending the meeting as the Chair of the Trust's Patient and Public Council.

3. It was noted that Trisha Bain was attending her last Trust Board meeting. The Chair thanked Trisha for her help and service in re-joining the Trust to provide cover for the position of Interim Director of Corporate Affairs at short notice. The Chair passed on the Board's thanks and best wishes for her retirement.

4. The Chair and Trust Board also noted that it would be the last Board meeting for Garrett Emmerson, who had announced that he would be stepping down from the role of Chief Executive.

Declarations of interest

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

Minutes of the meeting held in public on 25 May 2021

6. The minutes of the meeting held in public on 25 May 2021 were approved as an accurate record.

Matters Arising

7. The Board reviewed the action log and noted the updates provided in the paper. During a discussion of the action log, the following points were made:

- NHS 111 – preparatory work had taken place prior to commissioning a Lean Review of the service. The Chair asked to be informed of when the review would start and further updates would be provided to the Trust Board in September and November 2021.
- Resolution Framework – all appeals for dismissal will be allocated a NED to oversee the process, as per the best practice taken from the MHPS policy used for medical staff
- Digital scorecard – discussions had taken place at the Logistics and Infrastructure Committee with the Chief Operating Officer and assurance around the scorecard would link in with the digital strategy refresh.
- Change management – a practical example would be brought forward as a future staff story for the Board. Board Members advised that an integrated change management plan was needed to underpin the work and that this needed to be wider in scope than the Ambulance Operations Modernisation Programme. This would be picked up by the People and Culture Committee.
- Diversity Inclusion Plan – the Director of People and Culture confirmed that this would be captured in the summary of future reporting.

8. The Trust Board also noted the incredible pressures that the service had experienced over the previous few weeks. Particular reference was made to the flooding which had taken place in two London hospitals and the efforts of LAS staff to evacuate and transfer patients and support their NHS colleagues. Thanks had been received from the Chair of Barts Health and demonstrated a good example of integrated working. The Board noted that the incident was ongoing for colleagues in the North East of London and thanked staff, including Gold Commanders Brian Jordan and Pauline

Cranmer, for their support in the transfer of around 100 patients from Whipps Cross Hospital to the Royal London as part of their evacuation.

Report from the Chair

9. The Chair presented her report which provided an overview of meetings and events she had attended with internal and external stakeholders since the previous meeting of the Trust Board.

10. Noting that this would be his last formal Board meeting prior to stepping down at the end of August, the Chair thanked the Chief Executive for his work and noted the progress which had taken place over the previous four years. During his time with the London Ambulance Service, Garrett Emmerson had overseen the Trust's response to Covid 19, an unprecedented number of terrorist attacks on the Capital and the Grenfell tower fire. Under his leadership, together with the team, the Trust had emerged from Special Measures and been recognised by the Care Quality Commission with a rating of Good. On behalf of the Board, the Chair wished Garrett all the best for the future.

11. The Chair advised that Daniel Elkeles, an experienced CEO, had agreed to join the Trust on secondment as Chief Executive. Daniel is currently CEO of Epsom and St Helier University Hospitals where he had not only secured the funding for a new hospital but also gained a reputation for addressing longstanding culture issues at the hospitals. Daniel would join the Trust on 16 August 2021 for a handover period with Garrett.

12. The Chair discussed arrangements for the Board's next development session and suggested to Board Members that they take the opportunity to visit parts of the Trust's estate to see the fruition of the work which had been taking place. The Chair also noted the previous discussion held by the Board on its digital strategy with NHS Providers. Using a digital platform was noted to be a key part of transforming care.

13. The Chair also provided an update on the Health and Care Bill. The Bill, which would put in place the statutory framework for Integrated Care Systems (ICS), had received its second reading in the Commons. It was noted that there was a proposal for a regional board for the commissioning ambulance services and urgent care. Whilst the Trust's preferred option for future arrangements remained for the Ambulance Service to be considered as a separate ICS, the development of a regional board was a position which could be supported. Recent demand had highlighted the need for a coordinated approach to the provision of ambulance and 111 services.

Resolution:

The Trust Board noted the paper.

Report from the Chief Executive

14. The Chief Executive presented his report and provided a strategic update on the key activities and internal and external engagement by the Trust since the previous Board meeting.

15. The Chief Executive noted that this would be his final Board meeting prior to leaving at the end of August 2021 and looked back on his four years with the Trust. He stated that he had been honoured to lead the organisation through some of its most challenging and busiest days ever. These included the Grenfell fire tragedy and multiple terrorist attacks in 2017, the journey to get out of NHS 'Special Measures' in

2018 and the incredible response to the COVID-19 pandemic in 2020. Through all of this time, the outstanding dedication and commitment to patient care demonstrated by everyone in the Service, day in and day out, over such a long period of time, had been truly inspirational.

16. The Chief Executive thanked all colleagues across the organisation who worked tirelessly to deliver an outstanding service for London. He noted how incredibly proud he was of his time spent with the Service and that it had been the highlight of his professional career. Whilst he was sad to leave, he noted that LAS was in good hands and in a good position to respond to the operational challenges ahead.

17. The third wave of demand pressures which the Service faced had presented significant challenges. This was due to the range and variety of patient presentations, rather than being dominated by Covid cases, which were driving demand in 999 and 111 services to previously unseen levels. Whereas previous peaks had presented on a regional basis, the move recent wave was being experienced nationally. This made it more difficult to draw resources across from other areas as had helped in the previous waves. The Chief Executive advised of his gratitude and amazement at the work of colleagues in coping with these challenges as well as incidents such as the flooding which had been experienced in London the previous weekend.

18. Board Members discussed the changes in the behaviour of patients in accessing NHS services following the Covid pandemic waves. The Chief Medical Officer advised that patient cohorts were consisting of a mixture of Covid related cases, increases in more usual activity and a number of patients who have had some other treatments delayed. Patients were more willing to call 999 and 111 services, for which there was now much greater public awareness. The Clinical Hub was seen as crucial in advising on patient pathways. The Chair advised that there was a need to see this service further developed out of hours and at weekends.

19. The Chief Paramedic and Quality Officer noted that the pandemic had seen more enforced changes in the way that healthcare was being delivered and that the service would need to look to returning to more consultative approaches in future. In addition, support groups in society, such as parent and child groups, had not met and this had removed some informal networks leading to a greater reliance on 999. He also confirmed that a proportion of the additional service demand consisted of patients whose regular treatments had been suspended.

Resolution:

The Trust Board noted the paper.

Report from the Chief Operating Officer

20. The Chief Operating Officer presented his report, noting that it represented a snapshot in time. July 2021 was predicted to be the second busiest on record. The operational pressures had been recognised and LAS had in place an excellent planning team working with acute partners to share understanding of system pressures.

21. The increase in job cycle time had been identified as key to the pressures being experienced by the Service. The job cycle time was 10 minutes above pre-Covid levels. When multiplied by 3,000 incidents a day, this translated to about 500 hours of lost time or the equivalent of 10 or 20 ambulances unavailable at any given time. Work was taking place with system partners to address delays in hand over times at hospitals and it was noted that more was being done by ambulance crews on scene. This included the time taken to don personal protective equipment (PPE). The Chief

Quality Officer was noted to be undertaking a piece of work on job cycle time and it was expected that results could be presented to the Board in two months' time.

Resolution:

The Trust Board noted the paper.

Director and Board Committee Reports

- Integrated Performance Report

22. The latest Integrated Quality and Performance Report (IPR) was presented. This provided an Executive Summary for the Board and gave an organisational oversight of all key areas across the London Ambulance Service including Quality, Operations, Workforce and Finance.

Resolution:

The Trust Board noted the Integrated Performance Report.

23. The reports from directors, assurance committees and associated questions were taken in order. The Board noted the key themes as set out below.

Quality and Clinical Care

- Director's Report (Quality)

24. The Chief Paramedic and Quality Officer highlighted the following areas in his report:

    - The Care Quality Commission (CQC) had launched its new strategy. The Trust had ensured that it had systems and processes in alignment with the new strategy. Working together as a system, the Trust continued to meet with the CQC.
    - Call taking system had been through reaccreditation and continued to be credited as a Centre of Excellence for call handling for 999.
    - Work was continuing to ensure that the Trust had access to appropriate and high quality clinical education, making use of new partnerships including the University of Cumbria and Buckinghamshire University.
    - The Director had continued to maintain a visible profile and to actively engage and listen to frontline staff.

25. Board Members discussed the steps being taken to develop the pipeline for growing the Trust's patient facing clinical workforce. The Director advised on the steps being taken to find the correct balance between the number of London and UK graduate places being commissioned and the recruitment of international paramedics over the next four years. The Chair noted that the Board was very grateful for the work of international colleagues, who were very much wanted and appreciated, but also needed to ensure long term resilience through developing sustainable career pathways.

- Director Report (Clinical Care)

26. The Chief Medical Officer presented her report and advised that significant progress had been made with Same Day Emergency Care pathways. These had been co-designed with partners across London to support the Clinical Hub, 111 Clinical Assessment Service and paramedics on the road.

27. LAS would also be taking part in the CRASH-4 research trial for the treatment of Traumatic Brain Injuries. This would use early intramuscular treatment to potentially

improve patient outcomes significantly. The aim was to recruit 50 patients in the Wimbledon area for the trial in the summer.

28. In response to questions from Board Members, the Chief Paramedic and Quality Officer advised that the backlog in the patient scorecard had continued to decrease. A pilot asset tracking programme was in progress which would help with crew confidence on equipment provisions and reduce the need for personal checks by crews under the vehicle Make Ready contract. It was also confirmed that the mechanisms for learning continued to be in place, including the weekly patient safety panel. Some education opportunities for frontline staff had been delayed and this position would take some time to recover.

- Quality Assurance Committee

29. The Chair of the Quality Assurance Committee presented his report.

30. The Committee Chair advised the Board that the Quality Assurance Committee had given consideration to a filming proposal relating to a London Trauma Documentary. The filming proposal had received strong support from the trauma units. Whilst the proposal had been supported in principle, the Committee had requested assurance in relation to the consent process, addressing concerns previously raised to the Trust Board. The Committee had also asked that filming not take place during the current Covid wave so as not to add to pressures. The Chief Medical Officer confirmed that the specialist advice had been that it was not appropriate for filming to take place in the back of ambulances at the present time and so, due to time constraints filming had gone ahead solely in hospitals. The Chair agreed that the right decision had been made for patients.

Resolution:

The Trust Board noted the Quality and Clinical Care reports.

People and Culture

- Directors Report

31. The Director of People and Culture presented his report and highlighted the following areas:
    - Isolation protocols had been challenging to staffing levels. The Trust had been following the “Test to Release” programme and frontline staff were now also able to follow a procedure of taking seven days of lateral flow testing, following a negative test, as an alternative to isolating.
    - Sickness absence rates had been fairly static in month with a small increase driven primarily by non-Covid sickness absence. Anxiety, stress and depression were now main factors and the directorate had been asked to look at the package of measures on offer to managers and help to support staff. This would include benchmarking with other trusts.
    - Vacancy and retention rates were in line with key performance indicators (KPIs).
    - The Trust had welcomed 41% of new starters in May 2021 from Black, Asian and minority ethnic (BAME) community and the Director noted the success of diverse selection panels.
    - A survey of international paramedics had revealed that 28% were currently considering leaving. This was above the forecast exit of target of 20%. This measure would continue to be kept under review.
    - The Trust’s Wellbeing Hub had received positive feedback from staff, with over 3,000 contacts over the past year and 94% of responders rating it ‘good’ or ‘excellent’ on a 50% response rate.

32. The Board noted the update and the trends in sickness absences. The Trust was noted to have relatively low levels of sickness, pre-Covid, compared to other ambulance trusts, however this was above the NHS average. A lot of work had taken place prior to the pandemic response period to reduce the reliance on overtime staffing. This would need to be considered again once an understanding was in place as to what the long term level of demand would be post Covid and the funding in place for that resource. The Chair noted that questions as to the recruitment levels and whether the Trust should be working towards NHS, rather than ambulance trusts, best practice in terms of staff absence would be considered by the People and Culture Committee.

Action: People & Culture Committee to agree the appropriate sickness target.

- People and Culture Committee

33. The Chair of the People and Culture Committee provided an update on the work of the Committee.

34. Further to the discussion on levels of sickness absence, it was noted that the Committee had requested that a new scorecard be produced with all workforce KPIs in one place. This would include vacancies, turnover, sickness, employee relations casework, compliance data (Personal Development Reviews (PDRs), statutory and mandatory), health and wellbeing, culture, diversity and inclusion. The Committee had also been monitoring the implementation of the Trust's Resolution Framework and the potential benefits that this could bring to staff absences. Whilst complex, the time taken to close older cases had been noted and the Committee had sought assurance on the plan to resolve this.

35. The Committee had also considered the Occupational Health contract tender process. Discussion were underway with partners in NW London with a view to determining whether it was best to pursue that option or to proceed in parallel with an open procurement. The Committee had also discussed the strategy refresh and what that meant for the People Plan.

36. The Chair noted the success story represented by the Trust's approach to wellbeing and informed the Board that staff had advised her that they had found it to be supportive. The Chair thanked all those involved.

Resolution:

The Trust Board noted the People and Culture reports.

Finance and Audit

- Directors Report

37. The Chief Finance Officer presented her report.

38. The Trust continued to operate under an adjusted financial framework during the first half of the financial year April to September 2021 (H1) in response to the continued impact of the Covid pandemic. The financial framework set fixed expenditure arrangements funded through block payments via the host NW London ICS for the first half of the year.

39. The Chief Finance Officer noted the increase in capital spending which had doubled the previous year and noted that this step up position would need to continue. The Board would be presented with the Capital Plan for approval. Further sources of

funding had been identified so that a further £8m was now required from the initial £35m to fund the Trust's full ambition. NW London ICS had awarded just under £5m to two key projects.

40. The Chief Finance Officer provided an update on the national headlines and planning assumptions for the second half of the year (H2) which had been announced since the publication of the Board paper. Key points were noted to include:
    - The financial rollover and block allocations would continue into H2 with an increased efficiency or 'waste reduction' target of between 3-5% (preparations had been made for a pro rata increase)
    - Significant pressures on the ambulance sector had been recognised with the award of a special one-off payment of £7m from a national funding pot.
    - The earliest that H2 details were likely to be confirmed would be in the reporting to the Board's September meeting.
    - Work was continuing on a number of key improvements eg in procurement. This had added to assurance around compliance. The Trust would also be hosting the national procurement route for the next generation of ambulances.

- Finance and Investment Committee

41. The Board received the report of the Chair of the Finance and Investment Committee.

42. The Committee had considered a draft 10 year capital plan and an updated, prioritised 2021/22 Capital Programme. Since the Capital Plan was presented in May 2021, there had been a number of developments to the 2021/22 Capital Programme, including a £4.8m increase in capital resource limit (CRL), approval pending available funding of five urgent business cases and an increase in the cost to complete committed in-flight projects.

43. The Finance and Investment Committee had also considered the allocation of capital within the 2021/22 Capital Programme. Subject to additional assurance from the Executive relating to the prioritisation having taken into account current Trust risks, Members recommended to the Board that the Capital Programme be approved.

44. Board Members noted the consideration which had been given to the proposal to seek a bridging loan. Members were clear that the terms and cost of the loan needed to be understood to fully consider the risks and any necessary mitigations, as well as the risk of not securing the necessary disposal funds. The Chief Finance Officer provided an update to confirm that other options were also being explored, including accessing ICS brokerage. It was noted that the Trust's good track record with regards to capital had seen support for sourcing funding locally and this option would continue to be explored.

- Audit Committee

45. Sheila Doyle updated the Board on the work of the Audit Committee on behalf of the Chair of the Committee.

46. Board Members noted that the Trust was on a journey to strengthen and embed its internal controls. The Audit Committee would be reviewing work in place to further embed the 'linse of defence' approach into the Trust's culture. The Committee had also taken the opportunity to learn the lessons from the annual accounts and reporting process and had proactively agreed a draft timetable for consultation on next year's process. In addition to this work, the Audit Committee had also been seeking assurance arising from operational pressures and any performance impacts, as well as taking a forward view on the measures in place to ensure that changes in senior leadership were not disruptive to the Trust's goals.

Resolution:

The Trust Board noted the Finance and Audit reports.

Logistics and Infrastructure

- Logistics and Infrastructure Committee

47. The Chair of the Logistics and Infrastructure Committee presented her paper and highlighted the following areas:

    - Five of the Trust's transformation programmes had been reviewed, including Hub 1, fleet modernisation, the move of the Operations centre to Newham and the logistical support unit. The Committee had considered budgeting, the reporting of progress and ensuring access to both funds and expertise (internal or external). An integrated culture and transformation plan had been proposed.
    - The Committee had asked the Executive to look at how transformation risks could best be presented going forward. A similar approach to that taken with Covid related risks, utilising sub-category risks, was suggested.
    - The configuration and location of estates. It was noted that the 2023 compliance targets agreed with the Mayor's Office about the number of Ultra Low Emissions Vehicles (ULEVs) would need to be revisited depending on the demands on the ambulance fleet post pandemic.
    - Cyber and Data Security and Protection Toolkit compliance. The Trust had committed to an action plan and was due to be compliant by December 2021. The Committee would receive regular updates on progress.

Resolution:

The Trust Board noted the report

Remuneration Committee

48. The Director of People and Culture advised that the Remuneration Committee had met on 29 June 2021 and confirmed to the Board that it was fulfilling its terms of reference.

Resolution:

The Trust Board noted the update.

LAS Patient and Public Council

49. The Director of Communications and Engagement introduced Dame Christine Beasley, Chair of the London Ambulance Service Public and Patients Council (LASPPC). The Trust Board received an update on the role of the LASPPC and of progress made at the five meetings held since its launch in June 2020. The Chair noted the commitment of those involved during very busy times. This included her co-chair, Michael Barnes, who would share reporting duties at future Trust Board meetings.

50. Initial discussions had focused on concerns raised by the Covid pandemic, with Trust feedback being very helpful in providing assurance. Commissioning groups were noted to have responded positively to the Public and Patients Council. Ten sub groups had been established to enable Council Members to drill down into an issue in detail. Work had also taken place to support station accreditation visits. The Trust and Council

would work together to develop a two year work plan to further embed their influence. This would make use of the Patient Engagement Strategy and more work with the clinical teams, involving patients and the public with shaping care going forward.

51. The Trust Board noted that End of Life Care, Maternity and Mental Health had all received awards and demonstrated the benefits of listening to public and patient voices.

Resolution:

The Trust Board noted the report.

Finance
M2 Finance Report – data to 31 May 2021

52. The Chief Finance Officer presented the M2 Finance report. Key points included:

- A surplus of £0.6m for the year to 31 May 2021 was reported. This was in line with plan and was forecast to breakeven at the end of September 2021 (H1).
- A full year efficiency target of £9.7m (2%) and plans to deliver £4m in H1 had been identified. The Trust had delivered £0.9m year to date in line with plan.
- £4.1m had been spent on capital in the first two months against an initial full year plan of £21.4m.
- The cash balance was £39.3m

53. Board Members noted that higher levels of assurance were being received in terms of the delivery of efficiency savings. It was noted that a 'waste reduction' savings target of £12m was likely to be set for the full financial year.

54. The Trust Board agreed that it would be useful to have the breakdown of the Capital Improvement Programme available for future meetings. It was agreed that this would be included in future supporting documentation.

Action: Breakdown of the Cost Improvement Programme to be included in supporting documents for Trust Board meetings.

Resolution:

The Trust Board noted the report.

Risk
Board Assurance Framework and Corporate Risk Register

55. The Interim Director of Corporate Affairs presented the Board Assurance Framework.

56. The Board noted the increase in the overall risk rating relating to Covid from 12 to 16. Two specific risks were noted to have updates. The risk relating to the financial settlement would be reviewed at for the next Board meeting to take into account the H2 allocation. Operational risk had increased from 12 to 16 to reflect demand pressures. The remaining risks remained the same following review by the assurance committees. A review of Covid risk would take place in September with a view to restructuring how this was presented going forward. It was noted that the new Chief Executive would likely want to have an input on that discussion and that consideration should be given to a longer term view on the underlying financial and staffing aspects rather than Covid as an overall risk.

57. In response to questions from Board Members, the Chief Operating Officer advised that work was taking place on confirming the revised timeline for Computer Assisted Dispatch (CAD) replacement and that a plan was in place for Uninterruptable Power Supply (UPS) renewal and maintenance. Bow would be the second site to move to Newham. The original 'go live' date had been proposed as September, however the challenges in construction meant that a revised date of December for staggered move to Newham was being considered. It was noted that the Logistics and Infrastructure Committee had received an update on the position with UPS and generators and that more work was to be done on risk tolerance levels.

Resolution:

The Trust Board approved the Board Assurance Framework.

Any Other Business

58. There was no other business raised.

Additional Reports

59. The Trust Board received the following additional reports for information only:

- Infection Prevention and Control Assurance Framework
- Quality Report
- Use of the Seal
- Audit Committee Annual Report

60. The Trust Board noted that the Annual Accounts and Reports had been submitted in accordance with the delegation to the Audit Committee agreed at the previous Board meeting.

Meeting Close

61. The Chair brought the meeting in public to a close and it was resolved to exclude representatives of the press and other members of the public having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

The next Trust Board meeting in public will take place on 23 September 2021.

TRUST BOARD - Public Meeting: ACTION LOG

Ref.	Action	Owner	Date raised	Date due	Comments / updates *(i.e. why action is not resolved / completed)*
NHS 111 services	KM to hold deep dive on NHS 111 services. Updated action 30/3/21 - KM and RP to discuss assurance to be brought to Audit Committee	KM	02/11/2020	30/11/2021	An update on NHS 111 services will be given in the private part of the meeting. The scope of assurance to be provided will be progressed following discussion with the Board.
Digital Scorecard	Production of a digital transformation scorecard to be explored	FW	25/05/2021	30/11/2021	Planning is in progress as to the detail of the scorecard delivery in consultation with the Chair of LIC.
Change Management	AG presentation on change management to be considered for future Board development session.	HL	25/05/2021	26/10/2021	A presentation will be given at the Board's next development session in October 2021.
Cost Improvement Programme	Breakdown of the Cost Improvement Programme to be included in supporting documents for Trust Board meetings.	LB	27/07/21	23/09/2021	This has been incorporated into this month's financial reporting.
Staff Absence levels	People & Culture Committee to agree the appropriate sickness target.	DMG	27/07/21	30/11/2021	The Chair and P&C Director have agreed trajectory target, looking to report at least 6% by March 22 – taking into account current and forecasted winter pressures

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NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
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's attention:

The Chair's report provides an overview of meetings and events attended with external/internal stakeholders of the Service since the last time the Board convened.

Recommendation for the Board:

The Board is asked to note this report.

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

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes		No		
Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

Report from the Chair

Internal

Incoming CEO

I am delighted to welcome Daniel Elkeles as our incoming interim CEO. Daniel's previous role was as CEO of Epsom and St Helier Hospital where he gained funding for a new hospital and addressed staff cultural issues leaving a more inclusive organisation than when he arrived. Daniel has spent his first few weeks getting to know the organisation and has spent time meeting and listening to staff in the EOC, NHS 111, out at stations and has been on ride outs.

The departure of Khadir Meer, Chief Operating Officer has meant that Daniel has needed to address the restructuring of the executive team and I am pleased to inform the Board support his proposals for this.

Departing Chief Operating Officer

Khadir Meer leaves us at the end of September having spent two years as our Chief Operating Officer. He has worked tirelessly and his achievements have been numerous but to highlight has:

- Galvanised the senior COO leadership team, and appointing key individual into post as developing the talent and future leaders of the Trust
- Pioneered new innovations for the trust with the planned introduction of zero emission fleet
- Supported genuine blue light collaboration with partnerships with the MPS and LFB

We are grateful to Khadir and wish him well in his new role

Trust Board site visits

As part of the farewell to our departing CEO Garrett Emerson, the Board visited the new logistics supply unit based in Rainham which was due to open imminently. We met Claire Hill who impressed us with her knowledge and enthusiasm for her role. Without a doubt the opening of this centre will significantly improve services to front line staff.

We then visited the new pharmacy packing and storage unit and were able to see the flow, storage and security of drugs which when operational will address previous CQC concerns.

At Newham we visited one of the new educational centres providing an excellent work / learning environment for staff and students. Transport links are good to this site however staff concerns remain over parking and accessibility that the executive team are addressing.

This is also the site where our EOC currently based at Bow will move to once technical issues are resolved.

Lastly we visited the site of the potential Hub 1 where a number of issues need to be resolved.

External

Meeting with Lord Toby Harris

Lord Harris (author of the significant and wide-ranging independent report into what could be done to improve London's resources and readiness to respond to a major terrorist incident) has been commissioned by Sadiq Khan, Mayor of London to undertake a new review to consider the changing threat of terrorism facing London and any implications of the pandemic for London's preparedness for an attack. As has been recognised before, the nature of these attacks have changed over recent years and can be of a cyber-security nature or individuals/small groups preparing homemade bombs.

At the meeting we talked through the recommendations from the most recent inquiries into attacks in London and were able to assure Lord Harris that we had implemented the changes pertaining to our service. He was pleased to hear of the good working relationships between the three emergency services in London.

Emergency Services Day

I was delighted to attend a celebration of the Emergency Services Day at the Guildhall along with Daniel Elkeles - CEO, Antony Tiernan - Director of Communications and Engagement and a number of LAS colleagues, all of whom were proud to been invited to the event. There was representation from 999, NHS111, HART, Education and the Ceremonial Unit.

Heather Lawrence OBE
Chairman

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Report from the Chief Executive			
Agenda item:	6			
Report Authors:	Daniel Elkeles, Chief Executive			
Presented by:	Daniel Elkeles, Chief Executive			
History:	N/A			
Purpose:	☐	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

- The Chief Executive's report looks back over recent developments and 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 2021.

Recommendation for the Board:

- The Board is 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		No		John Martin
Finance	Yes		No		Lorraine Bewes
Chief Operating Officer Directorates	Yes		No		Khadir Meer
Medical	Yes		No		Fenella Wrigley
Communications & Engagement	Yes		No		Antony Tiernan
People & Culture	Yes		No		Damian McGuinness
Corporate Affairs	Yes		No		Diane Scott

Report from Chief Executive

1. Changes to the Executive Team

1.1. I was delighted to join London Ambulance Service on Monday 16 August, formally taking over as Chief Executive on Wednesday 1 September. I have spent my first few weeks gaining an understanding of the Service and meeting staff and volunteers from across the whole organisation.

1.2. Our Chief Operating Officer and Deputy Chief Executive Officer, Khadir Meer, will be leaving the Trust on Friday 24 September. I would like to extend a huge thanks to Khadir for his dedicated service to LAS over the last two years and for all the support he has given me in my first few weeks. I am currently in discussion with executive colleagues and the Board about plans to cover his portfolio.

Meeting our teams

2. Our people

2.1. I would firstly like to express my sincere condolences following the deaths of two colleagues. Sadly Orin Clarke from our Make Ready team who passed away on Sunday 22 August with COVID-19. Orin worked for us since June 2017 and will be remembered and dearly missed by his colleagues at Edmonton Make Ready Hub and other across the Service. I was also sad to announce in September that Debbie Baldwin, one of our volunteer Emergency Responders, had died. Debbie joined the Emergency Responder team in 2015 and worked out of Croydon and then Bromley. Debbie was a very popular volunteer and donated hundreds of hours of her team each year to the Service. She will be missed by all of her colleagues and our thoughts are with her family and friends.

2.2. During my first few weeks I have had the opportunity to meet a range of colleagues from across the organisation and I have seen first-hand just how hard our staff and volunteers are working to provide urgent and emergency care within London.

2.3. I have spent time meeting colleagues within our 999 Emergency Operations Centres (EOCs) and our 111 Integrated Urgent Care (IUC) call centres to see the first vital steps taken when a call is received by our staff. By listening to calls, speaking with our ambulance dispatchers and spending time with clinicians in our Clinical Hub (CHUB) and Clinical Assessment Service (CAS), I have been able to see the work being done to help ensure our patients are receiving the right care in the right place.

2.4. Patient care was also at the forefront of the three 'ride-outs' I have undertaken with teams across the capital. I spent two shifts with ambulance crews in North West and South West London, and joined the Cycle Response Unit (CRU) cycling around the West End to see how we reach patients in the more pedestrianised parts of London. During these shifts, I had the opportunity to meet colleagues at ambulance stations and on hospital 'ramps' to discuss hear about the things they are proud of, the challenges they face in their work and their ideas for improvements.

2.5. Along with our frontline teams, I have also been able to meet colleagues from a number of our 'behind the scenes' teams who keep the Service running, including those within our workshops who keep our ambulances on the road and our Make Ready teams who ensure our vehicles are fully prepped and ready to help patients. I also had the pleasure of attending the LAS Historic Collection open day and toured, with the Board, some of our newer sites, including the new logistics hub in Rainham, medicines packing unit in Hither Green and new EOC (north) and training centre in Newham.

2.6. All these experiences have given me a huge insight into the work our staff and volunteers are doing to ensure we can be there for when Londoners need us most, and I have been privileged to read a number of the thank you letters and emails our staff and volunteers have received from patients. You can see below (figure 1) the number of thank you letters and emails to our staff and volunteers which we have received from January to July 2021. I am delighted to see that 600 members of the public have taken the time to thank nearly 5,000 members of our staff and volunteers in 2021. When the information provided by patients makes it possible, we share these messages with the staff and volunteers mentioned.

Year	Month	Logged	Financial YTD total	Number of staff and volunteers thanked	Financial YTD
2021	January	113	1245	272	2986
2021	February	84	1329	177	3163
2021	March	103	1432	272	3435
2021	April	103	103	197	197
2021	May	38	141	91	288
2021	June	136	411	321	938
2021	July	54	465	131	1069

Figure 1

2.7. As part of LAS's response to the COVID-19 pandemic, we reduced the number of ambulance stations we had open from 68 to 33. Doing this allowed made it easier for us to distribute PPE and other materials, as well as with the movement, cleaning and restocking of ambulances and other vehicles. We could also provide increased managerial support to our staff and volunteers. We subsequently reopened eight stations in June 2020 and five more earlier this year.

2.8. Since I started with LAS, I have had significant feedback from staff and volunteers requesting that we reopen more of the closed ambulance stations to relieve pressure, especially as we recruit more staff over the coming months.

2.9. Based on the advice of our ADOs (assistant directors of operations) and LGMs (location group managers), we will be reopening the following stations. These stations were selected because they will have many crews working from them and they are in strategic locations.

- Coulsdon (SW sector)
- Feltham (NW)
- Greenford (NW)
- Mottingham (SE)
- Romford (NE)
- St Paul's Cray (SE)
- Walthamstow (NE).

2.10. Based on feedback from ADOs and LGMs, the remaining stations (11) will continue to remain closed. Doing this reduces the burden of moving equipment and supplies, as well as vehicles, to as many sites during the ongoing pressures. Moreover, these stations are the ones where fewest crews were based and where the buildings and estate are the poorest, which makes it particularly hard to install secure drugs rooms or where the access arrangements are difficult.

2.11. I would like to thank our staff and volunteers for their flexibility and patience over the last 18 months. I know it has been challenging. I would also like to thank the operational support teams who are going to need to mobilise additional resource to support this change, including logistics, pharmacy and fleet.

Improvements

3. Our patients

3.1. Throughout my visits, I've been able to see how colleagues have been driving change across the Service to improve the care we can provide for our patients, as well as the working environment for colleagues.

3.2. The Trust Board recently undertook a visit around some of our new estate locations. This included our new education facility at Newham which is home to simulation rooms and a learning research centre.

3.3. We also visited our new Medicines Packing Unit in Hither Green and Logistics Supply Unit in Rainham which will soon coordinate all the preparation and logistical movements of our equipment across London. The state of the art facilities will improve our efficiency and processes, helping to ensure our staff, volunteers and vehicles have the equipment they need more quickly and more effectively.

4. Recognition

4.1. I am pleased to share that some of those teams driving change have been recognised on the national stage for excellence. I would like to congratulate the following for their success in the awards this summer:

Mental Health Team	Winners/Highly commended/shortlisted in the Mental Health Service Redesign Initiative at the Health Service Journal (HSJ) Value Awards 2021.
Integrated Patient Care Directorate	Shortlisted in at the HSJ Value Awards the Unexpected Innovation Awards for their collaboration with Barts Health for the Barts Emergency Access Coordination Hub (BEACH) integration programme.
End of Life Care team	National winners of the Excellence in Urgent and Emergency Care Award at the NHS Parliamentary Awards
One London	Winners at the HSJ Value Awards for the IT & Digital Innovation Award, a collaboration of London's 5 STPs/ICSs, 3 AHSNs, London Ambulance Service and Greater London Authority for implementing a London-wide shared care record
Physician Response Unit	Highly commended at the HSJ Value Awards for Urgent and Emergency Care Initiative of the Year taking medicine into the community. Barts Health Trust, London's Air Ambulance Charity and London Ambulance Service.

4.2. I would also like to congratulate our communications team on being shortlisted for the NHS Communicate Awards for the way they communicated and engaged with staff and volunteers during the COVID-19 pandemic. The awards, which are organised by NHS Providers and the NHS Confederation, will be announced on Thursday 17 September. The nominated recognises the innovative way the team worked during COVID-19, including the introduction of LAS TV Live.

4.3. Congratulations also to those who have been recognised this summer for their outstanding service at LAS. I would like to express a huge congratulations to one of our Paramedics,

Gary Edwards, who has been awarded the LAS Chief Executive's Commendation award for his exceptional courage and bravery in the London Bridge terror attack.

4.4. I was proud to join the Chair and a number of colleagues at the City of London's 999 Day event in Guildhall on Thursday 9 September. We stood alongside our emergency service partners and held a two minute's silence to remember those who we have sadly lost over the last year and to pay tribute to all those working in the emergency services across London.

5. Supporting careers at LAS

5.1. Investing in our people is one of the Trust's priorities, and I have been in awe of the range of opportunities available to LAS staff to enhance their skills and expertise with the Service.

5.2. I was thrilled to hear that the NatWest Group has agreed apprenticeship funding to help support over 200 staff wanting to further develop their careers on the frontline. This month I was also excited to see the launch of our new BSc (Hons) Paramedic Science course in partnership with Buckinghamshire New University which will help us meet the strategic national workforce development priorities for the sector.

6. South West London Integrated Urgent Care/111

6.1. I am pleased to announce in line with our strategic objective to become London's primary integrator of urgent and emergency care that LAS will be taking on a proportion of South West London (SWL) NHS 111 calls to support South West London Urgent and Emergency Care system resilience and NHS 111 performance. This is an important step in delivering the Trust's strategy and our Chief Operating Officer's report goes into further detail.

7. Reflection

7.1. Reflecting on my first month with LAS, I have been overwhelmed with admiration for the 9,000 members of staff and volunteers – from call handlers and ambulance crews to fleet teams and corporate staff – who have so candidly shared their experiences with me about their time working for the Service. Gaining this broad understanding of all our teams and the challenges they are facing will be a huge help in informing me as I continue the work that has started to transform the culture of our organisation.

The Board is asked to note this report.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Report from Chief Operating Officer			
Agenda item:	7.			
Report Author(s):	Khadir Meer, Chief Operating Officer			
Presented by:	Khadir Meer, Chief Operating Officer			
History:	N/A			
Purpose:	☐	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

This report updates the Board on activities undertaken in COO Directorates since the last meeting and draws the Board's attention to any other issues of significance or interest.

Recommendation / Decisions for the Board:

The Trust Board is asked to note the content of the report.

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

Report from Chief Operating Officer

1 EXECUTIVE SUMMARY

Further to the last update to the Board in July 2021, the directorates within the COO Group have been primarily focused on continued delivery of operational performance, whilst significant and increased levels of patient demand remains and the Trust continues to operate at REAP 4 (extreme pressure). In the coming weeks and months, the Executive will be setting out the plans to ensure there are robust preparations in place in advance of the upcoming winter period.

As this is my final report as the Chief Operating Officer and Deputy Chief Executive, I would like to take the opportunity to recognise the immense achievements and progress made by the Trust over the past two years. The Trust has not only risen to, and met, the challenges faced by the global pandemic but has also delivered significant transformation in estates, infrastructure, workforce growth and workforce leadership. Whilst a huge amount of work remains, I fundamentally believe that the Trust is stronger and better placed to respond to the needs of patients today than it was two years ago. This progress has only been made possible because of the outstanding efforts of colleagues across the service.

1.1 Maintaining Resilience

The entire urgent and emergency care sector continues to experience unprecedented levels of patient demand. This demand is being felt by ambulance services across the country. Despite these challenging circumstances, it remains our focus to provide patients a response in a timely manner and to ensure their experiences remains positive. It has been essential during this time that we maintain close working with our national ambulance service colleagues to understand the collective pressures being faced, and what action services can take to mitigate risk and maintain safe care when under such exceptional pressure.

The three summer months of 2021 were all in the top five busiest months in the Trust's history. Our forecast and planning data suggests this level of demand will be sustained right through to winter. We expect 111 demand to remain significantly above funded levels, and 999 calls expected to reach over 6500 per day – over and above the pre-covid average of 5000 per day. The Trust has developed a number of sustainable proposals that can be mobilised and implemented quickly and these will form the basis of this year's winter plan.

This will include the likelihood of a further Covid wave in December. High-level details of these plans can be found in the relevant directorate updates below.

Whilst national performance targets is our barometer to determine how the Trust is providing timely care, our focus has been on: delivering safe patient care; progressing at pace the innovative plans to support and better manage incoming demand; rapidly increasing our operational capacity; and where we can, positively influencing and reducing the currently delays experienced at hospitals.

Based on national ambulance data in August, the LAS performance within the context of the wider ambulance sector was as below:

- Ranked the **top performing** Trust against the Category 1 average mean
- Received the **second highest** proportion of Category 2 calls nationally
- Performed **above the average** mean for Category 2 calls across all ambulance services

1.2 Our journey towards recovery

Whilst recovery to the 'new normal' will be important, the Trust is still focussed on the present and delivering plans to maintain service resilience in the short-to-medium term, especially as continued surges in demand are expected. Once forecast demand begins to show stabilisation, this will be the opportunity for the Trust to revisit and rethink how it will return to business as usual operations through the leadership of our new Chief Executive, Daniel Elkeles.

1.3 Responding to our staff

As per the previous report, our focus on staff wellbeing and safe return to work is a key priority. We continue to focus on providing the following support to our staff and managers:

- Ensuring that all our staff and volunteers feel supported is paramount, and our dedicated **Wellbeing Hub** continues to provide staff with tailored support and guidance and ensuring there is easy access to relevant health and wellbeing resources.
- Release of the revised **agile working policy** for corporate staff and providing guidance on the safe return to working at our corporate sites at Waterloo HQ and Pocock Street.
- Supporting the NHS England directive to ensure all NHS employees participate in the **Covid vaccine programme and lateral flow testing** to help keep colleagues and

patients safe from COVID-19. This was previously focussed on our operational staff, but is being encouraged for all staff across the organisation. To date 94% of LAS frontline staff have engaged with the vaccine process.

- Following the request from front line clinicians, the Trust has invested in and made available disposable **FFP3 Personal Protective Equipment (PPE) masks,** in addition to existing reusable personal issue FFP3 mask, to improve on-scene communication and comfort whilst wearing PPE.
- Clear guidance and support to all colleagues on **managing absences**, particularly around the need to isolate and managing short and long term illnesses. Our aim is reduce current absence levels of 8% to 6% by March 2022.
- Ongoing availability of **Tea Trucks** to give staff and volunteers a chance to have a pause, chat and refresh whilst out on shift.

1.4 To refocus on our strategic ambitions

The Trust continues to press ahead to deliver actions that remain aligned with our strategic ambitions. Key areas of progress has been made in the following areas this quarter:

- The Trust is continuing to deliver our **strategic ambition to be the primary integrator of urgent and emergency care services in London**. The next step on this journey has been to take on management of a proportion of South West London NHS 111 calls from September, as a step-in arrangement to support South West London Urgent & Emergency Care (SWL U&EC) 111 system resilience ahead of the winter period.
- **Construction at our new Logistic Packing Unit commenced** at Rainham are progressing well and delivering within the approved capital financial envelope, with the operational go-live still on track for the end of September.
- Completion of the **Medicines Packing Unit** site based in Lewisham remains on course for a go-live date in mid October, providing the Trust with a compliant and fit for purpose medicines and storage facility.

2 OPERATIONAL PERFORMANCE UPDATES

2.1 Integrated Patient Care

Directorate Updates:

- The **Dispatcher of the Year Award** highlights the fantastic values and attributes that our emergency dispatchers show every day. The award not only recognises their success from one call, but also focuses on their role within the workplace, and how they deliver excellent patient care, by going above and beyond to help others. Seven members of staff from our EOC staff were nominated for their outstanding work, in recognition of the particular challenges our control staff faced throughout the pandemic.
- In September, the Trust **mobilised NHS 111 call handling assessment in South West London (SWL)**. The agreed scope and scale of services required to support SWL has been designed to ensure that contractual agreed call volumes align to the ramp up of Trust capacity and enables future development in 2021/22:
    - The first phase includes NHS 111 call answer and assessment for 14% of SWL NHS 111 over a 24/7 hour, 7 days a week
    - The second phase due to commence in mid October will include NHS 111 clinical consultation of category 3 & 4 ambulance validation and *5 clinical response for 6% of SWL NHS 111 over a 24/7 hour, 7 days a week profile

Performance Update:

Indicator (KPI Name)	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Trend
111/IUC (NEL) - Calls Answered within 60 sec	>95%	81.2%	87.8%	82.0%	72.0%	87.2%	
111/IUC (NEL) - Calls Abandoned within 30 sec	<3%	0.9%	3.7%	1.3%	1.0%	1.0%	
111/IUC (SEL) - Calls Answered within 60 sec	>95%	80.2%	85.9%	81.3%	72.6%	86.4%	
111/IUC (SEL) - Calls Abandoned within 30 sec	<3%	3.9%	10.4%	5.1%	4.8%	9.0%	
111/IUC (NWL) - Calls Answered within 60 sec	>95%	80.9%	74.3%	58.8%	47.2%	70.0%	
111/IUC (NWL) - Calls Abandoned within 30 sec	<3%	1.1%	5.8%	1.4%	1.6%	1.8%	
999 Mean Answering Time	<5 secs	0	10	17	51	27	

We have seen **levels of demand across our 111 services in North East, South East and North West London tracking significantly above long term forecasts** since April 2021, and is forecast to remain significantly above the respective contract through winter.

In addition to the actions being progressed by Integrated Patient Care Directorate to maintain service resilience as part of surge plans, there have been a number of other initiatives being progressed to address the high levels of patient call demand. These include:

- **A pilot to evaluate the effectiveness of a clinical assessment being carried out on specific Category 2 disposition codes** to determine whether a different response is more suitable and therefore will preserve our frontline vehicles for the most urgent patients. Through this initiative we have been able to assess over 35% of Category 2 calls across three specific disposition codes. Of these calls, we have closed up to 10% of clinically assessed calls with hear and treat, closing 25-30% of calls with see and treat, and over 50% to see and convey to ED/non-ED. There will be continued review of this pilot, and consideration as to whether this opportunity can be extended further.
- **Enhancing 111 *5** capacity in order to support our crews on scene in arranging a direct GP referral rather than convey the patient to hospital.
- A review of **referral criteria for the Healthcare Professionals Line** in order to provide guidance to GPs and other healthcare professions when to use the direct line to the Trust and to advise the **alternative transport options** that may be available.
- Exploration of resources to enable **increase usage for alternative transport options**, such as non emergency transport or taxis, when deemed clinically appropriate
- **Accelerating recruitment activity** in order to increase establishment levels this year:
    - **111 health advisors** will rise from 276 wte to 396 wte (+120), an increase of 43% on last year's establishment.
    - **999 (all staff)** will rise from 539 wte to 608 wte (+69), an increase of 12% on last year's establishment
    - **Clinicians in the 999 Clinical Hub** will rise from 87 wte to 134 wte (+47), an increase of 55% on last year's establishment

2.2 Ambulance Services

Directorate Updates:

- A special thanks to our colleagues who played an important role in August providing medical support and offering a reassuring presence to people arriving at **Heathrow Airport from Afghanistan.**
- Ambulance Services within LAS have recently been recognised in a joint report by the Association of Ambulance Chief Executives and NHS Providers, on managing the long-term impact of COVID-19 and transforming urgent and emergency care (UEC) services and delivering the NHS long-term plan. The two LAS pioneering initiatives LAS have been recognised for is the **Barts Emergency Access Coordination Hub (BEACH)** integration programme and the **Advanced Paramedic Practitioners in Urgent Care.**

- The LAS Emergency Preparedness Resilience and Response Team have led national work in the development and agreement for **local training for Hazardous Area Response Team (HART) operatives** to ensure we maintain resilience of our specialist assets in the event of a major incident. This approach will be adopted by other ambulance services across the country.
- Although the Trust has been subject to extreme operational pressures, specialist training has been protected to ensure **78 front line clinician have been dually trained** to attend incidents relating to Chemical, Biological, Radiological, Nuclear, and Explosives (CBRN) and Marauding terrorist attacks (MTA).

Performance Update:

Indicator (KPI Name)	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Trend
Category 1 Response - Mean	7 mins	00:05:38	00:06:05	00:06:33	00:06:59	00:06:57	
Category 2 Response - Mean	18 mins	00:16:32	00:20:00	00:27:00	00:39:50	00:39:15	
Category 3 Response - 90th Centile	120 mins	01:48:44	02:27:00	03:26:03	04:27:12	04:13:08	
Category 4 Response - 90th Centile	180 mins	04:14:41	05:12:48	07:19:39	07:47:25	07:36:45	

Historic trends indicate an increase in demand during December and January plus there is a risk of a further Covid-19 wave, where the number of contacts in our Emergency Control Room could peak above 7000 contacts per day, which is in excess of the highest number of contacts previously experienced of 5000 contacts per day in 2015.

In addition to the actions being progressed by Ambulance Services to maintain service resilience as part of surge plans, there have been a number of other initiatives being progressed to improve responsiveness and reduce hospital handover delays. This includes:

- **Increasing the Ambulance clinical workforce** from 3363 to 3741 wte (+378 wte), an increase of 11% on last year's establishment.
- **Mobilising 97 final year Paramedic Students** following the completion of their training in mid-September, allowing them to be available for frontline shifts via the Trust bank.
- **Continued support on the frontline from our blue light service colleagues** in the Metropolitan Police and London Fire Brigade, and usage of an external provider to supplement our blue light driving capacity up to 162 wte.
- **Enhancing our rotas through continued use of twilight shifts** between 1500 – 0300 hours, which has had a positive impact on reducing the congestion of frontline crew availability between the changeover times from early to evening shifts.
- Employing enhanced **dispatch principles** to ensure the right number of clinical resources are sent to patients to ensure they receive the appropriate level of care, reducing the need for multiple clinicians to attend on scene where it is not necessary

- Agreement with CEOs across all London hospitals to **standardise ED access codes to Emergency Departments** to improve the timeliness of patient handover at hospitals. As our staff work across a wide geography, they can end up in areas where they may not be as familiar with local processes and struggle with access to EDs that they do not regularly attend.

2.3 Strategic Assets and Property

Directorate Updates:

- The Directorate held the **inaugural Length of Service Award Ceremony** in recognition of the dedicated and valuable contribution made by colleagues to the Trust over many years.
- The performance of the department has, and continues to, forge forward to provide a safe work environment for staff, visitors and contractors alike. **Statutory compliance across the Service has improved significantly** and full Trust wide compliance has been achieved.

Fleet and Supply & Distribution

Measureable	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Trend
Total Number of Ambulances in Service	450	532	542	542	542	541	532	532	533	
Rostered Hrs. Covered at Workshops incl. Overtime hrs.	>90%	101%	99%	96%	100%	96%	96%	N/A	N/A	
Out Of Service (OOS) due to No Vehicle (hrs)	<1%	0.06%	0.06%	0.03%	0.02%	0.02%	0.09%	0.03%	0.03%	
Average number of DCAs unavailable due to Road Traffic Collisions (RTC) per day	<15	16.3	18.1	17.1	15.8	12.5	11.0	12.0	16.5	

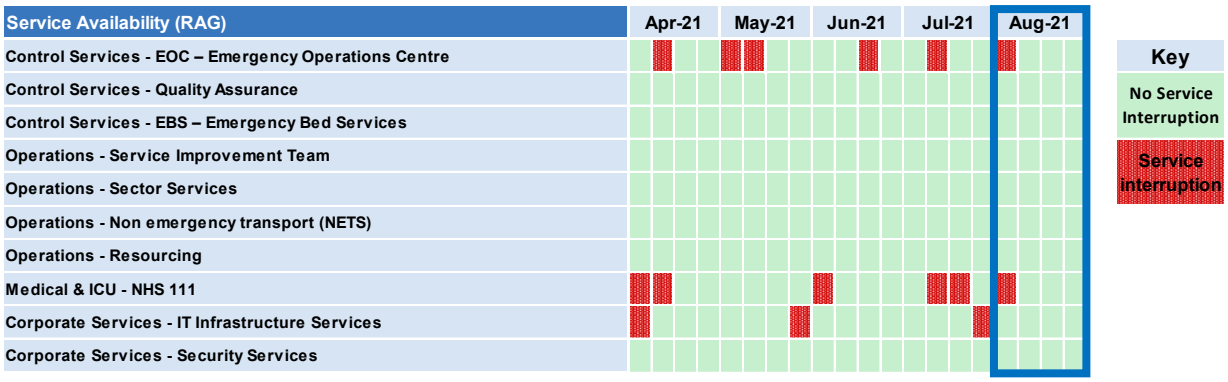
- We continually work alongside our operational colleagues to understand the Trust demand and subsequent requirements on the department, including **robust monitoring of the double crewed ambulance availability** to maximise availability of vehicles at the start of shift for operational crews.
- The **crew safety system project** includes the installation of telematics and camera systems onto double crewed ambulances and this will see this system fitted to 300 vehicles due for complete roll out by the end of September.
- The **increase in double crewed ambulances unavailable due to road traffic collisions** is under urgent review to ensure frontline vehicles are returned to service in a timely manner and in line with agreed contractor service level agreements.

Estates

Compliance dashboard	Description	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Trend
Fire Risk Assessment	Fire risk assessments carried out annually per high risk site.(carreid out by H&S) A report is provided on the number of risks at each site. For lower risk sites this is done every 3 years.	100%	100%	100%	100%	100%	
Fire Alarm Tests	The alarm system is to be tested weekly by site management per site (not included in this compliance requirement as it is covered by H&S). A qualified engineer must run test bianually. This includes software updates and a silent alarm test. The numbers reported here relate to the biannual test.	89%	100%	100%	100%	99%	
Fire Fighting Equipment	Check of all fire fighting equipment must be carried out biannually (Fire extinguishers are anually, gas supression / sprinklers bianually)	96%	97%	100%	100%	100%	
Fire Drill	Carry out an annual fire drill at each site. (carreid out by H&S)	37%	50%	63%	68%	68%	
PAT Testing	All items tested annually	100%	100%	100%	100%	100%	
Asbestos	Sites have an up to date Asbestos survey. Time period can vary but needs to be reviewed annually	96%	26%	27%	100%	100%	
Emergency Lighting	Anually a complete discharge - all emergency lights are turned on and time how long the batteries last. Biannually a flash test is also carried out which turns the lights on and off.	96%	92%	100%	96%	96%	
Legionella Risk Assessments	Weekly temperature check per site and take remedial action if required. Tank Temperature Check needs to be conducted biannually. Scaling check - once per quarter	97%	100%	100%	99%	99%	
Lightning Protection	Annual test - per site	100%	100%	100%	100%	100%	
Gas Appliance Testing	Gas appliance testing. Annual test	73%	100%	100%	100%	95%	
Pressure Vessels	Insurance inspection by contractor and Allianz. Inspection annually. Fleet undertake this safety check	100%	100%	100%	100%	100%	
Diesel Tank Maintenance	Biannual check on tanks	100%	50%	50%	100%	100%	
Tyre Compressors	Insurance inspection for compressors. Annual Test	100%	100%	100%	100%	100%	
Lifts, Hoists & Cradles	Allianz inspector and contractor - put equipment through a test biannually	99%	100%	100%	100%	100%	
Air Conditioning	Service operational sites (999 Control rooms / 111 control) rooms - biannually Office spaces - annually	99%	82%	91%	97%	85%	
Fixed Wire Testing	Five yearly check of fixed wires	85%	90%	92%	92%	92%	
Waste Pre-Acceptance Audit	5 yearly check for each site. Spot checks also done. More than 500,000kg annual audit	100%	100%	100%	100%	100%	
Waste Audit - DGSA Audit	In depth - annual audit	100%	100%	100%	100%	100%	

- The Health and Safety team are refocussing their attention on **fire drills** to bring compliance to required levels.
- Going forward with scheduling, the **planning and timing of statutory tests** and checks will be brought forward to ensure new current valid certification has been received before expiry of the preceding compliance documentation. This will therefore increase frequency of testing however, trust wide compliance will be achieved and maintained.

2.4 IM&T



Directorate Updates:

- The LAS in partnership with NHS England and London ICS was awarded the **IT & Digital Innovation Award at the HSJ Value Awards** for their work with the #OneLondon collaboration - implementing a London-wide shared care record to transform London's health and care services through the join-up of information to support faster, safer, more effective care.
- In late August the Trust marked one year since we saw our first ever patient using **electronic Patient Care Record (ePCR)**, and since its introduction we have seen uptake of over 94% of our clinicians routinely using ePCR.
- The Trust experienced a technical issue with the CAD system in September due to an external connection failure, which was recovered quickly and a review commissioned to understand the baseline cause and steps to maintain system resilience.

2.5 Programmes and Projects (P&P)

Directorate Updates:

- In August, the **Trust Board attended a site visit** of all the key estate infrastructure programmes currently underway, including the Medicines Packing Unit in Lewisham, Logistics Supply Unit in Rainham, the current Hub 1 site in Dagenham, and the site in Newham which houses one of our new Education Centre and the Trust's second 999 Emergency Operations Centre site.
- The current programme portfolio is **on track to deliver 39 projects in FY21/22**. To date 17 project have gone live and there are a further 22 projects in flight, with the majority due to go live across the next six months.

- Since the last Board in July, the following projects have been launched:
    - Implementation of a cloud-based **Central Asset Management System** for asset management and central stock control of Clinical Consumables and Standard Clinical Equipment
    - Implementation of an **Automated Temperature Monitoring System** to ensure all medicines used in LAS are maintained in line with manufacturers' temperature specifications, and effective when administered to any of the patients we serve.
    - Trust Wide rollout of the **HR ESR Manager Self Service** functionality which enables managers across the Trust to view information and compliance about their staff, complete tasks directly in the system and carry out reporting
    - **Directory Manager**, which is an IT system that integrates with the ESR system and other systems that provide identity information, needed to automate handling of joiners, movers and leavers.
- September is expected to see are largest number of projects going live, including:
    - Delivery of the new **Logistics Supply Unit** and the new **Medicines Packing Unit**
    - Installation of a new **Crew Safety System** into vehicles capable of capturing, tracking and monitoring activity to provide a mechanism for safeguarding our staff and patients, and managing fleet and assets.
    - **Replacement of some of the Trusts oldest vehicles** and utilisation of available stock for improved, dedicated IRO vehicles to contribute towards ULEZ compliance of the fleet, and provide a more reliable service and improve levels of patient care.
    - **Satellite Navigation Upgrade** to replace obsolete units that use outdated maps
    - Creation of a dedicated and fit-for-purpose space for **Special Operations Centre** on of Waterloo HQ which has been shown to deliver material and measurable benefits to the Trust and patient care.
    - **Critical replacement** of the UPS (Uninterrupted Power Supply) and Generator at Waterloo HQ
- Delays due to the unavailability of construction materials have pushed the completion of the construction element of **Newham EOC** from September to November, with the expectation that full occupation will be completed by March 2022.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	Thursday 23 September 2021			
Report title:	Integrated Performance Report			
Agenda item:	8			
Report Authors:	Key Leads from Quality, Finance, Workforce and Operations			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	N/A			
Purpose:	☒	Assurance	☒	Approval
	☒	Discussion	☐	Noting

Key Points, Issues and Risks for the Board'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 page in the report.

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

Recommendations for the Board:

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

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes	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 Affairs	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 2021** 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 report (July 2021)

Provide outstanding care for **our patients**

999 Performance in national measures were challenged in July 2021. The Trust saw a sustained pressure in 999 calls and face to face incidents as a response to the end of lockdown and warmer weather. Despite this, nationally the Trust was 1st in C1 mean and 3rd in C3 90th centile. The C2 mean continues to be challenged in July, where nationally we finished 7th, and 8th in C4 90th centile. Work to improve these positions is ongoing , with a sustained focus on improving staffing levels while facing difficulties due to isolations and sickness and continuing our recruitment work streams.

111 Performance on calls answered within 60 seconds SLA and abandonment rates were outside target for North East London (NEL), South East London (SEL) and North West London (NWL) due to increased demand for 111 service. Despite being outside the national target, the Trust has achieved 1st and 2nd place for Call Answering and Calls Abandoned for North East London and South East London. We were outside target for calls closed with no onward referrals for all sites.

- *NEL/SEL have shown reduced performance in call answering. This resulted in a review of the forecasts moving forward and increased responsiveness in the form of staffing changes.*
- *Trust leadership are focused on responding to sustained increased demand due to warmer weather, the summer holiday period and increased Covid-19 calls. The Trust is working closely with system partners to respond to the ongoing challenges.*
- *Sustained focus with plans being formalised for the preparedness of additional Covid-19 demand incorporated with forecasted Winter activity.*

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

In July the P&C team have continued to support frontline colleagues with their staffing requirements and are reporting positive staffing in EOC and are on-track to achieve a full call handling establishment in October for IUC. Whilst Ambulance Operations are currently behind plan, an additional 100 TEAC courses should help to bring this back on plan. The turnover rate has remained stable and is below the level for the same period last year. Increases in MSK in July have seen an increase in the overall sickness rates and HRBPs are working with managers to support colleagues to return to work. The REAP 4 pressure levels have continued to affect performance in July for Statutory and Mandatory training (which has remained stable but below target) and PDR rates (which have reduced and are below target).

- *Resolution Framework now implemented*
- *Supporting managers in managing Covid absence and returning colleagues back to work. Additionally focussed work on returning long term absentees to work across the organisation.*
- *The well-being team are working with PAM to improve the access to counselling services and have been heavily promoting 'Keeping Well – NWL'.*
- *Secured £132k Health Education England (HEE) funding to support collaborative learning and development opportunities across corporate services teams.*

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

As of M4, the Trust is reporting a YTD deficit of £1.181m (£1.161m deficit on an adjusted financial performance basis) which is behind plan. Significant additional expenditure is being incurred to respond to operational pressures in Ambulance Services (overtime and secondees), and in the Trust's 111 Integrated Urgent Care Service (external resource, agency and overtime), but is currently partially offset by lower than planned recruit numbers and vacancies. Total COVID costs YTD (excluding centrally provided consumables and equipment) are £19.6m primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, as well as associated operational support services.

Capital spend net of disposals and excluding donated assets was £7.1m YTD (full year forecast £26.2m up from the planned position of £21.4m following identification of additional CRL through NW London partners) the bulk of which comprised of spend on ongoing property projects, and the month end cash position was £31.4m.

- *At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6 including fixed income envelopes which are being managed at STP or ICS level and incorporating Cost Improvement Programmes. Other contracting and commissioning processes (including CQUIN) remain paused.*
- *For the first half of the year the Trust is planning a £25k deficit (breakeven on an adjusted financial performance basis) as agreed with NW London partners, and this planning includes a CIP target of £4m.*

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

Work is ongoing to improve on our Patient handover metric through continuous dialogue with hospital management teams pan London, particularly in the North East and North Central sectors. During the month of July the handover to green metric was within the target of 15.5 minutes at 15.1 minutes. ED conveyance during July was in a good position, continuing on the trend from June.

The Trust performance for Hear & Treat was ranked 1st nationally for July, continuing in the top position from June. The Trust ranked 4th for ED conveyance. It is worth mentioning that the variance between Ambulance Trusts for this metric is small, with the Trust just finishing at 1% lower than the Trust that ranked 1st.

- *ED conveyance performance in July was within target at 47.9% against the agreed contract figure of 57%*
- *Hear & Treat performance saw us achieve 16.5% during July, which is significantly better against the same month last year where we attained 9.2%*
- *Trust continues to work with system partners to improve on these metrics, both of which are included in the LAS Business Plan for 2020/21. Significant progress has been made.*

Trust-Wide Scorecard - 999

Patients Scorecard

July 2021

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-21	G	07:00	A	00:06:59	00:06:23	00:06:02	08:33	06:59	1
Category 1 response - 90th centile	mm:ss	Jul-21	G	15:00	A	00:11:49	00:10:48	00:10:14	15:15	11:49	1
Category 1T response – 90th centile	mm:ss	Jul-21	G	30:00	N	00:18:43	00:17:18	00:16:04			
Category 2 response – Mean	mm:ss	Jul-21	R	18:00	A	00:39:50	00:26:09	00:23:45	41:04	20:09	7
Category 2 response - 90th centile	mm:ss	Jul-21	R	40:00	A	01:26:27	00:57:58	00:50:53	01:27:44	00:41:08	7
Category 3 response – Mean	h:mm:ss	Jul-21	R	1:00:00	A	01:45:04	01:12:30	00:56:48	02:33:43	00:49:53	2
Category 3 response - 90th centile	h:mm:ss	Jul-21	R	2:00:00	A	04:27:08	02:59:11	02:14:29	06:20:48	01:54:34	3
Category 4 response - 90th centile	h:mm:ss	Jul-21	R	3:00:00	A	07:46:39	06:24:18	04:41:33	06:52:02	02:48:45	8
Call Answering Time - 90th centile	ss	Jul-21	R	4	I	193	83	36			
ROSC at Hospital	%	Apr-21	R	31%	N	27.8%	27.8%	27.3%	27.2%	32.1%	6
Severe Sepsis Compliance - (national AQI reported quarterly)	%	Mar-21	R	95.0%		91.0%	92.8%	92.8%	83.5%	91.0%	1

*National average YTD

Benchmarking Key
Top 3
Ranked 4-7
Ranked 7+

Please note: 999 performance data is correct as at 16/08/21 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

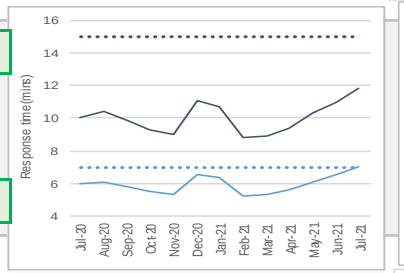
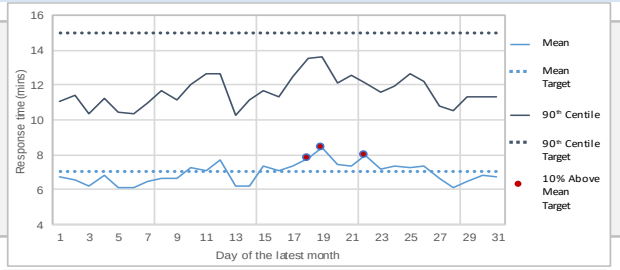
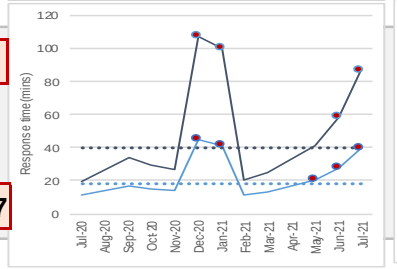
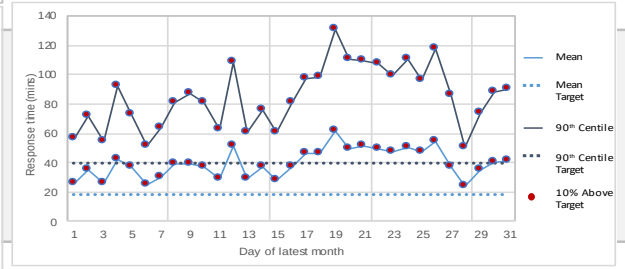
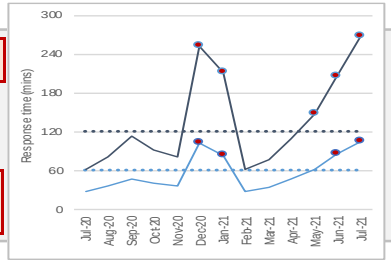
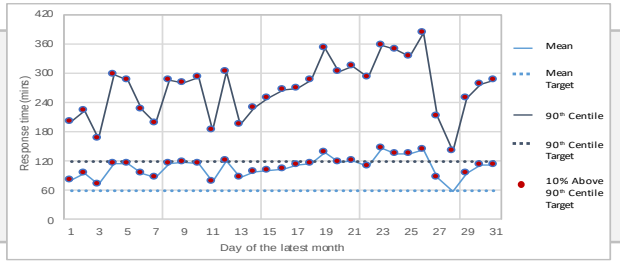
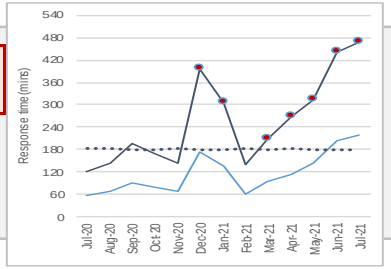
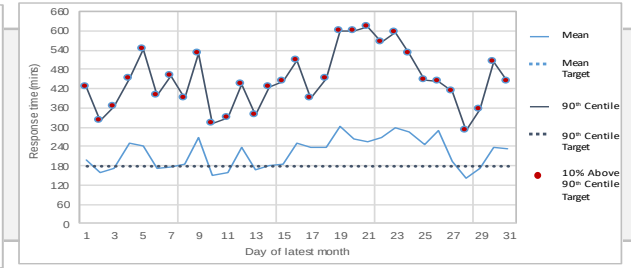
*Note: **Sepsis** is measured quarterly*

1. Our Patients

999 Response Time Performance

The Category 1 mean in July returned 6 minutes and 59 seconds while the Category 1 90th centile was 11 minutes and 49 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. The latest nationally published data shows that the Trust is ranked first in the Category 1 mean measure and ranked first in the Category 1 90th centile measure when compared to all Ambulance Trusts across England. The result of no restrictions, London returning to normal activities and warm weather throughout the country has seen an impact on our demand across the performance categories.

Please note: 999 performance data is correct as at 16/08/21 and is subject to change due to data validation processes

		Monthly Trend	Daily Analysis	
C1	**Mean: 6:59** Target: 7:00 **90th Centile: 11:49**			The C1 mean performance had been continuously within target, apart form the peaks of Covid demand through December 2020 – January 2021. Throughout July, the target was met despite an increase in demand. The C1 90th centile was also within the national standard of 15 minutes.
C2	**Mean: 00:39:50** Target: 18:00 **90th Centile: 01:26:27**			During July 2021, our C2 mean and 90th centile were both outside target. We experienced an increase in demand due to the ease of lockdown restrictions and other challenges, making it harder to reach patients within national targets, particularly in specific areas of London where hospitals were experiencing their own challenges.
C3	**Mean: 01:45:04** Target: 2:00:00 **90th Centile: 04:27:08**			Both C3 mean and C3 90th centile were not within national standards. On particularly challenged days C3 follows the trend of C2 and was affected quicker than the higher acuity calls in an effort to attend sicker patients promptly.
C4	**90th Centile: 07:46:39** Target: 3:00:00			C4 90th centile was not met in July due to increased pressure on the higher categories. This category of calls was particularly impacted due to a low number with each delay having a higher impact on the overall average. Work is continuing to improve C4 by reconfiguration and realignment of rosters to best fit call demand and reviewing the process response, and the type of resource that can respond to these calls.

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.

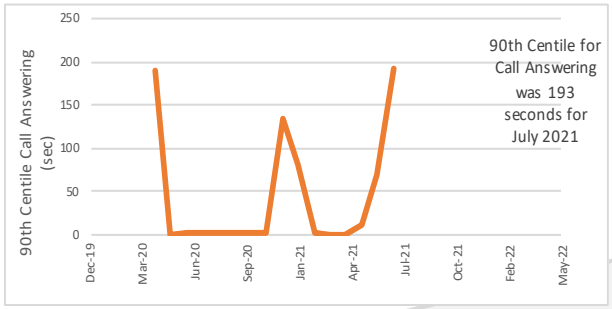
The analysis below describes: **1)** Calls Received, **2)** Incidents and Response Type (incl. Hear & Treat, See & Treat, See & Convey), **3)** Incident Category

Please note: 999 performance data is correct as at 16/08/21 and is subject to change due to data validation processes

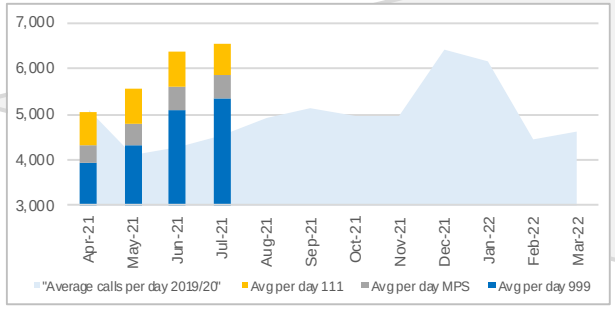
999 Calls Received

July 2021 saw a significantly higher number of calls compared to the equivalent period in 2020/21. As a result of the increased demand, call answering performance has been outside of the target on call answering 90th centile.

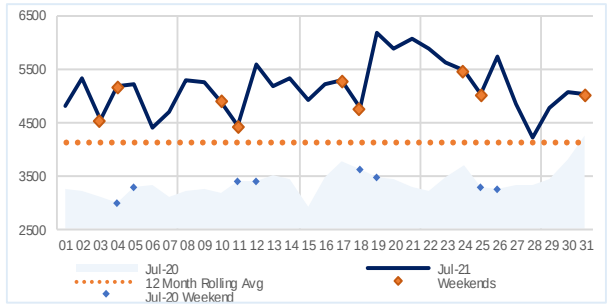
Performance (90th Centile)



Average Calls Per Day



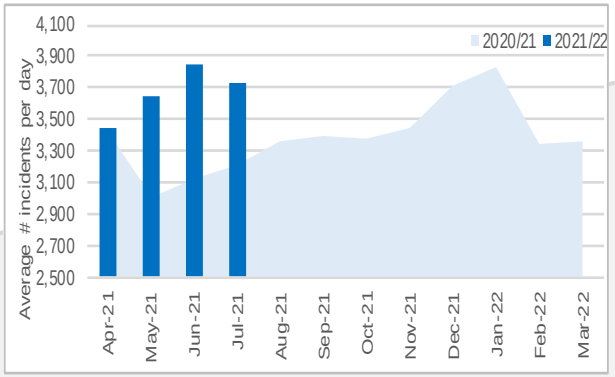
Daily Calls Answered



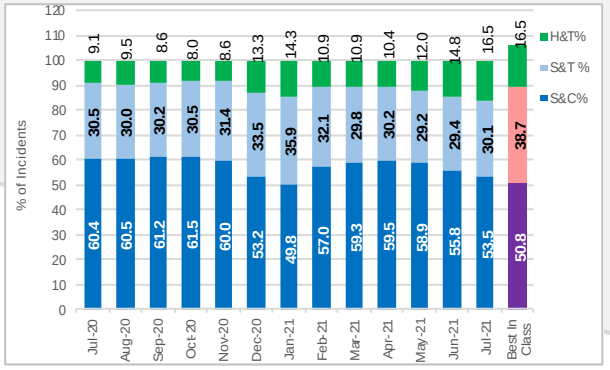
Incidents and Response Type

In July 2021 the number of incidents per day was significantly higher than in 2020/21. Performance improved for ED conveyance and Hear & Treat was better than the target due to concentrated effort on these measures.

Incidents



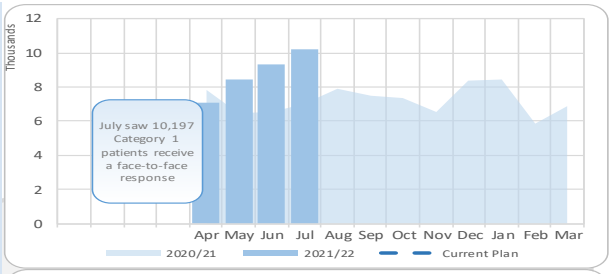
Response Type



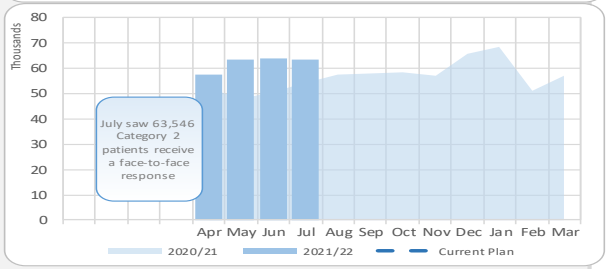
During July 2021, SWAS was best in class for both See & Treat and See & Convey categories, achieving 38.7% and 50.8% respectively. The Trust gained 1st place and was best in class for the Hear & Treat category achieving 16.5%.

Incident Category (By Month)

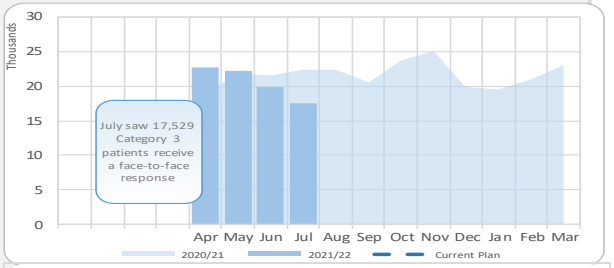
C1



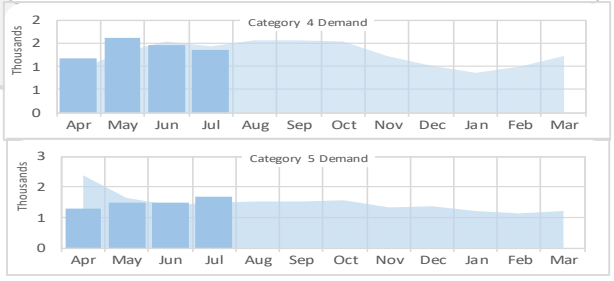
C2



C3



C4/C5

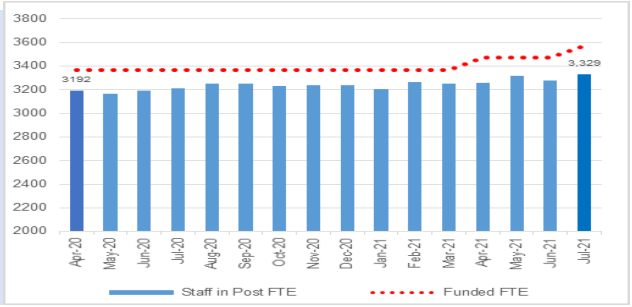


Our ability to meet this demand is dependent on our operational capacity and our ability to minimise the time that this unavailable. We consider two aspects of our capacity: our operational staff and our fleet of response vehicles.

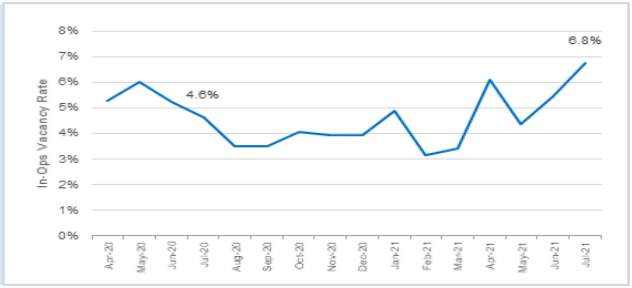
Frontline Operational Staff

The frontline FTE establishment has increased from 3,370fte to 3,770fte (400fte) to reflect the forecast demand in 2021/2022. This increase has been phased over the 12 month period (100fte per quarter). Our current operational vacancy rate as at 31st July is at 6.8% and this increase from June (5.5%) is largely due to the phased increase (100fte) in establishment this month. 118fte staff are in classroom training which includes the 28fte joiners this month. The 6.8% gap is currently being filled by overtime and will reduce through the delivery of this year's paramedic and non-registrant recruitment programme.

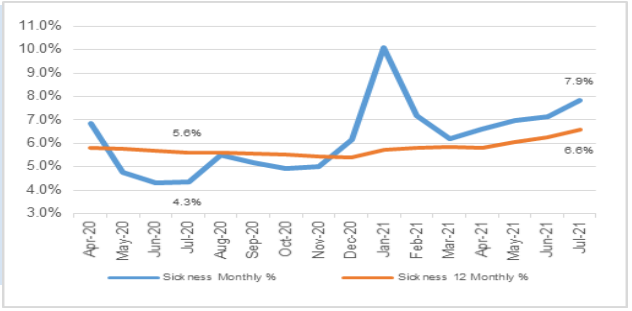
Filled FTE



Vacancy Rate



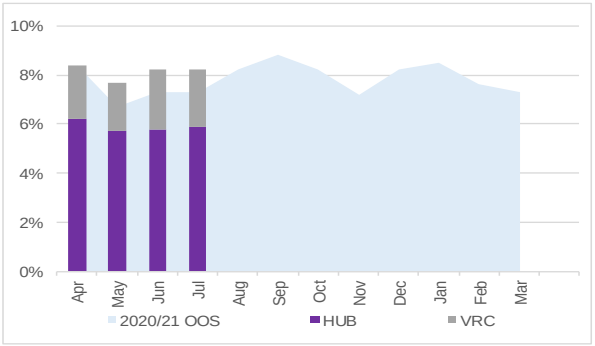
Sickness Rate



Vehicle Availability and Patient Facing Hours

Overall Out Of Service rate averaged **8.38%** for **July 2021**, a decrease of **0.02%** from the previous month. The Trust has provided an average of **9,223.5hrs** patient facing vehicle hours per day in **July 2021**, a decrease from **June 2021** which averaged **9,365hrs**. Although reduced the PVR remains a high level – June **409 >** July **390.** We do see an increase in vehicle activity due to the 1500hrs DCA overtime shift starts however this is managed within the teams keeping Out of Service for **VEHNO** below 1%. The SA&P Teams supported the Operational rotas incurring limited downtime, this is demonstrated by a healthy DCA vehicle availability. This is also evidenced in the VRC Performance reflecting a total of **71.18hrs (0.03%)** accrued against OOS category **VEHNO** (no vehicle at start of shift) against total DCA and OPC hours for July 2021 of **191,096.88hrs.** We continue to work with our external partners, **Mansfield,** who work overnight to complete vehicle repairs and boost DCA vehicle availability as well as the **VP Hospital Day Teams** who assist crew turnaround at Queens Hospital, Romford in the NE Sector. We have implemented plans to ensure we are in a state of readiness to increase the DCA availability should this be required. We maintained our PPE Stock target of 14 days stock at our distribution centre and continue to receive weekly deliveries from the NHS Push Stock. Our teams continue to respond to operational demand, working in partnership with our operational colleagues, to ensure we maximise the availability of ambulances and minimise avoidable down-time.

Out Of Service %

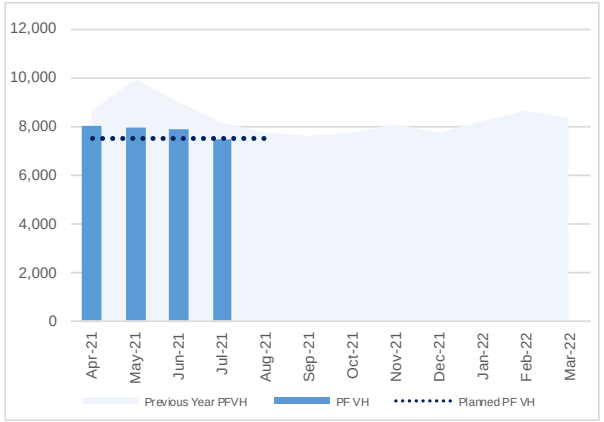


Note:

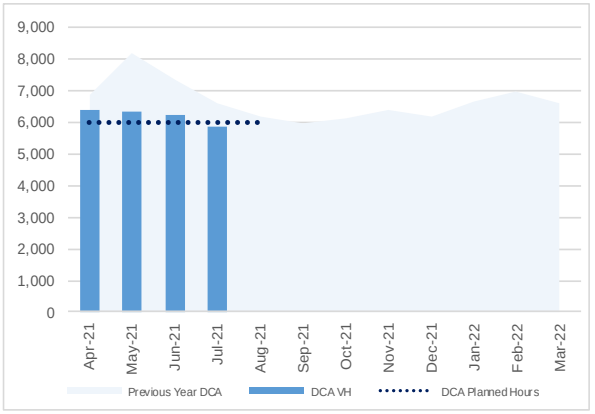
OOS HUB *- This account for out of service codes related to people/crew reasons for out of service hours*

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

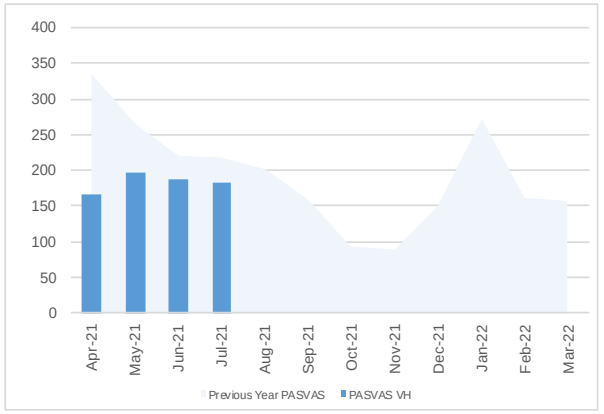
All Vehicles (Avg per day)



Ambulance Hours (Avg per day)

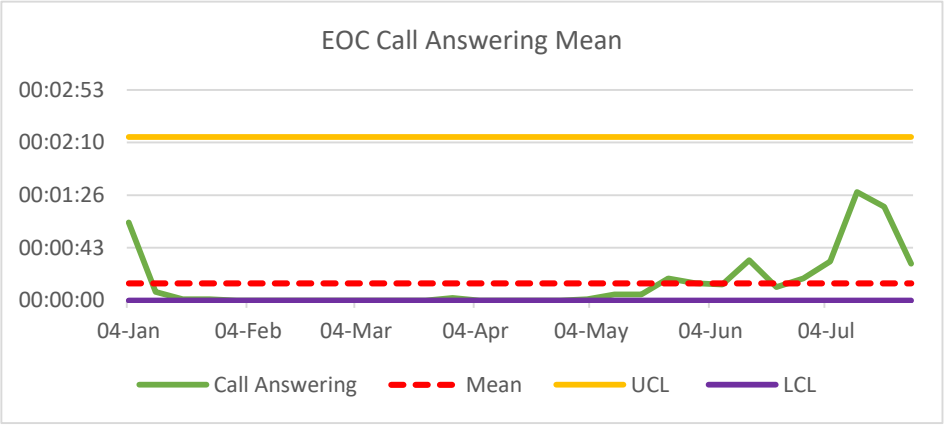


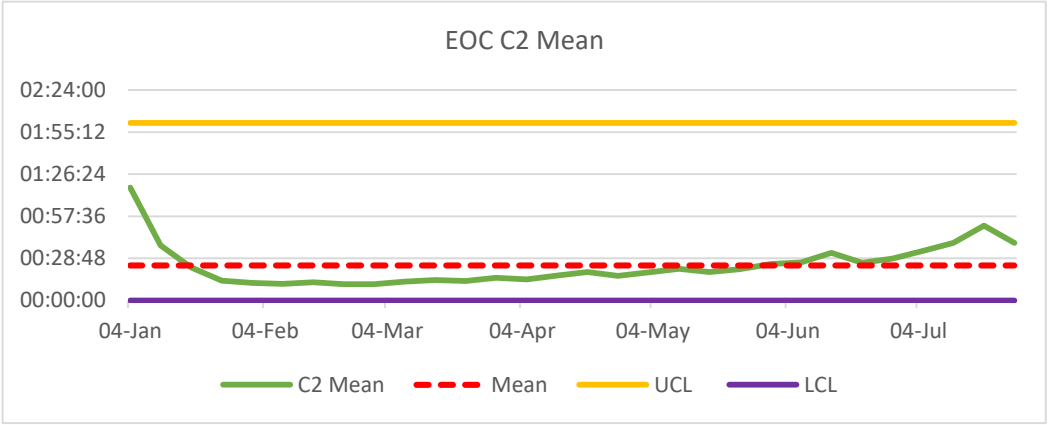
PAS / VAS (Avg per day)

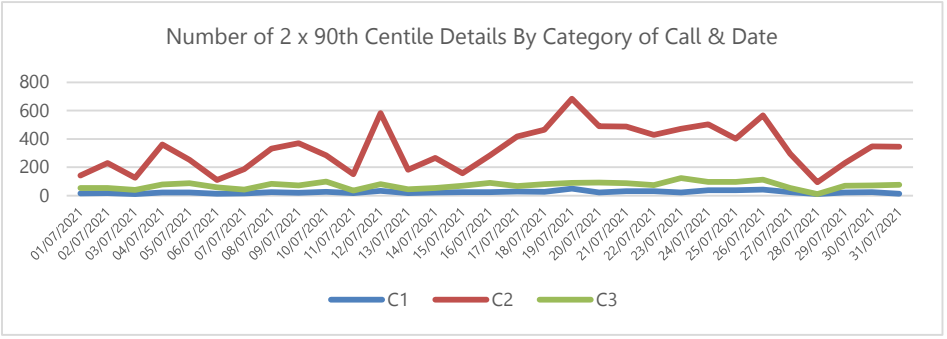


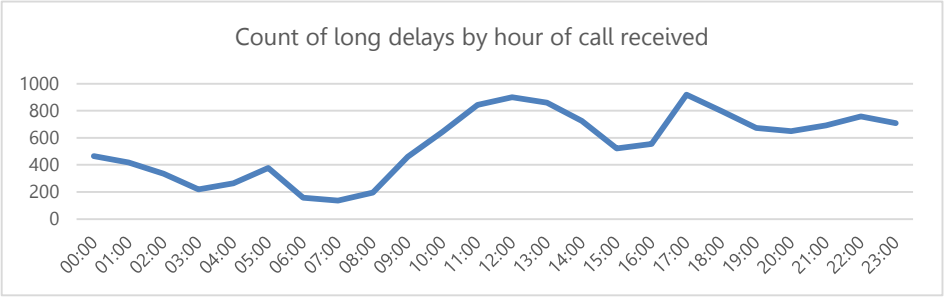
The service is meeting some operational delivery KPIs, with call answering and mean response times for Cat 1 within national set timeframes. There have been some challenges in the delivery of Category 2, 3 and 4 and actions are being taken to recover the performance.

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









In July 2021 there were 13,272 long delays, 9% of these resulted in a blue call.

	C1	C2	C3	Grand Total
Total	759	10258	2255	13272
Blue Call	152	922	72	1146

This is 95% increase from June 2021. From the table below we can see from Apr'21 – Jul'21, each month the number of long delays have nearly doubled from the previous month.

Apr-21	May-21	Jun-21	Jul-21
1764	3160	6789	13272

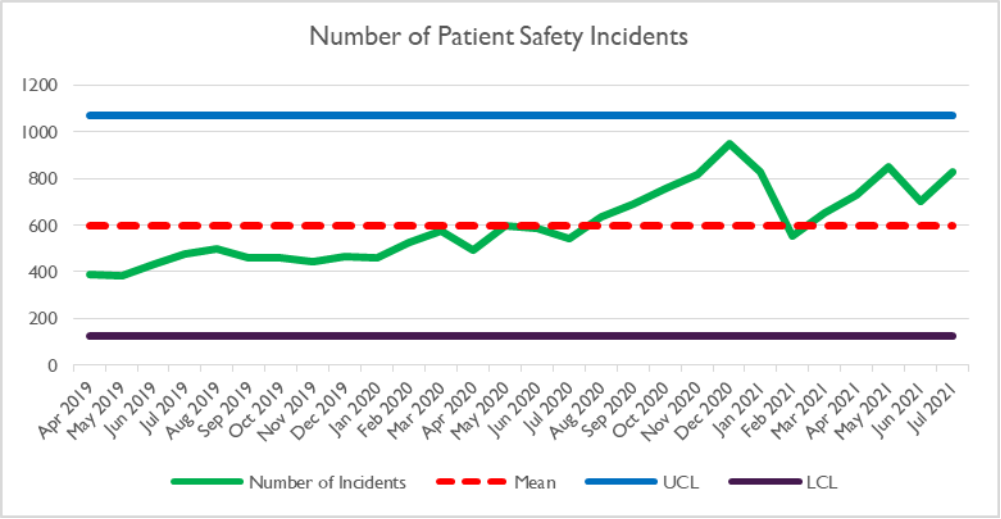
The top three determinants where a long delay incurred was:

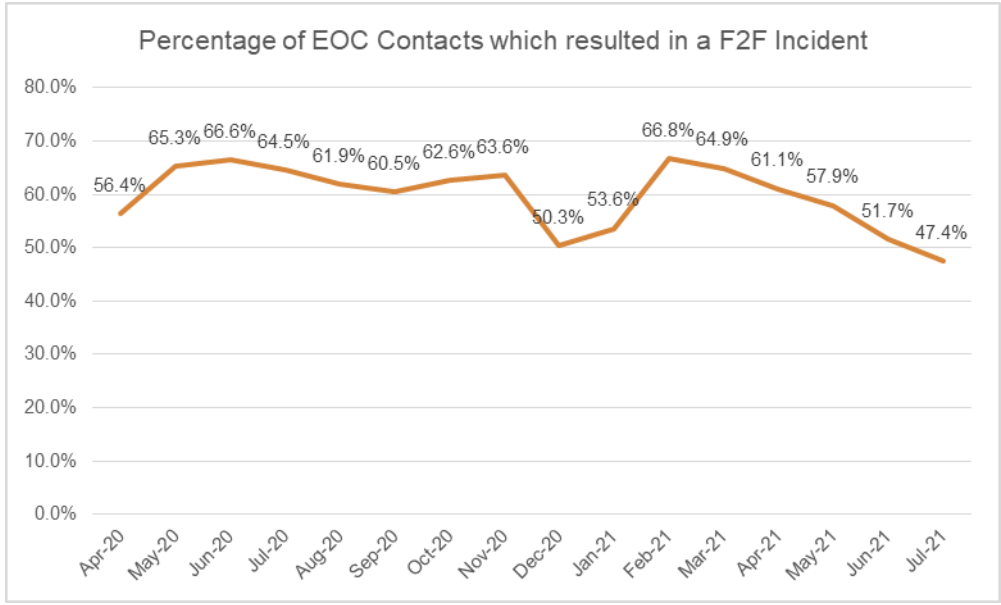
- DX012 - Emergency Ambulance Response (Category 3) (8% n = 1124)– 47 required a blue call
- DX0112 – 111 referral chest pain (5% n = 682) – 35 required a blue call
- 36C5A – Protocol 36 Pandemic Card High Risk Conditions (5% n = 598) – 14 required a blue call

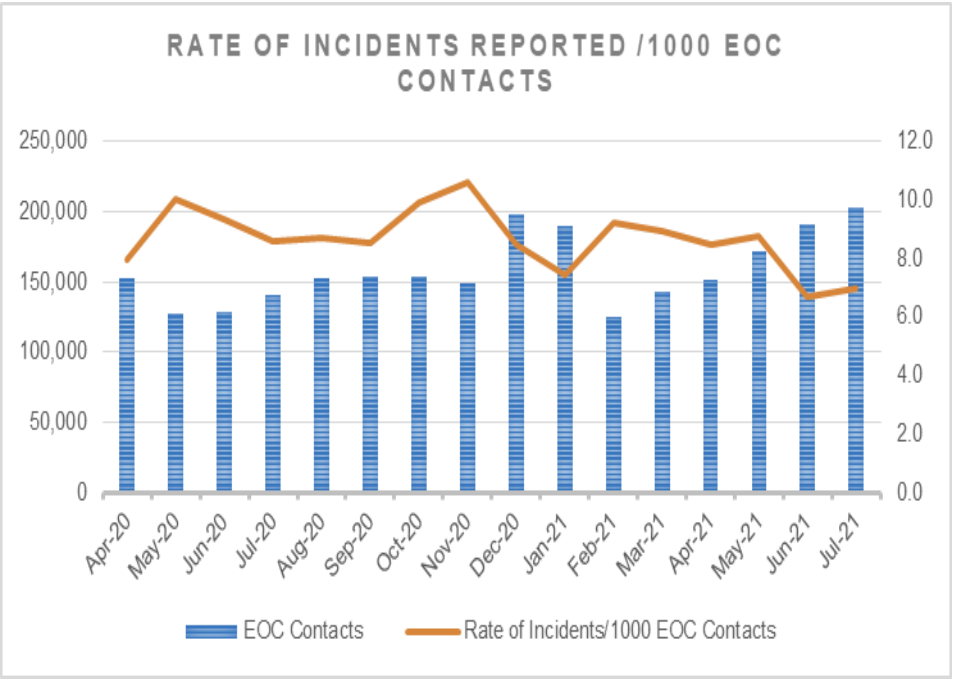
51% (n=6815) experienced a long delay were not conveyed and 49% were conveyed. It was also found that 13% (n=1760) of all long delays occurred between the hours of 11:00 and 14:00.

Action being taken include:
Forecasting and planning focus remains a part of the Strategic Response Group (SRG)
Daily operational performance review and actions via the Strategic Delivery Group (SDG)
Daily clinical safety reviews and daily patient safety reviews to oversee quality and clinical safety

The number of patient safety incidents reported across the 999 service remains steady when compared against the number of EOC contacts and face to face incidents.







The number of patient safety incidents reported per month has varied between April 2019 – July 2021. From March 2020 there has been an increase which correlates to the 1st national lockdown within the UK and the peak of the 1st COVID19 pandemic wave. The number of reported patient safety incidents then increases again correlating to the second COVID19 wave on the service in the winter of 2020.

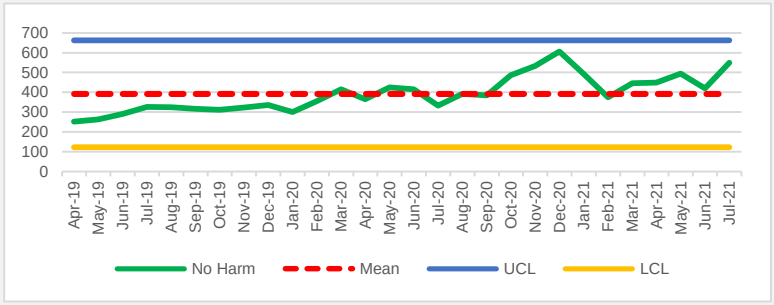
The number of patient safety incidents per month between February 2021 – present has been increasing, with 831 PSIs reported in July 2021, the 3rd highest month between April 2019 – July 2021, this can be attributed to the current REAP 4 level the trust has been at since 17th June 2021.

The rate of incidents reported per 1000 EOC contacts has slightly decreased the last few months, this is because the number of EOC contacts has increased, hence the rate of incidents is lower, with July 2021 showing as 203,434 contacts which is the highest between April 2020 – July 2021. Likewise, the graph on the left, shows a decrease EOC contacts resulted in a face to face incident as a result of the increase in EOC contacts.

The severity of harm of patient safety incidents indicates a good reporting culture of no and low harm incidents. Moderate harm and above incidents are reviewed for an enhanced investigation in line with the Patient Safety Incident Response Framework.

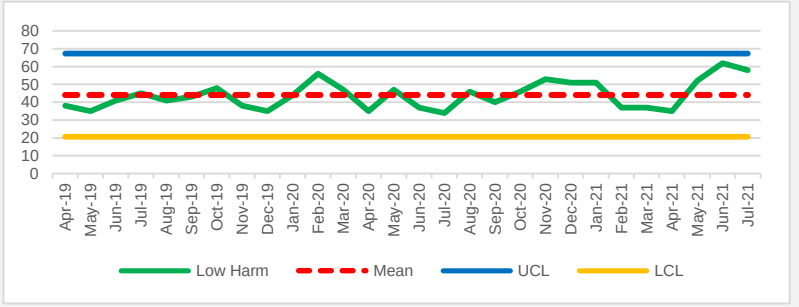
No Harm/Near Miss

Jul'21: **550**



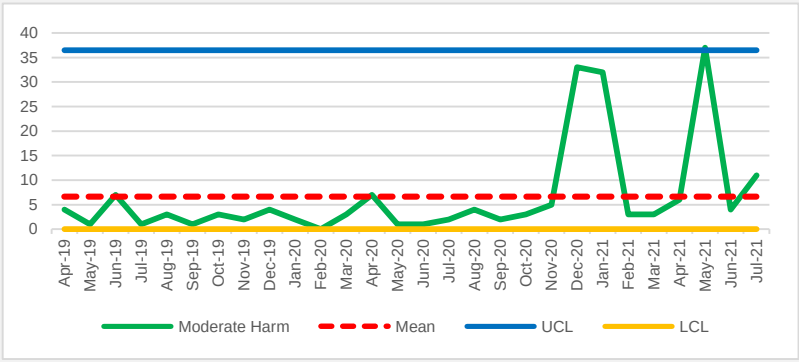
Low Harm

Jul'21: **58**



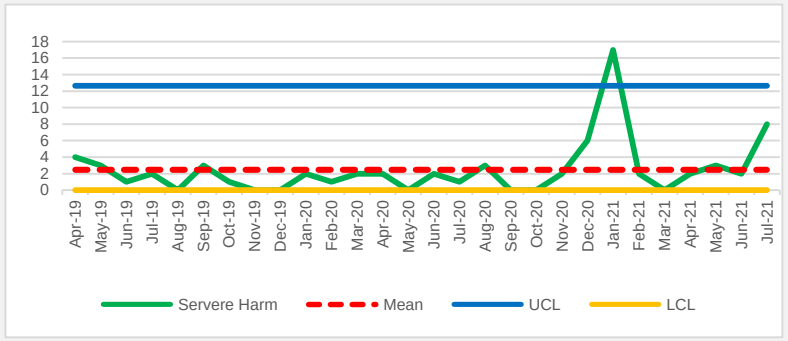
Moderate Harm

Jul'21: **11**



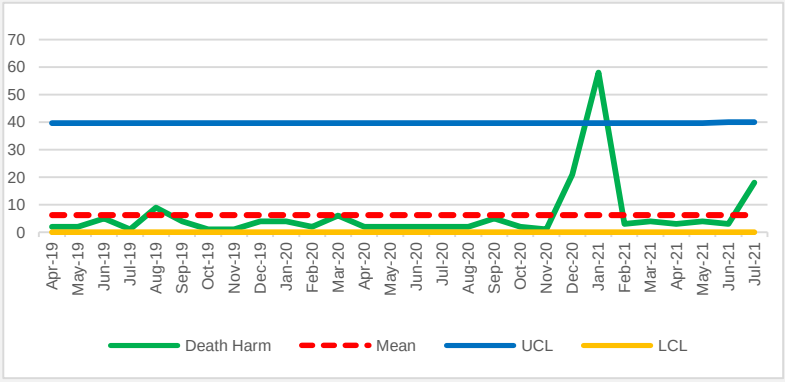
Severe

Jul'21: **8**



Death

Jul'21: **18**

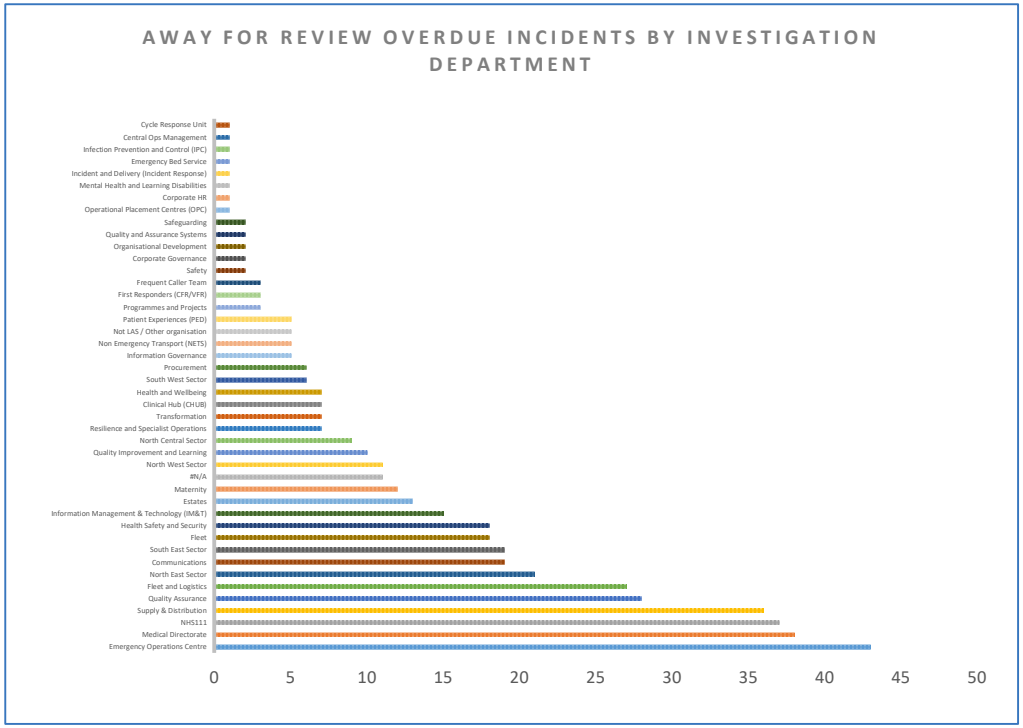


Analysis of SPC graphs:

The number of reported no and low harm incidents continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust's Safety Investigations Assurance and Learning Group (SIALG). There has been an increase in no harm incidents over the last few months which, in part, can be attributed to the increase in demand being experienced by the Trust.

The number of moderate, severe and death patient safety incidents reported increased in July 2021. This is due to an increase in the number of delayed response incidents highlighted via the team's daily review of delays experienced both in call answering and dispatch of resource. In addition, 8 of the 18 death incidents, 2 of the 11 moderate harm incidents and 1 of the 8 severe harm incidents were found via the re-contact audit which is auditing the months of December 2020 and January 2021;the height of the winter COVID19 wave experienced by the Trust.

The number of overdue incidents on the Trust's risk management system, Datix, continues to be monitored centrally with action being taken within sectors/directorates to ensure investigations are completed and action are moved to closure.

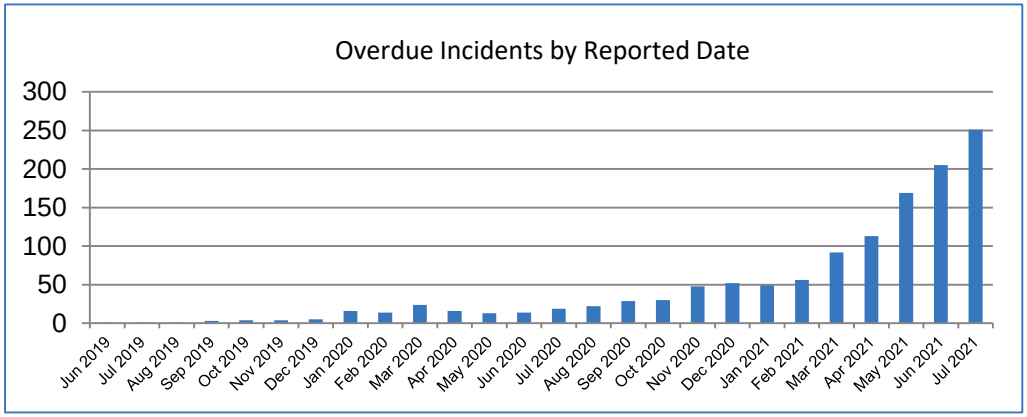


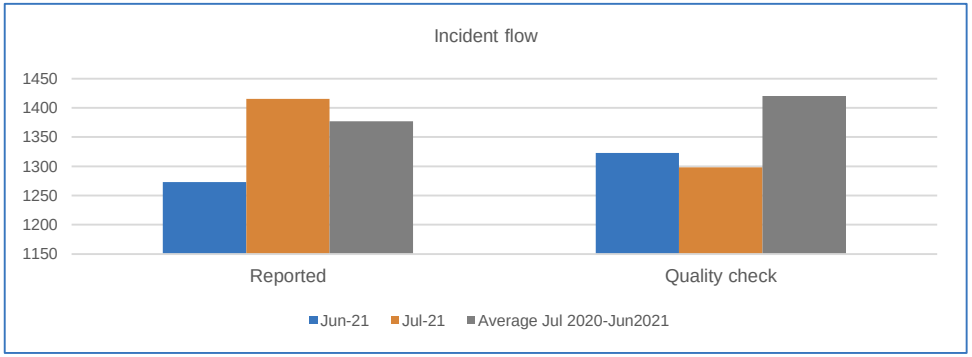
There are 1022 incidents (as of 13/08/2021) which have been opened on the system longer than 35 working days (this excludes SIs, PSIIs and COVID19 reviews). This is a 10% increase from June 2021 where there were 928 overdue incidents. This breaks down to:

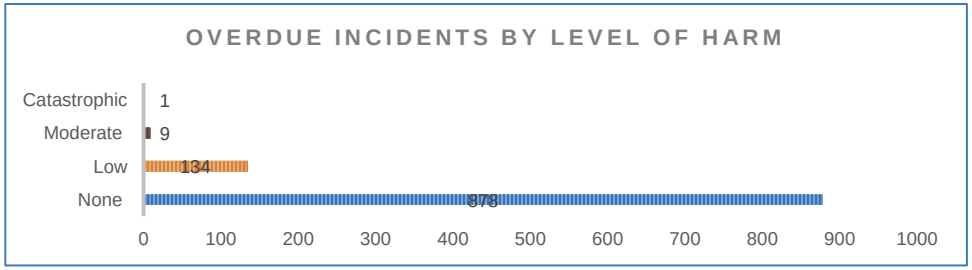
- 554 patient incidents
- 242 staff incidents (the 9 overdue moderate harm incidents are staff related)
- 12 visitor incidents
- 214 Trust related incidents

On average (Jul 2020 to Jun 2021) 1377 incidents are reported monthly on the system and 1420 incidents are investigated and moved to Quality check for final closure. During July 2021 the number of incidents reported was slightly higher than average, and the number of incidents moved to Quality check significantly lower than average. This can be attributed to the increased pressures being experienced and being at REAP 4.

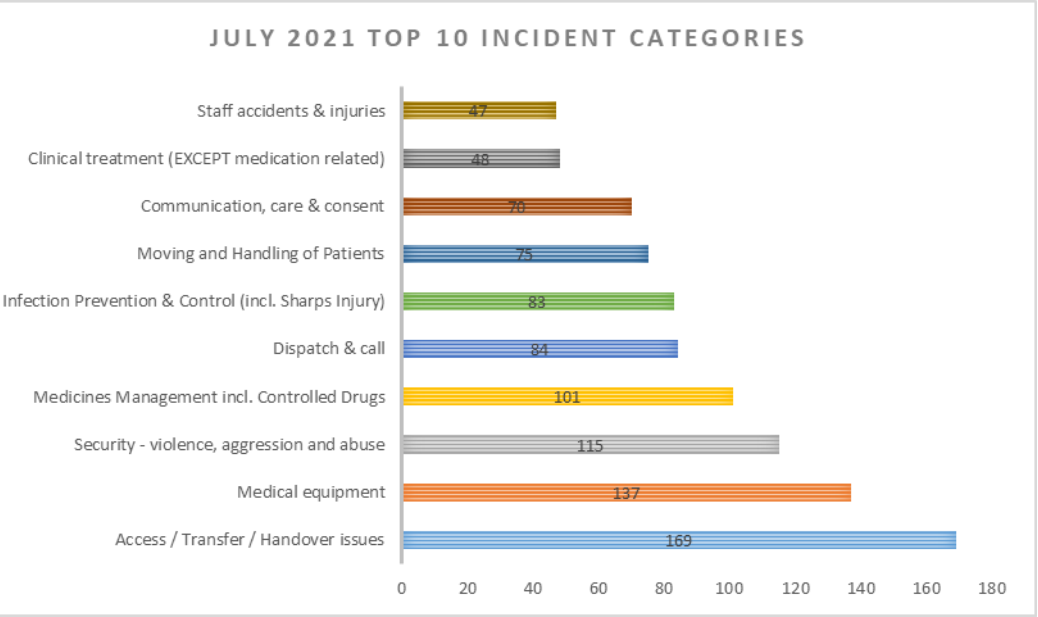
All incidents continue to be monitored daily by the Incident and Risk Hub. The Quality Governance and Assurance Managers (QGAMS) also work with the sectors/depts. to ensure incidents are investigated in a timely manner. Of the overdue incidents, the highest number, 142 incidents (14%) sits within EOC. In regards to harm levels, 86% of overdue incidents have been labelled as No Harm and 13% as Low Harm.







Incident trends and themes are monitored by the Trust's Safety Assurance and Learning Group to ensure improvement and actions are being taken to address recurrent incidents.



The top 3 incident categories in July 2021 were Access/Transfer/Handover, Medical Equipment and Security – Violence, Aggression and Abuse.

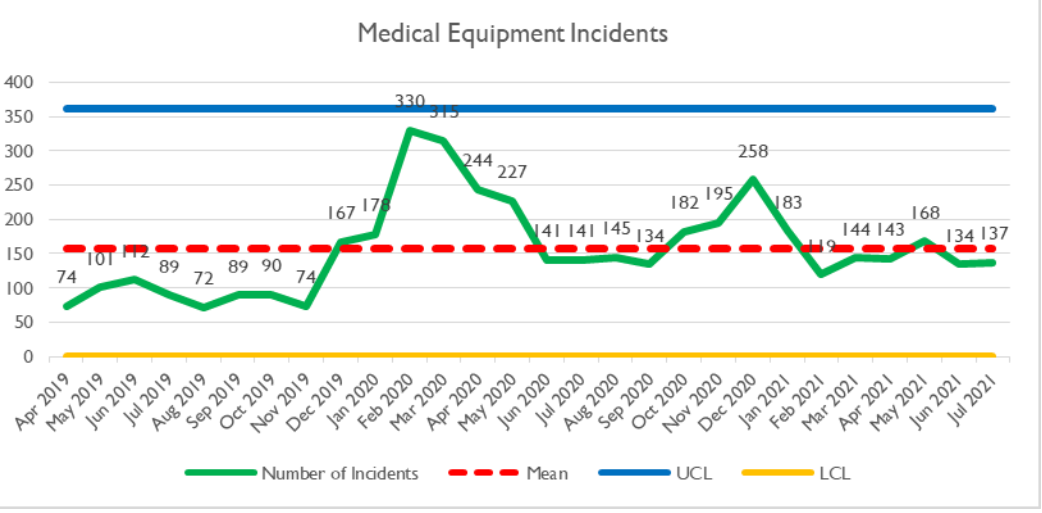
There were 169 Access/Transfer/Handover Transfer issues in July 2021. Delayed Handover in ED (Over 60 Mins) (98 incidents) and Delayed Handover in ED (Over 30 Mins) (62 incidents). This can be attributed to the high demands the service is currently seeing.

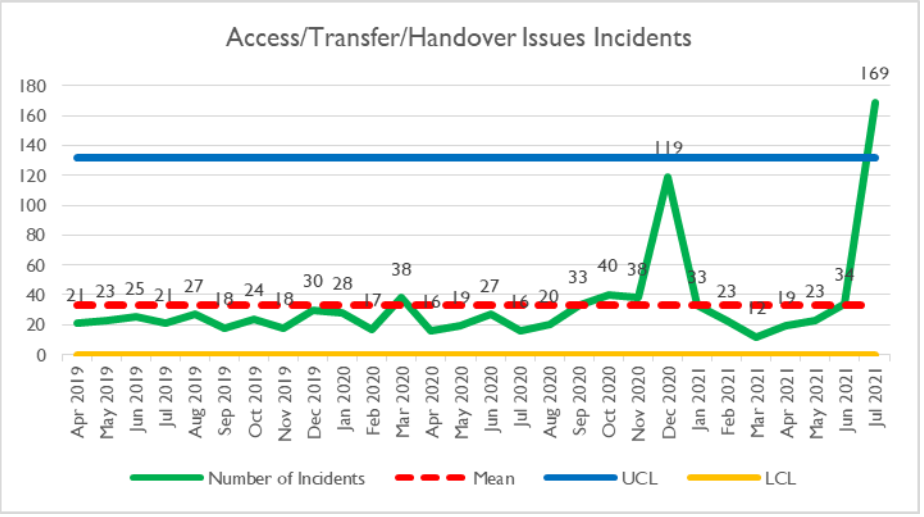
Themes relating to medical equipment indicate that there has been a change from missing equipment to failure of equipment in recent months.

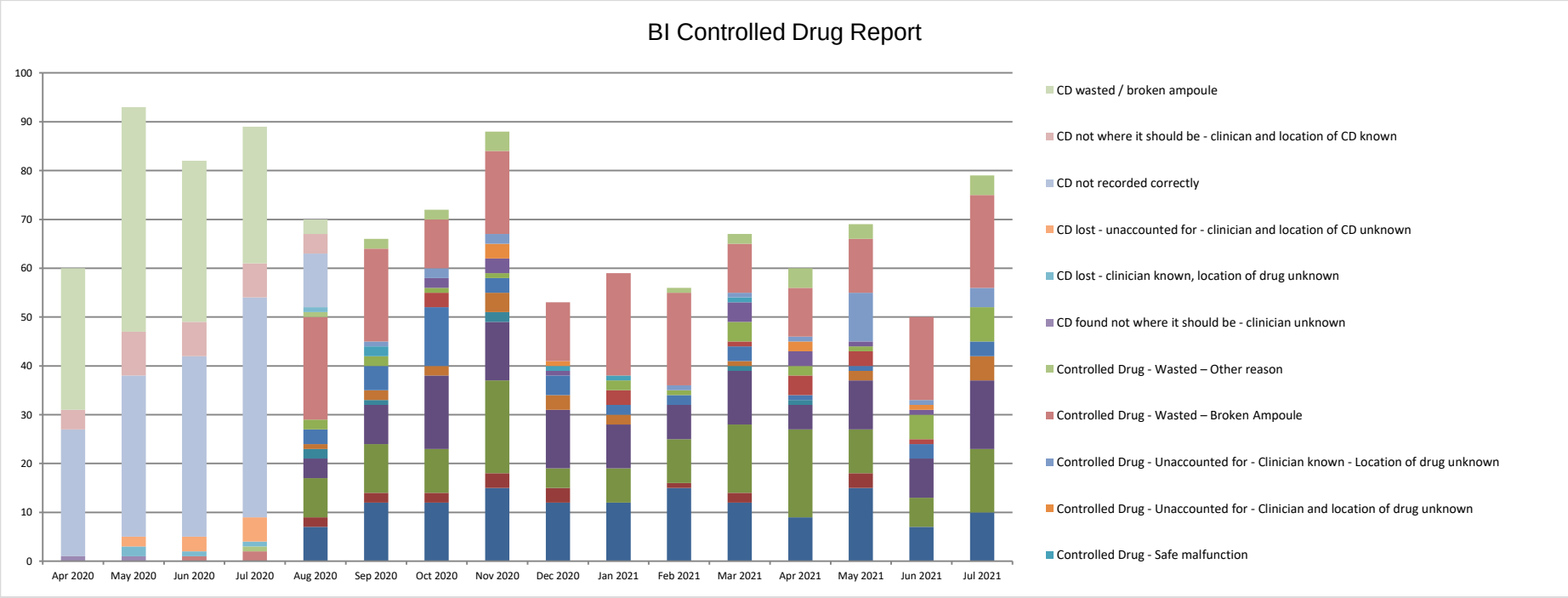
The supply and distribution leadership team is almost complete with the last appointment starting on the 16th August 2021 being the new Medical Equipment Specialist who will be responsible for overseeing where all the devices are and for ensuring they are brought in for scheduled maintenance/servicing and ensuring all ambulances have the equipment they need.

Over the last month there has been one reported failure of a BM Kit, which was immediately replaced with new stock, no other issue has been reported. Following up on previous issues the new BVMs are in stock and being feed into circulation via the Make Ready Hubs, over 300 Tympanic thermometers have been place in circulation and there is currently a pro-active focus on ensuring adequate Oxygen saturation Probes are available.

The Central Asset Management System has been successfully trialled, and with support from Mitre, will start a phased go live from the 9th August for consumables with equipment following. This will see the systematic tagging of all medical equipment with passive RFID tags to manage the tracking, inventory, storage and maintenance of all medical devices







- No unaccounted for losses of schedule 2 controlled drugs
- Total of 82 other controlled drug (CD) incidents including
    - Documentation errors (n=44)
    - Morphine retained off-duty (n=8)
    - Morphine reaction (n=1)
    - Breakages, wastage or damage (n=29)
- Non-controlled drugs incidents
    - Kitprep discrepancy (n=10)
    - Breakages (n=5)
    - Drugs unsecured (n=2), supply issue (n=1) drugs not available (n=2) or temperature breach (n=1)
    - Drugs usage form discrepancy (n=1) or expired medication (n=1)
    - Allergic reaction to medicine (n=1) or administration error by non-LAS staff (n=3)
    - Inappropriate administration of diazepam (n=2), hydrocortisone (n=1), ipratropium (n=1), naloxone (n=1), Entonox (n=1), paracetamol (n=4) and TXA (n=1)

Assurance

- Incidents where morphine retained off duty identified in a timely fashion ensuring drugs returned and secured promptly.
- No further losses of Abloy key devices ensuring CD safe access and security not compromised

Actions

- Addition of further diazepam supplies to ensure further doses can be given at scene where required
- Costings for system modifications to enable paramedic prescribing complete
- Preparation of medicines packing unit continues

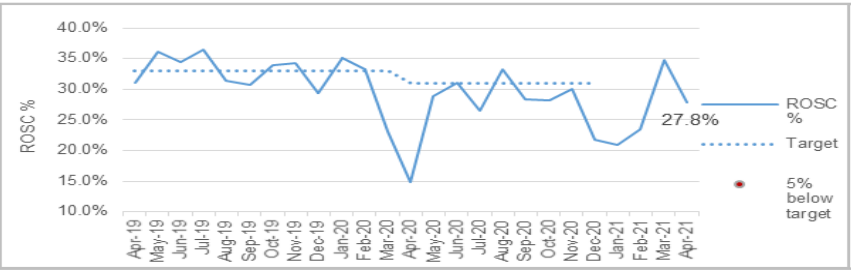
Clinical Ambulance Quality Indicators (Latest Reported Month)

*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 **April 2021**, which is the most recent month published by NHS England.*

ROSC at Hospital

Month: 27.8%

Target: 31.0%



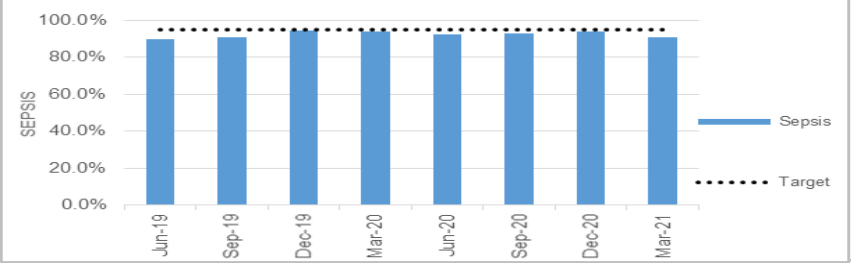
In April 2021, the LAS ranked 6th nationally for ROSC on arrival at hospital for the overall group with 27.8% (down from 1st; 27.1%), slightly above the national average of 27.2% and 8th for the Utstein group with 44.2% (down from 3rd; 52.2%), below the national average of 50.3%. The LAS ranked 5th for 30 day survival in the overall group with 11.1% (down from 1st; 12.7%), marginally above the national average of 10.8% and 8th for the Utstein group with 25.0% (down from 1st; 41.9%), below the national average of 29.2%.

Post ROSC Care Bundle data for April ranks the LAS 3rd with 85.5% which is greatly above the national average of 77.0%.

Sepsis Care Bundle

Month: 91.0%

Target: 95%



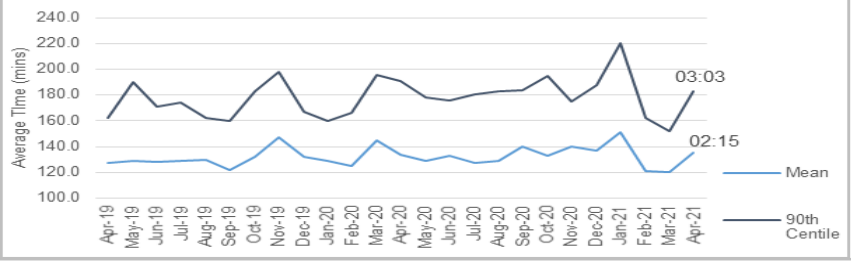
Despite a fall of 3.1% since December 2020 when it was last reported, in March 2021 LAS were once again the top performing trust for the Sepsis Care Bundle nationally with 90.9% compliance. Whilst we are consistently the top performing trust in this area, this is the lowest figure we have reported since June 2019 (89.9%).

NHS England did not publish Sepsis Care Bundle data for April, the next data due to be published will be for June (in November).

STEMI call to angiography

Mean: 02:15

Target: 02:10



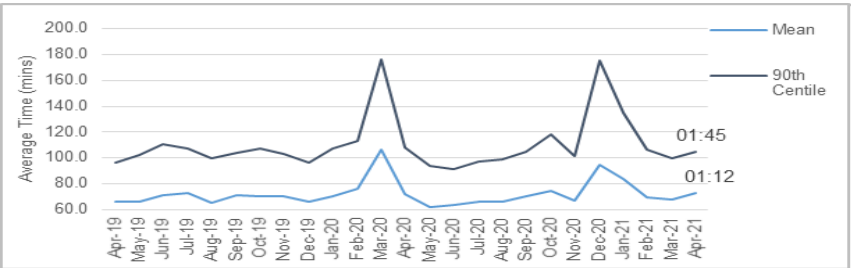
In April 2021, the LAS ranked 4th overall for the call to balloon measure, with a time of 02:15. This was 2 minutes shorter than the national average.

The STEMI Care Bundle published for April 2021 showed 63.7% of STEMI patients received the full care bundle (or had valid exceptions). Although this is a 3.9% increase from the last published figures (for January 2021), the LAS continues to rank in 9th place overall. The analgesia component of the Care Bundle continues to be the element with least provision; only 73.9% of patients received analgesic treatment.

Stroke call to door

Mean: 01:12

Target: 01:10



The LAS ranked 2nd for the mean call to hospital for suspected stroke patients (01:12) in April 2021, well above the national average of 01:24. This position is slightly lowered from March 2021 when the LAS ranked 1st in England (with a mean call to hospital time of 01:08).

NHS England did not publish Stroke Diagnostic Bundle data for April, the next data due to be published will be for May (in October).

Trust-Wide Scorecard – NEL & SEL IUC

Patients Scorecard (NEL IUC)

July 2021

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-21	🔴	95.0%	A	71.5%	81.3%	83.3%	56.8%	72.3%	2
Proportion of calls abandoned	%	Jul-21	🔴	3.0%	A	12.7%	7.7%		15.1%	12.3%	2
% of calls closed with no onward referral (health advisor and clinician)	%	Jul-21	🔴	33.0%	A	27.3%	25.9%	25.1%			
% of calls transferred to 999	%	Jul-21	🟢	10.0%	A	7.2%	6.7%	7.9%	7.6%	5.2%	2
% of calls recommended to ED	%	Jul-21	🟢	10.0%	A	8.2%	10.2%	10.7%	9.5%	5.6%	2

Patients Scorecard (SEL IUC)

July 2021

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-21	🔴	95.0%	A	72.3%	80.6%	84.2%	56.8%	72.3%	1
Proportion of calls abandoned	%	Jul-21	🔴	3.0%	A	13.9%	11.3%		15.1%	12.3%	3
% of calls closed with no onward referral (health advisor and clinician)	%	Jul-21	🔴	33.0%	A	30.0%	30.5%	29.6%			
% of calls transferred to 999	%	Jul-21	🟢	10.0%	A	7.5%	7.0%	7.3%	7.6%	5.2%	3
% of calls recommended to ED	%	Jul-21	🟠	10.0%	A	10.1%	11.6%	12.2%	9.5%	5.6%	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

Trust-Wide Scorecard – 111 North West London (NWL)

London CCGs have awarded the provision of 24/7, 365 day 111 call handling services to London Ambulance Service NHS Trust (LAS) with London Central and West Unscheduled Care Collaborative (LCW) and Practice Plus Group (PPG) as mandated sub-contractors.
The Trust has rolled out phase 1 on 17th November, which involved taking a small concentrated number of night calls. Phase 2 of the service provision has begun where the Trust is now increasing its capacity on call taking with the intention to uptake 33% of the calls through extended hours for NWL.

The scorecard below shows the performance for NWL including data from all 3 providers, combined. Further detail when available will allow us to provide a further detailed analysis in this report, as with our other 2 contracts.

Patients Scorecard (NWL IUC)

July 2021

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-21	R	95.0%	A	46.7%	65.5%		56.8%	72.3%	3
Proportion of calls abandoned	%	Jul-21	R	3.0%	A	14.4%	4.4%		15.1%	12.3%	4
% of calls closed with no onward referral (health advisor and clinician)	%	Jul-21	R	33.0%	A	14.2%	14.4%				
% of calls transferred to 999	%	Jul-21	G	10.0%	A	8.8%	8.2%		7.6%	5.2%	4
% of calls recommended to ED	%	Jul-21	R	10.0%	A	11.4%	12.5%		9.5%	5.6%	4

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

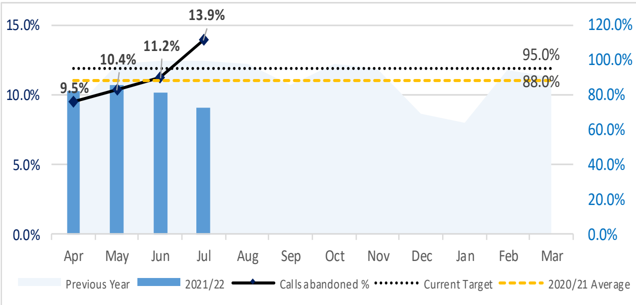
1. Our Patients

111 IUC Performance

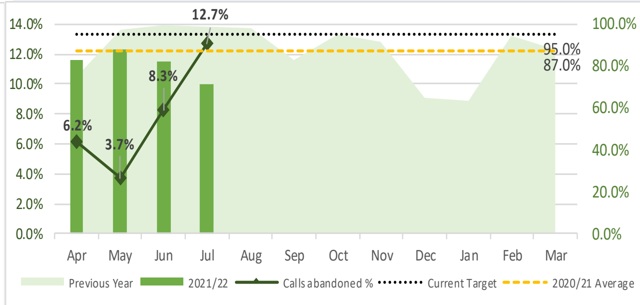
Call answering was outside target in July for North East London (NEL), South East London (SEL) and North West London (NWL) due to a rise in demand following the ease of lockdown, warmer weather and increased Covid related calls. All sites were within target for calls transferred to 999, where we consistently performed better than the London average. The abandonment rates were outside target for July across the board and we were challenged in the recommendation to attend ED performance for two out of the three areas, with North East London being within target.

Call Answering & Abandoned Calls

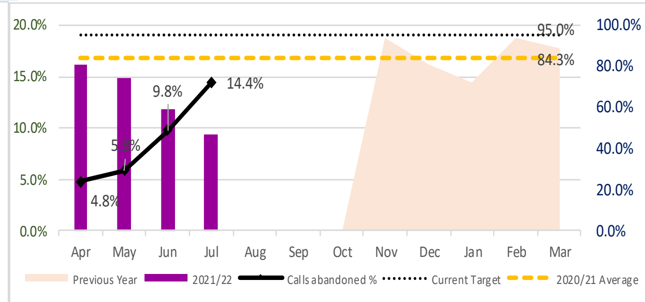
South East London (SEL)



North East London (NEL)



North West London (NWL)



Target: 95% (CA) and 5%

SEL: 81.3% / 11.2%

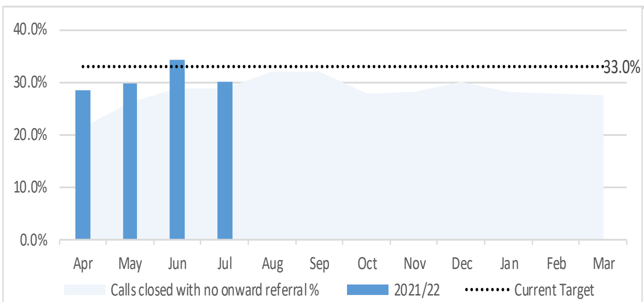
NEL: 82.0% / 8.3%

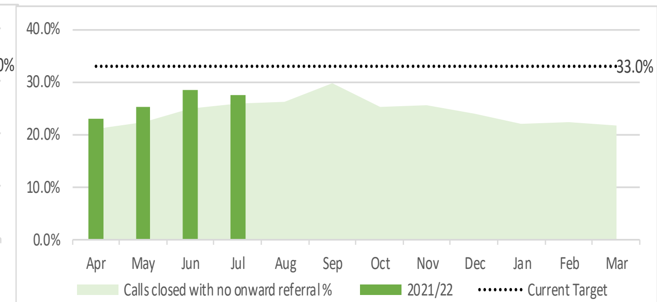
NWL: 58.8% / 9.8%

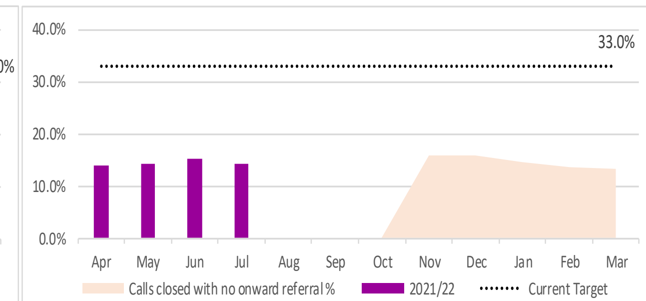
The 111/IUC centres have been critically important in national Covid-19 response as any concerns were directed to 111 across England. The call demand in July increased due to warmer weather, London returning to normal activities and the easing of national restrictions, which challenged the 111 performance.

The number of calls abandoned by patients exceeded the SLA, despite this North East London ranked 2nd nationally.

% of calls closed with no onward referral







Target: >33%

SEL: 30.0%

NEL: 27.3%

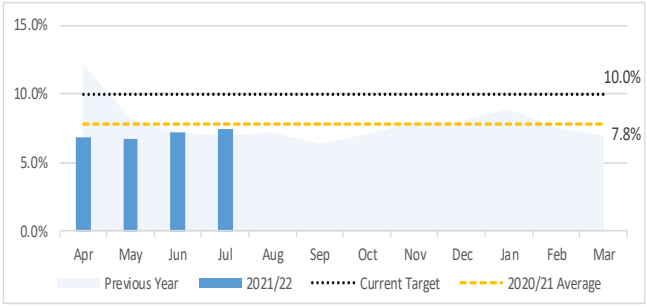
NWL: 14.2%

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.

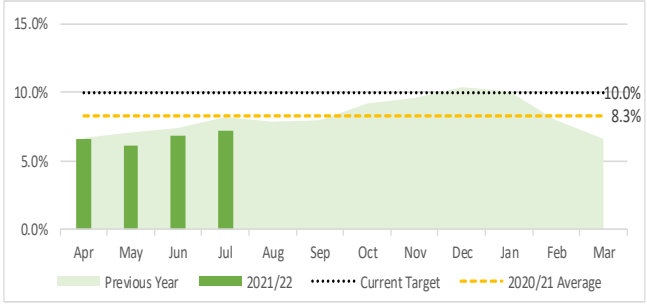
111 IUC Performance

Calls Outcome: Transferred to 999

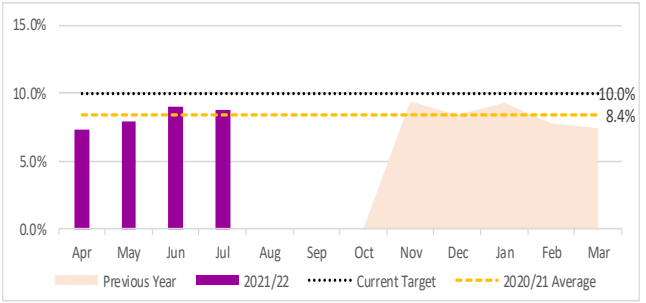
South East London (SEL)



North East London (NEL)



North West London (NWL)



Target: <10%

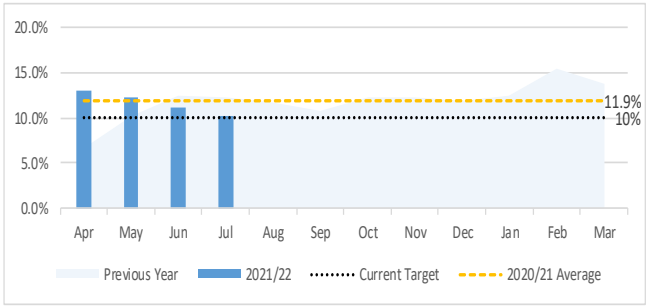
SEL: 7.5%

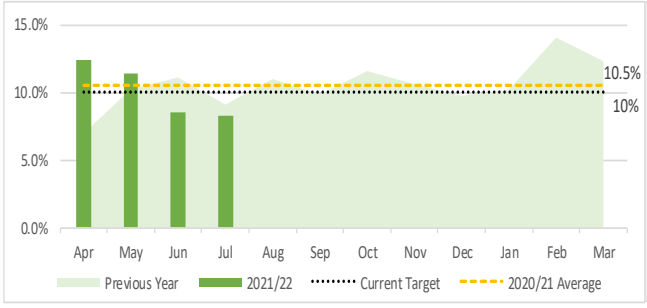
NEL: 7.2%

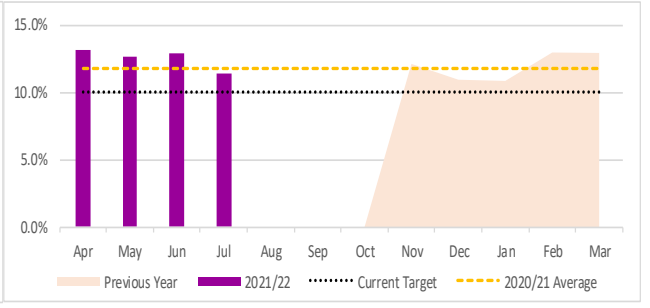
NWL: 8.8%

Referrals to 999 services remain within the 10% national standard for both NEL and SEL. During September, NEL delivered 8.0%, with SEL delivering 6.4%. This performance compares positively against the London average which was circa 8%, demonstrating the benefits of a clinical assessment service (CAS).

Call Outcome: Recommended to attend ED







Target: <10%

SEL: 10.1%

NEL: 8.2%

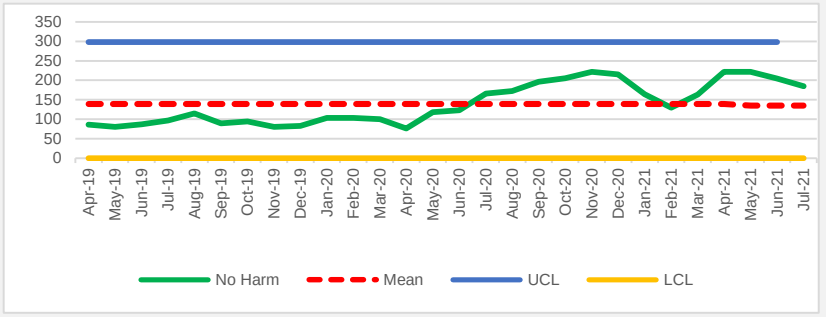
NWL: 11.4%

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. We are undertaking a clinical end-to-end audit of calls and will be engaging with partner agencies to provide feedback and learning. This significantly improves the quality of care provided over a standard 111 service and releases pressure on the wider healthcare system.

The severity of harm of patient safety incidents indicates a good reporting culture of no and low harm incidents. Moderate harm and above incidents are reviewed for an enhanced investigation in line with the Patient Safety Incident Response Framework.

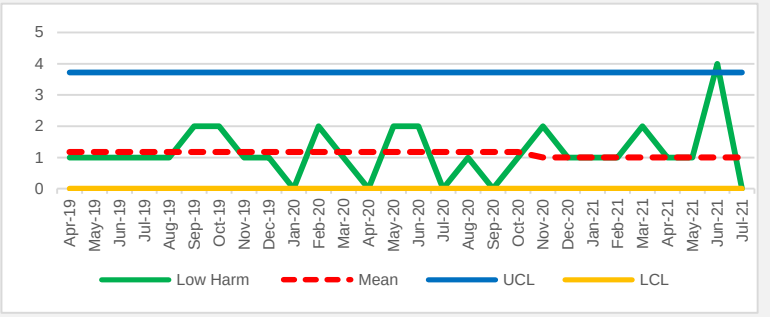
No Harm/Near Miss

Jul'21: **185**



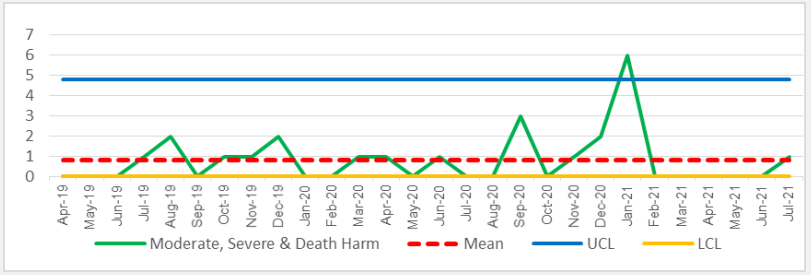
Low Harm

Jul'21: **0**



Moderate, Sever & Death Harm

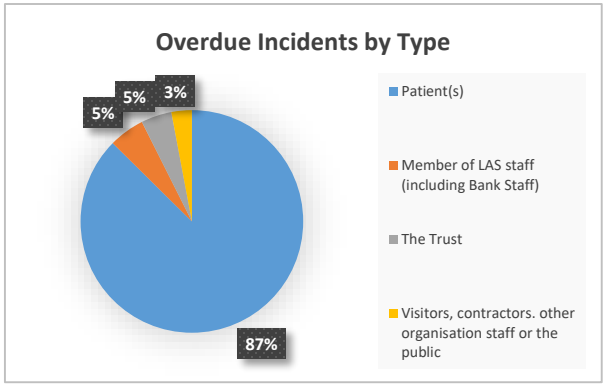
Jul'21: **1**

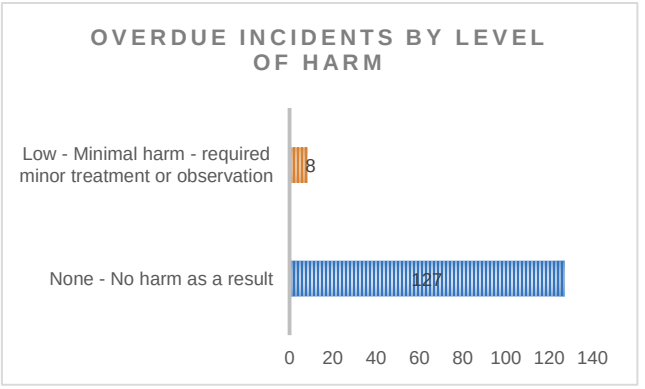


Analysis of SPC graphs:

The number of reported incidents continues to be positive in reporting numbers. This is a sign of a good reporting culture. There has been an increase in the number of no harm incidents reported in the last year.
The reason for the increase in no harm incidents is because IUC have increased incident reporting for language line issue, a new category has been added on Datix for such issues, supervisors and team managers are working hard to ensure they report all incidents of issues to help provide improved learning and promote a good reporting culture within LAS.

Incident Management



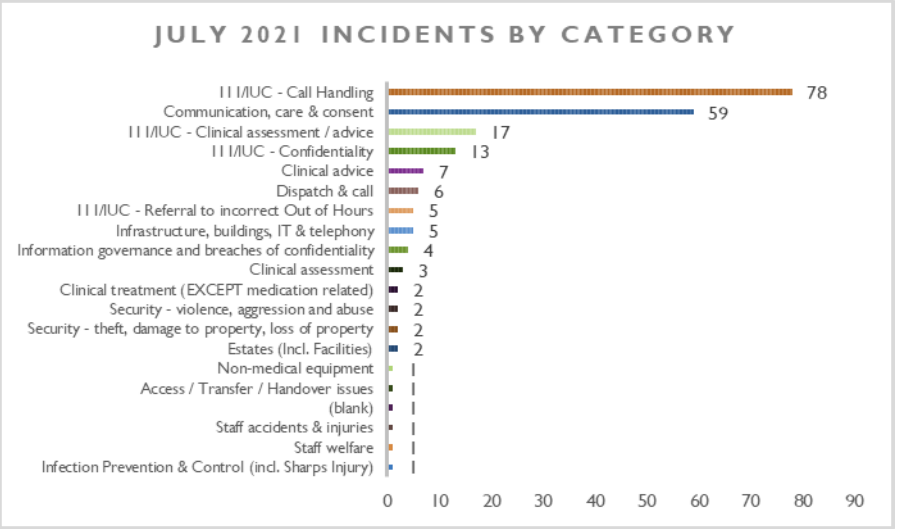


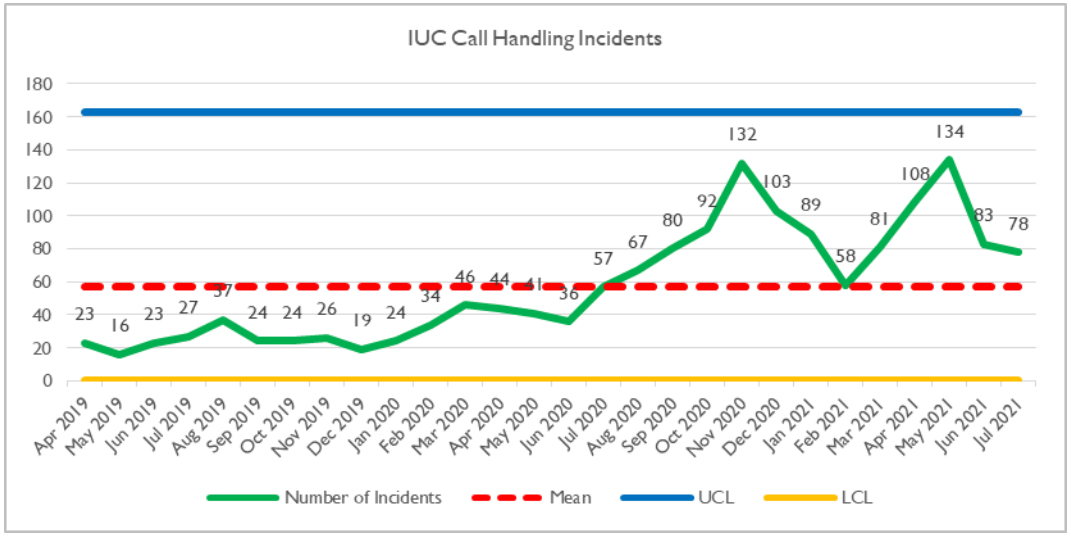
There are 135 incidents (as of 13/08/2021) which have been opened on the system longer than 35 working days (this excludes SIs & COVID 19 reviews).

This breaks down to 118 patient incidents, 7 staff incidents 4 visitor incidents and 6 Trust related incidents.

55% of incidents are in the Local Review stage and 45% in the Away for Review stage. 94% of incidents have been classified as No Harm.

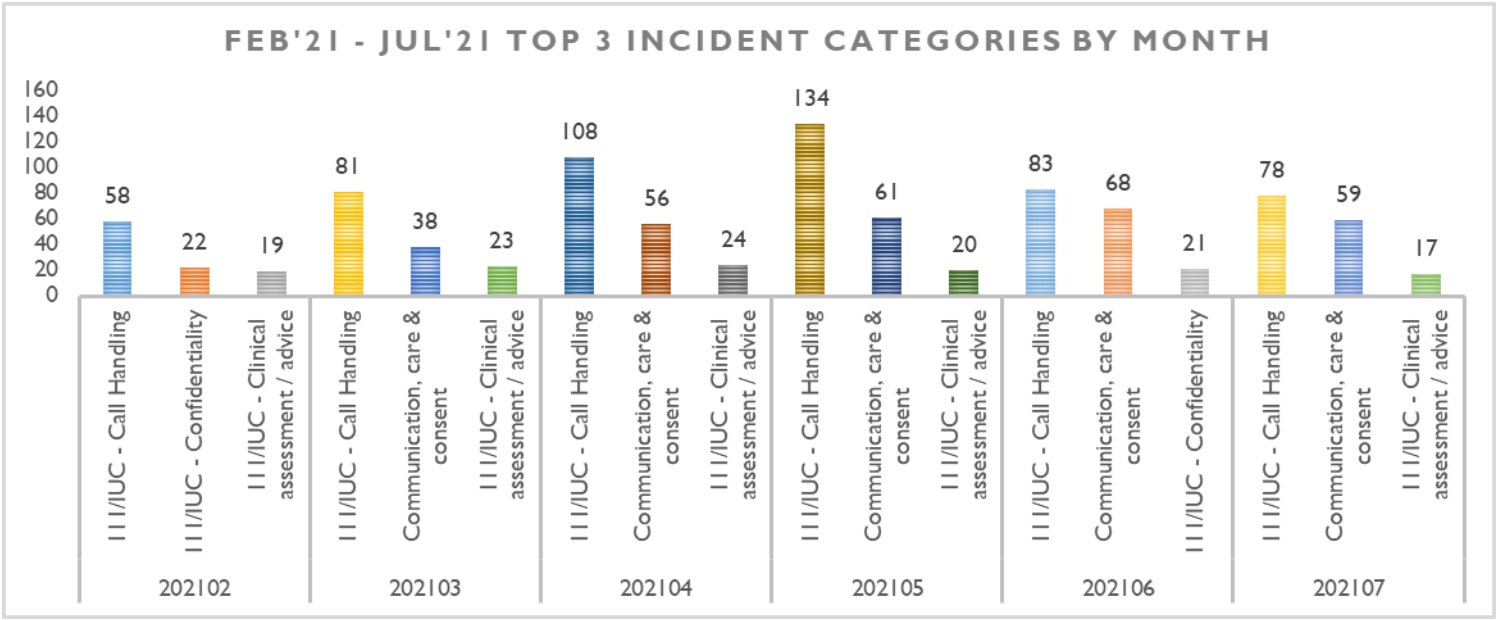
Incident trends and themes are monitored by the Trust's Safety Assurance and Learning Group to ensure improvement and actions are being taken to address recurrent incidents.





The top 3 Incident categories in July 2021 were Call Handling, Communication Care and Consent and Clinical Assessment and Advice.

The number of Communication, Care and Consent has been increasing, this is because incidents whereby an ambulance is sent without patient awareness (including lab contacts to request ambulances for patients based on blood results and times where the line has dropped out with clinical concern, etc.) will no longer be reported as an authorised breach of confidentiality. These will be reported on Datix under "Communication care and consent" --> "Communication failure with patient". It has been deemed that there are no patient confidentiality breaches as the information has not been sent to a third party and/or the ambulance has been sent in the patient's best interest. This includes when an ambulance is being sent for a patient via another ambulance service (e.g. NWAS).



The Trust continues to test and develop the Framework to ensure it is correctly embedded within supporting processes and governance structures. All learning is fed back to NHS E/I to support the national development of the overall framework ahead of national roll out in 2022.

During July 2021, a total of **26** (including NHS 111) reported incidents were assessed under the Patient Safety Incident Response Framework (PSIRF) and the Trusts Patient Safety Incident Response Plan (PSIRP).

Of these 26, 18 were identified as requiring an enhanced level of investigation. The breakdown of the 28 are as follows:

National Priority – Patient Safety Incident Investigations (PSII)

1 incident met the Nationally - defined priority requiring an internal investigation where a death was clinically assessed as more likely than not being due to problems in care. This case had been first reviewed by the Trust's Learning from Death process.

Local Priority – Patient Safety Incident Investigations (PSII)

1 incident met the Trusts Patient Safety Incident Response Plan (PSRIP) under the Local Priority of *Face to Face Clinical Assessment* and is being investigated as a PSII.

1 incident met the Trusts PSIRP under the Local Priority of *Emergent Patient Safety Incident* and is being investigated as a PSII.

Patient Safety Review (Non PSII) including Thematic Review

1 incident met the Trusts PSIRP under the Local Priority of *clinical assessment of spinal injuries* and is being investigated as a PSR.

1 incident met the Trusts PSIRP under the Local Priority of *Face to Face Clinical Assessment* and is being investigated as a PSR.

1 incident met the Trusts PSIRP under the Local Priority of *Call Handling* and is being investigated as a PSR.

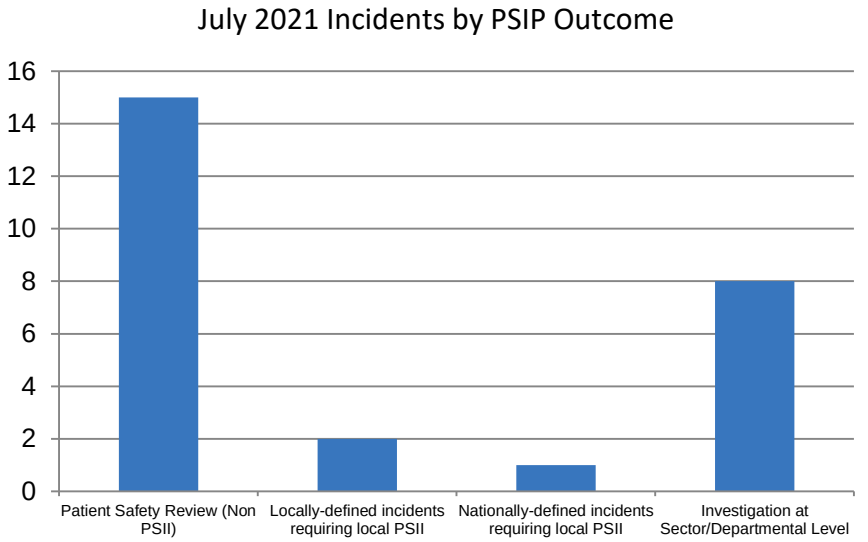
12 incidents did not meet the Trusts PSIRP and are are being investigated as a PSR via a structured Judgement Review. The incidents involve a delayed response with the possibility of harm caused as a result. The other two incidents are being investigated as PSRs.

Local Review

The remaining 8 incidents were referred to Sector/Department management teams to continue with a local investigation.

The following mitigating actions have taken place:

- Re distribution of the guidance relating to the dispatch of FRUs to 10D2 and 10D4 determinants.
- Themes from patient safety incident have been shared with managers via the Monthly Managers Incident and Learning meeting which is hosted by the Quality Improvement and Learning Team.



Implementation of PSIRF:

The Trust went live with the PSIRF on the 1st April 2021 and the focus is now on developing a set PSRIF process and governance structure that will be tried and tested.

The implementation has seen strengthen governance and assurance processes regarding investigation of incidents from the point of being reported, ensuring that those meeting the PSII criteria are escalated in a timely manner to the PSIP for confirmation. In terms of assurance, this has been further strengthen for those incidents re-categorised with clear rationales and clinical reviews recorded on the incident records.

Next Steps of the implementation:

- Continue to implement Framework and communicate across the service
- Engaged with the Trust's Patient and Public Council (PPC) to support the development of the desired patient standards as part of the PSIRF.
- Continue to attend monthly PSIRF webinars with early adopters to fed back and also learn from others.
- Looking at the QI element of the framework and beginning to take this forward.

The number of safety investigation actions on the Trust's risk management system continue to be monitored centrally to ensure they are closed within their set timeframe.

There continues to be a focus on SI actions, at the end of July there were **191** open actions, of these **30** 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 sends 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 (SIALG) where escalations to departments are communicated, if required.

The ability of some actions owners to make progress on their actions has been impacted by the Trust Reap 4 level and action owners performing alternative roles.

There are 2 incidents which are oldest and highest in priority:

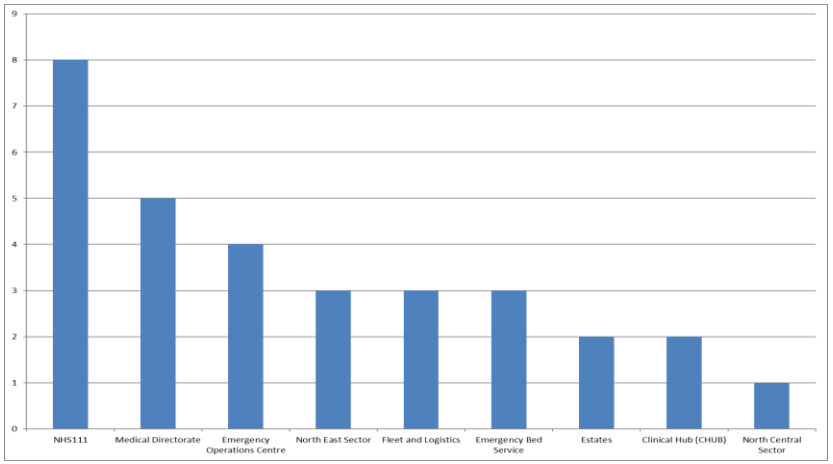
The Trust to review the discharge guidance for paramedics located in Appendix 3 of the Managing the Conveyance of Patients Policy and Procedure.

Update
The review has taken place and is awaiting assurance to be updated.

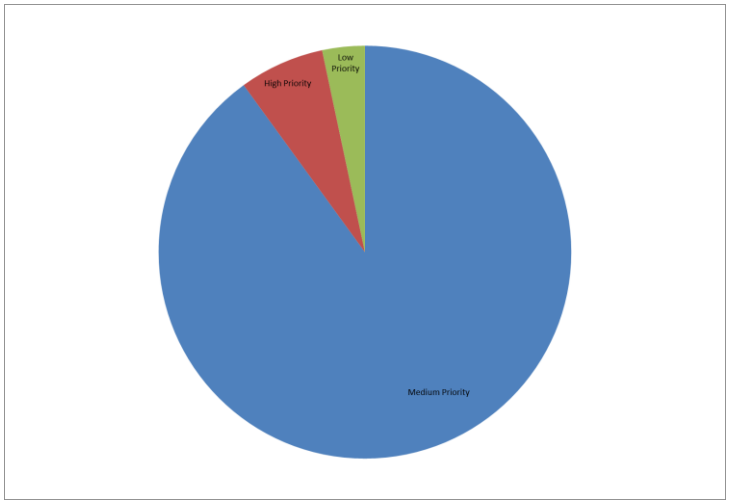
The Trust to Implement a process whereby appropriate internal stakeholders discuss clinical staffing in Integrated Urgent Care and identify areas of concern. Any remedial action required in extreme situations should be discussed and agreed to prevent the Clinical Assessment Service queue from reaching such escalation levels

Update
Recently appointed Deputy Director of 111/999 & Clinical Assessment Service as part of the IUC restructure will give greater assurance regarding capacity to review staffing levels. In the interim this is discussed on a weekly basis at the IUC clinical meeting with all relevant stakeholders engaged

Overdue actions by Sector / Department



Overdue actions by priority of action



People Scorecard

July 2021

Indicator (KPI Name)	Frequency	Basis	Data From Month	Target Status against current month	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: FY2021/ 2022 Trajectory	Target Status against trajectory
Trust Vacancy rate	Monthly	%	Jul-21	G	5%	Internal	4.6%	3.7%	3.6%	3.5%	G
Operational Vacancy Rate	Monthly	%	Jul-21	G	5%	Internal	6.8%	5.7%	5.6%	7.0%	A
Operational Staffing FTE (actual against plan (21-22)	Monthly	(n)	Jul-21	A	0	Internal	-68.0	-68.0	-68.0	-118.0	A
Staff Turnover (% of leavers)	Monthly	%	Jul-21	G	10%	Internal	9.5%	9.0%	8.8%	10.0%	G
Stability Index (% of staff in post >1 year)	Monthly	%	Jul-21	G	>90%	Internal	91.4%	92.0%	92.0%	90.0%	G
Staff Sickness levels (current month) (%)	Monthly	%	Jul-21	A	5%	Internal	7.3%	6.7%	6.2%	6.0%	A
Staff Sickness levels (12 month rolling) (%)	Monthly	%	Jul-21	A	5%	Internal	6.2%	5.9%	5.5%	5.5%	A
Trust Covid Vaccination Rate	Monthly	%	Jul-21	A	100%	Internal	82.0%	81.0%	81.0%	TBC	
Frontline Covid Vaccination Rate	Monthly	%	Jul-21	A	100%	Internal	87.0%	85.0%	84.0%	TBC	
Statutory & Mandatory Training (85% or above)	Monthly	%	Jul-21	A	85%	Internal	82.0%	83.0%	83.0%	85.0%	G
Information Governance Training	Monthly	%	Jul-21	G	95%	Internal	94.6%	94.0%	93.0%	95.0%	G
Staff PDR Compliance (85% or above)	Monthly	%	Jul-21	A	85%	Internal	68.0%	76.0%	74.0%	85.0%	G
Number of disciplinary cases	Monthly	%	Jul-21		N/A	Internal	24	26		N/A	
Number of grievance cases	Monthly	(n)	Jul-21		N/A	Internal	11	11		N/A	
Number of dignity at work cases	Monthly	(n)	Jul-21		N/A	Internal	10	7		N/A	
Number of Employment Tribunals	Monthly	(n)	Jul-21		N/A	Internal	12	10		N/A	
Number of Suspensions	Monthly	(n)	Jul-21		N/A	Internal	8	7		N/A	
% of Trust Staff who are BAME	Monthly	%	Jul-21	G	20.0%	Internal	19.0%	18.8%	17.9%	20.0%	G
% of joiners who are BAME	Monthly	%	Jul-21	G	>30%	Internal	58.0%	46.0%	44.0%	40.0%	G
% of leavers who are BAME	Monthly	(n)	Jul-21	A	<20%	Internal	26.0%	18.0%	20.0%	15.0%	G

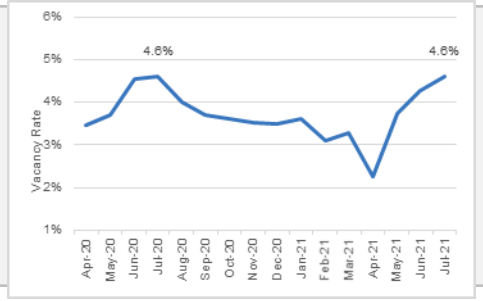
- G — KPI on or ahead of target
- A — KPI off target but within agreed threshold
- R — KPI off target and outside agreed threshold
- KPI not reported / measurement not started

Vacancy Rates, Staff Turnover and Sickness

Vacancy rate

Month: 4.6%

Target: 5%



The overall vacancy rate has increased during Quarter and Quarter 2 1 due to the establishment increases in Ambulance Operations (+200fte) but remains below target at 4.6%, the same level as July 2020. Recruitment continues for the 999 call handling which is fully established and is forecast to reach above establishment to provide the additional resilience required given the CAD / Bow changes and the potential for a third wave of Covid-19. CHUB staffing levels have improved in July with rolling recruitment for permanent positions in place. The team remain heavily reliant on secondments from Ambulance Services. The call handling establishment in IUC is on track to be fully delivered by October and course fill rates remain positive. In total there were 69 starters in July. 58% were from a BAME background covering roles in 111, 999 and Ambulance Services.

Ambulance Ops Recruitment

Month: 87fte

Target: 114fte

Required Frontline: 872 FTE

Forecast Supply: 804 FTE

YTD Actual v forecast : 68fte behind plan

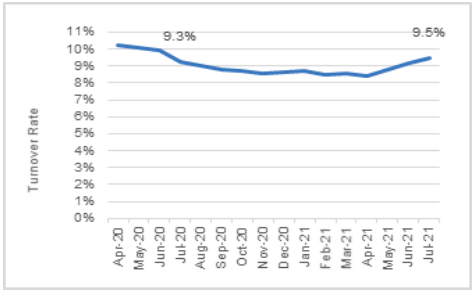
Forecast end of year position: 118fte gap

Frontline new starters are 68 FTE behind plan to July 2021, but an additional 100 TEAC places have been added in Q4 meaning the Trust should recover in year. If all remaining course places are filled, Ambulance Ops will close the year 11 FTE below establishment. Based on current course fill rates, the 'worst case' scenario is forecast to be 118 FTE below establishment. The AAP recruitment pipeline remains challenged due to continued competition with the TEAC course. A task & finish group has been established to review options for a unified non-registrant pathway from next year. All surplus driving course places which were assigned to AAPs have been filled by NQPs and iparas from the waiting list and the driving backlog has now been reduced to almost zero for the first time in recent years. UK NQP recruitment has so far been unaffected by the reduction in the welcome incentive and the Recruitment team is confident all course places will be filled to October. A kick-off meeting with MSI International, the Trust's new international recruitment partner, will take place on 10th August to ensure there is a healthy pipeline of candidates from the end of 2021.

Staff Turnover

12 Month Rolling: 9.5%

Target: 10%



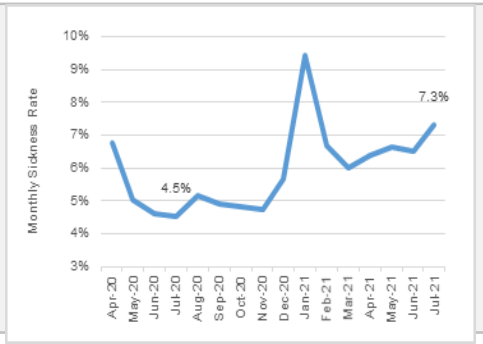
Turnover has remained stable in July and at a similar level for the same period last year. The stability rate, which measures the % of staff in post for > 1 year, has remained above 90% and the number of frontline leavers remains below plan. The Trust has recently appointed a Head of Retention who will lead on a number of activities, focusing initially on the 'quick wins' identified from the recent international paramedic survey and focus groups. These include streamlining the process for bursary funding, shared relief bags and opportunities to standardise secondment and development opportunities across all Groups. Although identified through the iPara survey, these improvements will benefit all of our paramedic colleagues. In total there were 58 leavers in July. 28% were from a BAME background covering roles in 111 and 999 teams.

Sickness

12 Month Rolling: 6.2%

Monthly: 7.3%

Target: 5%



The monthly Trust wide sickness has increased from 6.5% to 7.3%. Episodes of anxiety/stress/depression and back problems have remained at similar levels to June although there were increases in levels of MSK (24 to 37 episodes) and gastrointestinal problems (159 to 196 episodes). Proactively the P&C Business Partners and HR Managers have reviewed all staff with over 100 days absence and are working to have an action plan in place in order to resolve all cases by September. They are also working with their respective teams to review trends and develop strategies to reduce absence with a specific focus on MSK (musculo-skeletal) cases. The well-being team are working with PAM to improve the access to counselling services and have been heavily promoting 'Keeping Well – NWL'. Work is also on-going to review the number of staff who are in excess of four week's absence and who have not yet been referred – this will provide an earlier opportunity to identify the required support for staff and the potential to reduce the length of absence. The number of staff support groups continues to increase including cancer, post-Covid and menopause support and work is also underway to look at ways to increase the number of peer support workers.

Additional Workforce Analysis

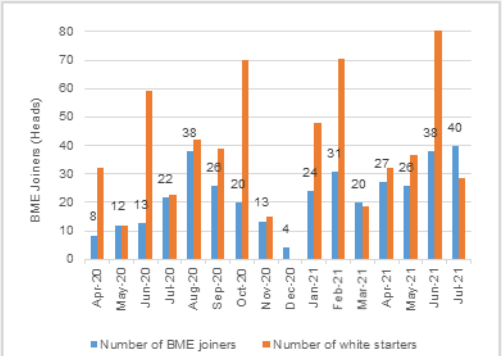
Ensuring that we try to build and retain a diverse workforce that is representative of the city of London is critical to our continued success. We must also ensure that our staff are properly trained and their performance regularly reviewed to ensure we support their development.

Equality, Diversity and Inclusion Standards

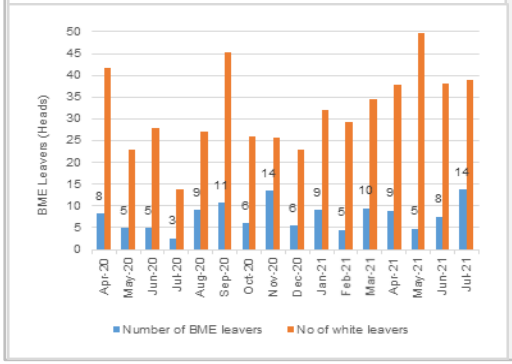
These graphs show the numbers of BAME starters and leavers from April 2020 to July 2021. During this period the Trust has recruited 361fte BAME starters and there has been 124fte BAME leavers, a net increase of 237fte.

In 2020/21, 35% of total starters were BAME. For the year 2021/22, this has improved to 42%.

BME Starters



BME Leavers



Overall numbers of BAME staff continue to increase (currently 1,263 – 19%) although this representation varies at different levels in the organisation.

% of BME staff in band		
	Jun-21	Jul-21
Bands 1-4	40.4%	39.3%
Bands 5-7	12.9%	13.8%
Band 8A to 9	14.2%	15.3%

First People Pulse survey ran in July. It achieved a low response rate (5%), but in line with NHS average. The team are now analysing the results.

Good early engagement with Picker Institute to improve level of analysis for this year's survey results

Menopause/Andropause – Guidance document produced and we delivered Menopause Masterclass session for NHSE which attracted 40 participants.

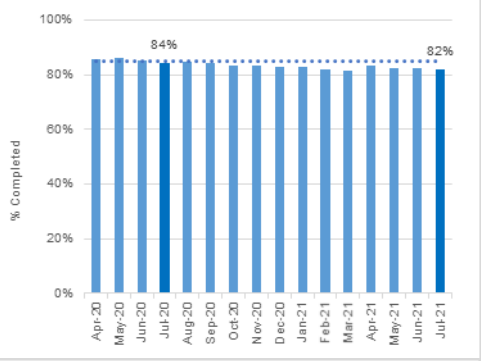
The Equality, Diversity & Human Rights e-learning has improved from 89% to 90%.

Statutory and Mandatory Training and Appraisals

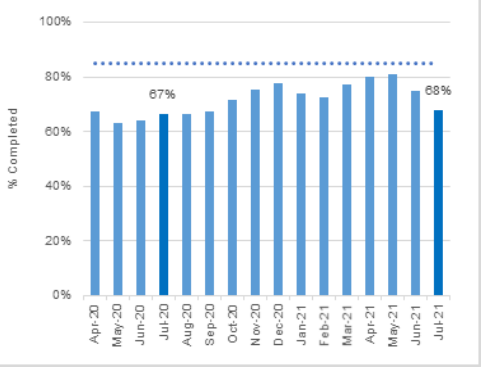
Trust compliance in Statutory and Mandatory training is **82%.**

Appraisal completions at 68**%** at the end of July.

Statutory & Mandatory



Appraisal Compliance



Information Governance is at 94% for July against an annual target of 95% to meet the requirements of the NHS Digital's IG Toolkit.

The REAP 4 pressure levels have affected performance in July for Stat and Mand training (which has remained stable but below target) and PDR rates (which have reduced from 75% to 68% and is below target).

Weekly reports are being sent out to all Managers highlighting those who have an expired PDR date and those who are due to expire in the next three month period, to aid the effective scheduling of these reviews.

Additional Workforce Analysis - Level 3 Safeguarding Training Completion

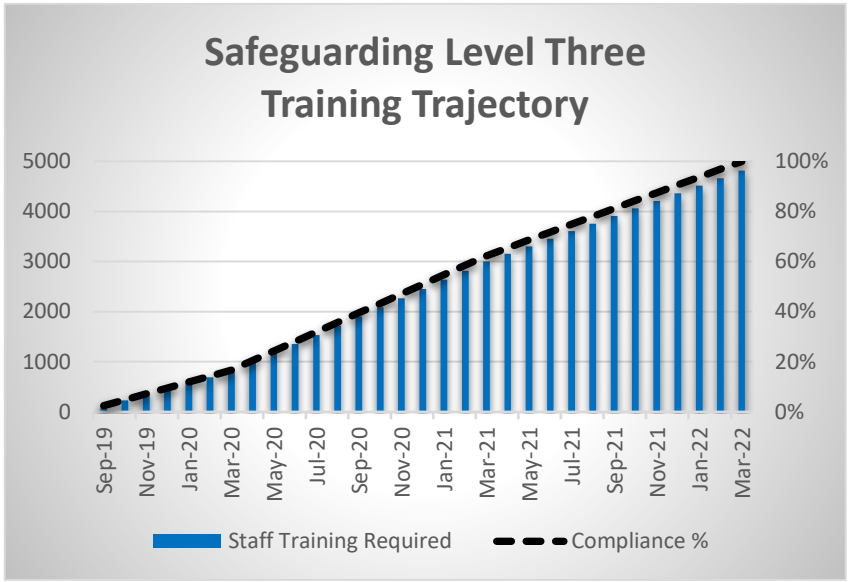
Current position

- Safeguarding Level 3 is now a National Requirement for all paramedics/clinical staff as of the 1st April 2019.
- There are 4,816 staff who need to be trained.
- A training plan was agreed with our Commissioners to deliver the training to all clinical staff by March 2022, and targets have been set for each of the years 2019/20, 2020/21 and 2021/22 as follows:
- For year one we achieved 103% completion with 913 having completed the Level 3 training.

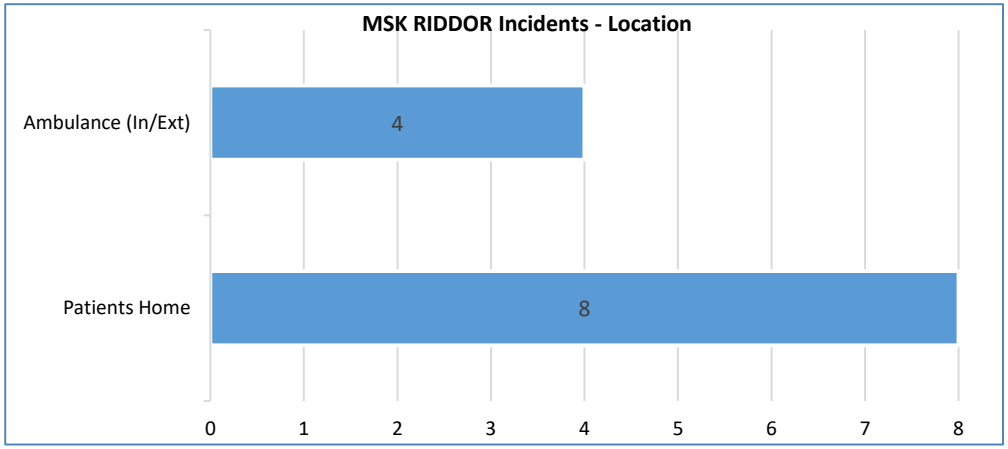
	Year Start	Year End	Compliance Target	% Completed
Year 1	Apr-19	Mar-20	800	17%
Year 2	Apr-20	Mar-21	3,000	62%
Year 3	Apr-21	Mar-22	4,816	100%

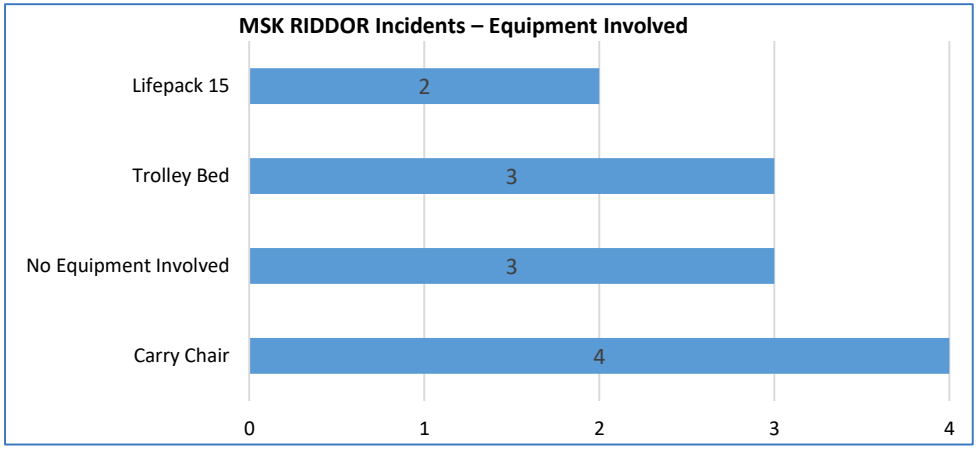
- As a result of Covid 19 and the changes required to training we are currently seeking agreement to the new compliance target for year 2 of 2500 compliance whilst still completing full compliance by end of year 3.
- This training is part of the CSR hours of allocation and 8 hours was given to safeguarding.
- We are currently developing a mixture of e learning and virtual training via teams that equates to 8 hours. Just awaiting operations agreement to the new delivery plan.

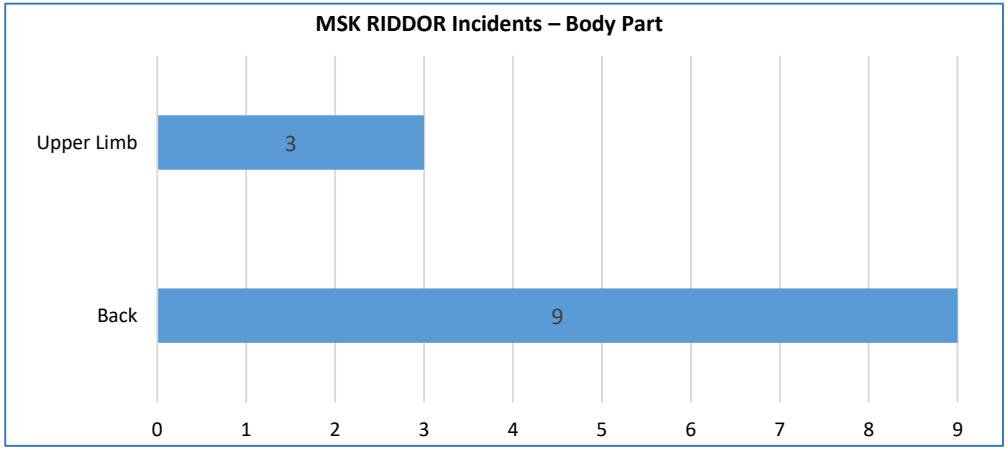
Safeguarding Trajectory

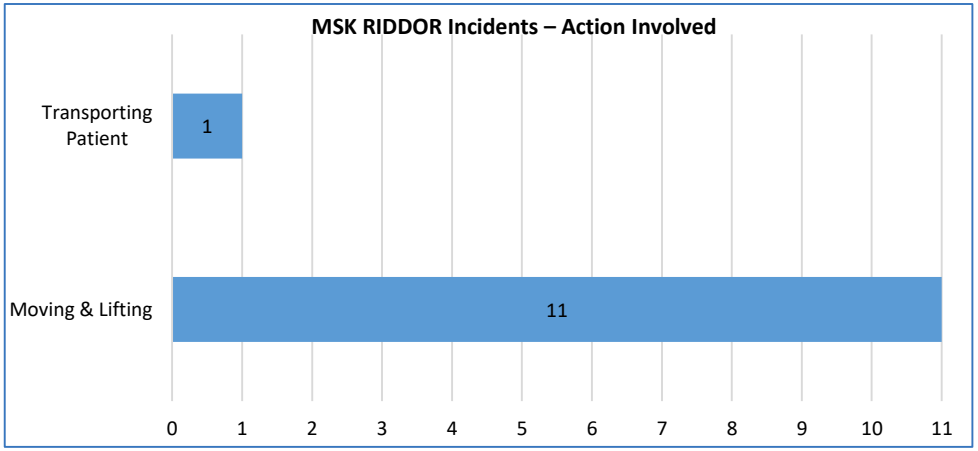


Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) – July 2021



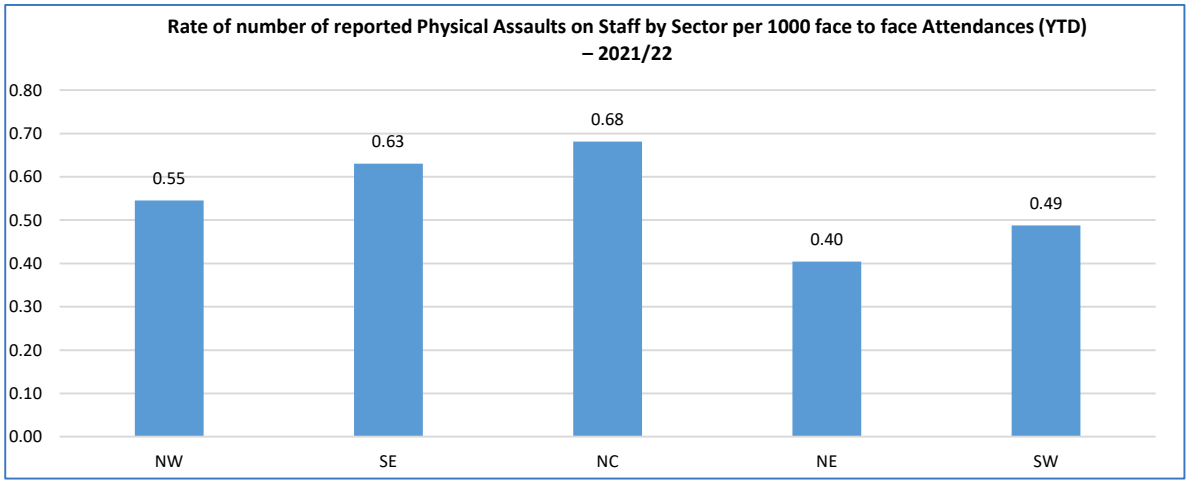






The above graphs provide details from the thematic analysis of 9 reported RIDDOR incidents in July'21 (1 incident was occurred in February'21, 6 incidents were occurred in June'21 & 5 incidents were occurred in July'21). These relate to Manual Handling (MSK):

1. 8 reported RIDDOR incidents occurred in Patients Home (n=8), 4 incidents occurred in Ambulance In/Ext (n=4).
2. 4 reported RIDDOR incidents involved Carry Chair (n=4), 3 incidents involved Trolley Bed (n=3), 2 incidents involved Life Pack 15(n=2), and 3 other incidents involved no equipment (n=3).
3. 9 reported RIDDOR incidents resulted in Back injury (n=9) and 3 incidents were resulted in Upper Limb injury (n=3).
4. 11 reported RIDDOR incidents occurred during Moving & Handling (n=11) and 1 incident was occurred Transporting Patient on the Ambulance (n=1).



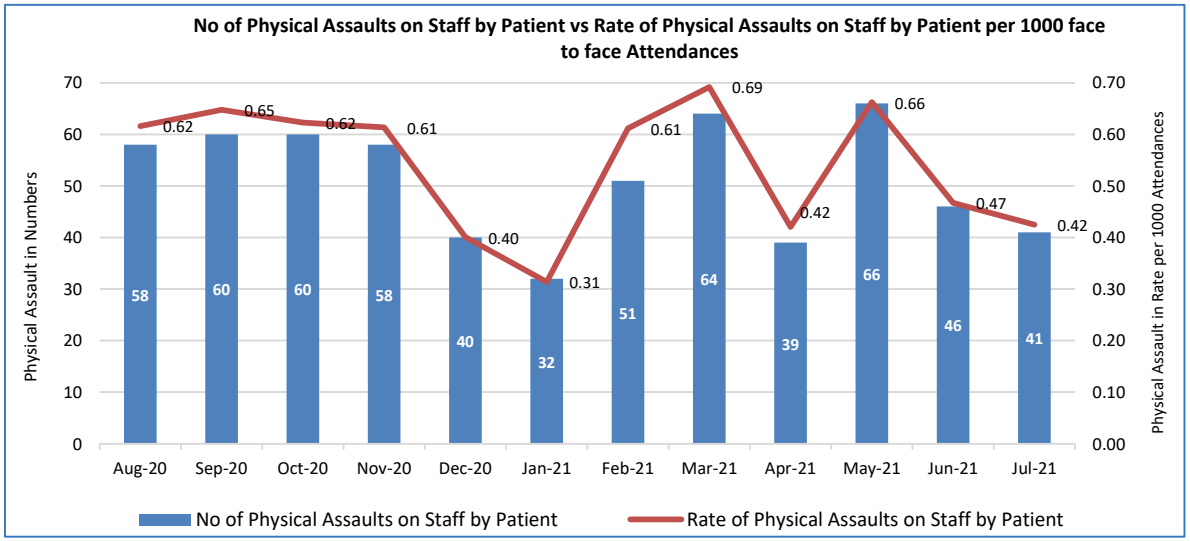
Sector	Rate of Physical Assaults on Staff
NW	0.55
SE	0.63
NC	0.68
NE	0.40
SW	0.49

Notes:

- The graph and dashboard (left side) provides the Rate of reported Physical Assault on Staff by Sector per 1000 face to face Attendances.
- According to the number of reported incidents: In all 5 sectors, approximately one physical assault incident occurred per every 2000 face to face attendances.

Key Update:

- 3 RIDDOR reportable Violence & Aggression related incidents were recorded during 2021/22 (up to end July'21) .



Month	No of Physical Assault on Staff by Patient	Rate of Physical Assault on Staff by Patient
Aug-20	58	0.62
Sep-20	60	0.65
Oct-20	60	0.62
Nov-20	58	0.61
Dec-20	40	0.40
Jan-21	32	0.31
Feb-21	51	0.61
Mar-21	64	0.69
Apr-21	39	0.42
May-21	66	0.66
June-21	46	0.47
July-21	41	0.42

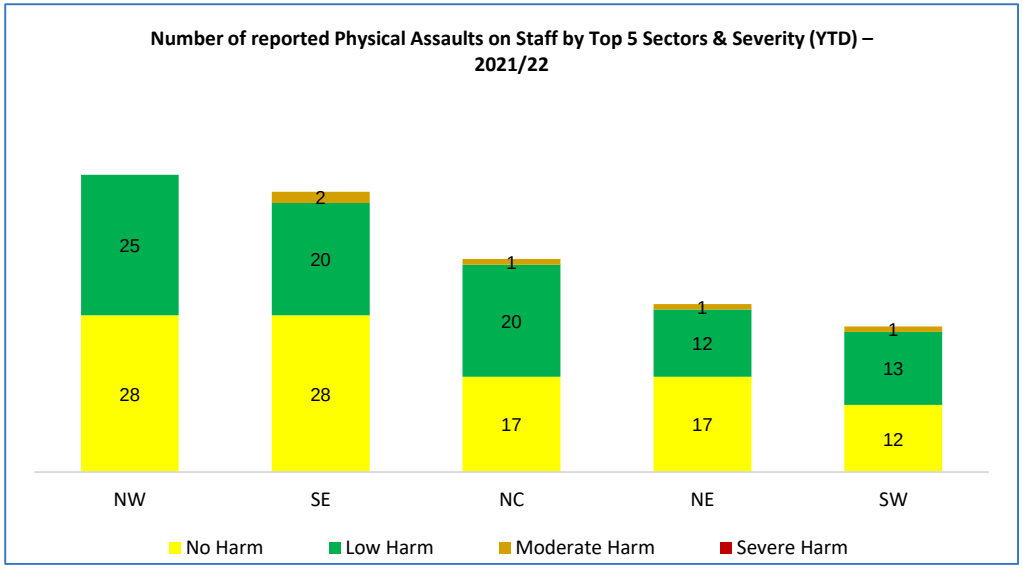
Notes:

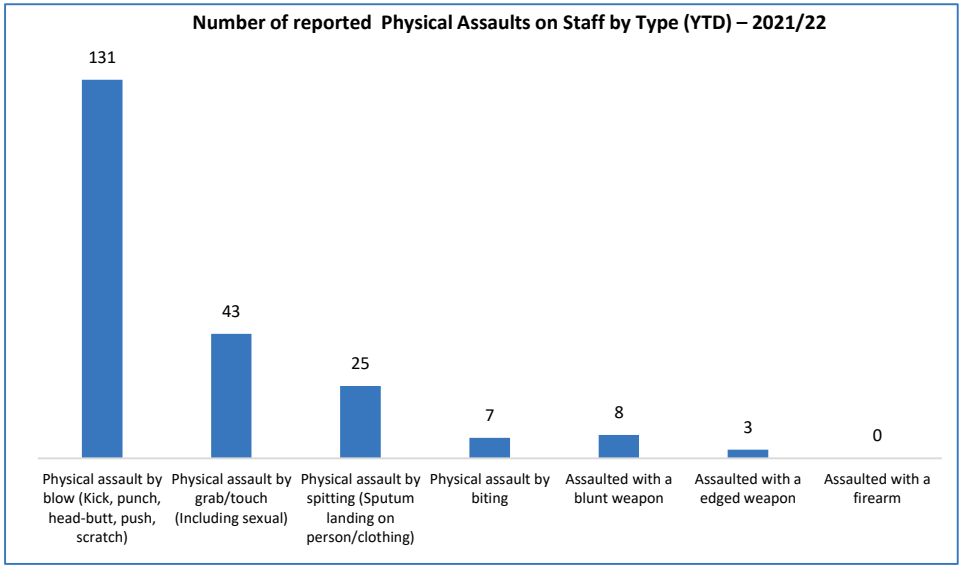
- **The graph and dash board (above) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (August'20 to July'21).**

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 July result from such things including the effects of prescribed medication, mental health issues, and post-ictal state.



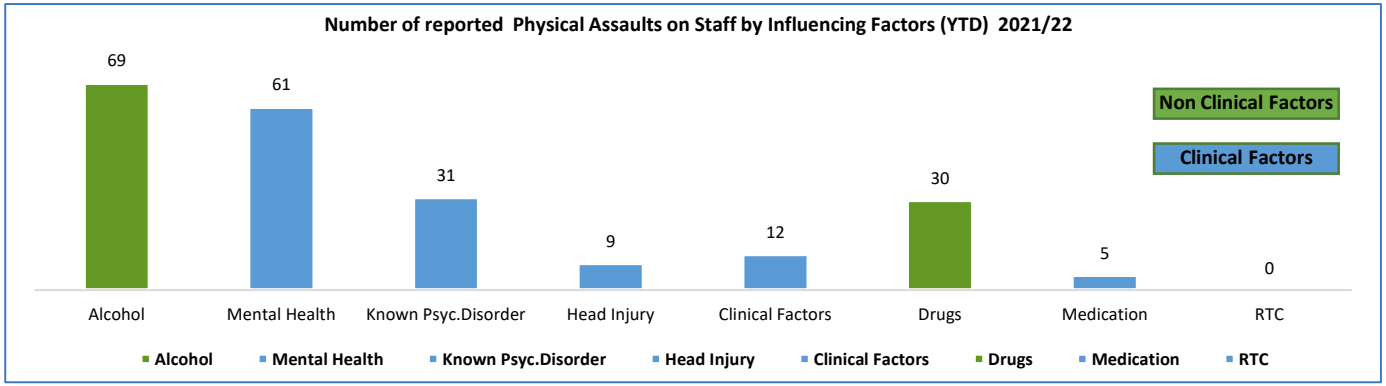


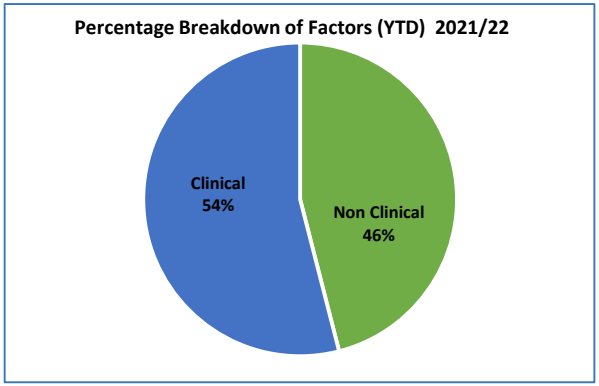
Notes:

- **A total of 217 Physical Assaults on Staff were reported during 2021/22 (up to end July'21).**
- **114 (53%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 103 incidents resulted in Harm. 98 (45%) of the harm related incidents were reported as 'Low Harm and 5 (2%) incidents were resulted in Moderate Harm.**
- **22 out of the 217 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc.).**

Notes:

- **Physical Assault – by blows, kicks/ assault to staff (60% , n=131) accounted for the highest number of incidents reported during 2021/22 (up to end July'21).**





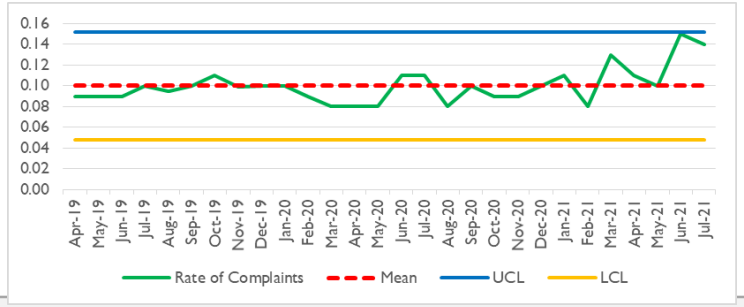
Notes:

- **Clinical Factor: 118 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=61), Known Psyc.Disorder (n=31), Head Injury (n=9), Clinical Factors (n=12), Medication (n=5).**
- **Non Clinical Factor: 99 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=69), and Drug (n=30).**

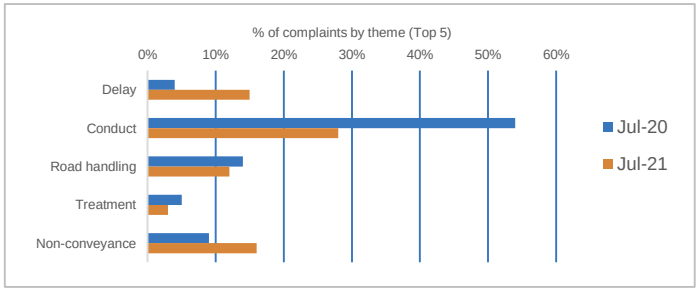
Complaints are an integral way of enabling the Trust to receive patient and public feedback about their experience of our service

Rate of Complaints

Latest month: **0.14**



Categorisation



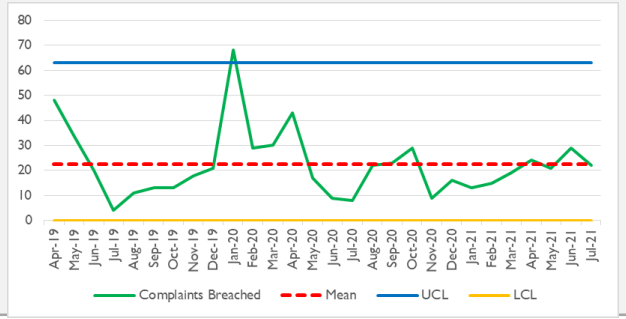
Responding to complaints

Complaint numbers continue to be above the annual average (88) at 134. The percentage of complaints versus the call rates against calls attended has also increased.

There were 489 x PALS enquiries which includes 266 added to the duty spreadsheet that did not require any further actions other then referring the enquirer to the correct team. Slightly lower than June 2021 and the 2020/21 average of 555 per month

We managed 48 Quality Alerts of which 5 were from LAS staff. This is an area that we expect to increase once we have been able to improve the referral process both externally and internally.

Latest Month: 22



Complaints where there was a delayed response and where the patient was either not attended or not conveyed have seen an increase during the extreme pressures to the Trust

We are in liaison with the Quality Assurances Management team to only request a QA report for a complaint when it is essential. The rationale will be explained in our final response to the complainant. A QA report may be obtained at a later date so that we can review such cases.

We are also seeking support from NASPEG (National Ambulance Service Patient Experiences Group) for Ambulance Trusts to adhere to a further 'pause' to the complaints process and to inform the Ombudsman and NHSE/I of the outcome of that.

We are also seeking approval from the Ombudsman to extend the time frames as a pilot site for the Complaints Standard Framework. The implementation of REAP 4 across the Trust has delayed sharing the Maturity Matrix with other LAS colleagues and impacted on our ability to progress this.

The recording of duty phone calls has been approved and functionality will be installed on the duty telephone at HQ post January 2022

Actions and Learning

<u>Patient Experience – July 2021</u>
Despite the pressures to the team, we have maintained a good turnaround. The following examples relate to complaints responded to during July and highlight the complexity of cases:

Example one
We were able to reassure a very worried parent who was concerned about the protracted amount of time the ambulance crew spent on scene with her daughter when she was experiencing a mental health crisis. We explained that the patient had been taken to the ambulance as she felt unsafe but was reluctant to return home or attend A&E. The ambulance crew had acted with the patient's welfare foremost in mind, appropriately requesting the Police for their assistance in applying Section 136 of the Mental Health Act (1983) and liaising with the community mental health Crisis Assessment and Treatment Team (CATT). Ultimately the CATT practitioner attended scene for a face-to-face discussion with the patient and the patient voluntarily agreed to attend A&E to receive the help she needed.

Example two
Following a complaint from a Sickle Cell patient, we were able to explain why the crew were obliged to take her to the nearest hospital rather than her preferred choice. The crew had consulted with the hospital whose care she was under who had a bed on the ward available but the patient needed to be taken to A&E for a COVID-19 test before being transferred on to them. The crew also contacted a clinician based in EOC and a decision was made that the patient should be conveyed to her local hospital as she was presenting with chest pain and that she could be transferred on from there.

<u>Compliments July 2021</u>

As of 3rd August 2021:

June 2021, 47 logged, relating to 115 staff
July 2021, 2 logged, relating to 4 staff

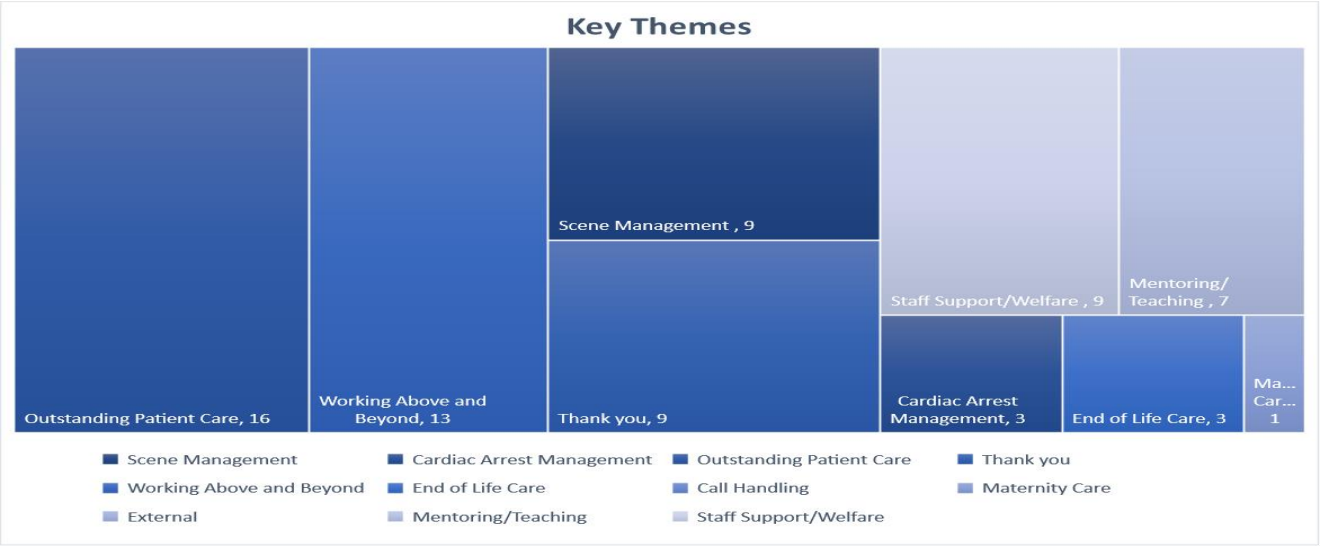
The team are working through a backlog and these numbers will increase

Excellence Reporting
Excellence is everywhere

In July 2021 70 ***Excellence Reports*** submitted were submitted.

Key themes identified from June reports include:

- ❑Outstanding Patient Care
- ❑Working Above and Beyond
- ❑Scene Management



Outstanding Patient Care

He attended an elderly patient as a welfare check whilst working on an FRU. He identified that the patient was incredibly vulnerable and her house was in disrepair with parts of the roof collapsing in. When we arrived as the transporting crew, he was on the phone completing a safeguarding referral, he has already completed thorough documentation, had LFB come assess the patients flat for safety, had raised concerns to the patients social worker, and convinced the patient to come to the hospital. He gave us a detailed handover. His documentation showed a thorough assessment of many of the numerous risks and hazards in the patients house.
He was an excellent advocate for this patient. And did everything he could to ensure this patients best interests were met. It could have been easy for him to just leave the patient when she answered the door and stated she was medically fine and didn't need an ambulance. But he quickly identified and acted upon a number of risks and hazards. The documentation was incredibly thorough and didn't require much to be added by our crew.

They attended a call to a police crime scene where 4 young children had witnessed the event and subsequently needed assessing. I was so impressed with how they demonstrated such professionalism, empathy and skill whilst assessing the patients. The caring way in which they approached the patients allowed them to make a very thorough assessment without distressing them any further. This was an extremely emotive call, but neither of them allowed this to affect the excellent patient care that they delivered. Very well done!

Working Above & Beyond

I had the privilege of working with this individual recently. He is one of the warmest, kindest and knowledgeable colleagues I've come across. They go above and beyond with patients and is incredibly caring and compassionate. He showed great empathy with the number of patients we visited with complex mental health issues. They really are one of the best in the LAS and can be an inspiration to us all.

Since arriving as part of the team, this individual has consistently gone out of his way to support the needs of the Trust and ensure that operational resources have the equipment they need in a timely manner. Nothing is to much trouble; be that at the start of shift or end of shift and his commitment has a direct bearing on the care that ambulance staff ultimately deliver.

This individual was recently appointed into a new secondment in clinical education and standards department. They have gone above and beyond their duties to ensure that the tutors and learners who come to Dockside Education Centre have the best experience. Their attention to detail and passion to creating an excellent centre is a real credit to the department. When Operation Braidwood was delivered, they came in early and stayed late to ensure everything was prepared and ran smoothly. Their organisational skills are outstanding and she should be recognised for all of her hard work over the last two months. Well done, you are an inspiration to all associate tutors.

Scene Management & Thank You

Great leadership on scene, great delegation, great communication. He made sure the scene was calm and it created the best possible atmosphere for success. The manner also how he spoke to the patients family after the arrest was very respectful and the family looked very appreciative of it.

Whilst attending an unwell patient the ambulance keys were accidentally dropped into a drain. This individuals quick thinking using a ring magnet and oxygen tubing allowed him to retrieve the keys and saved considerable time on not waiting for another ambulance.
They showed excellent out of the box thinking and whilst not directly clinical brought significant benefit to the patient. Great work!

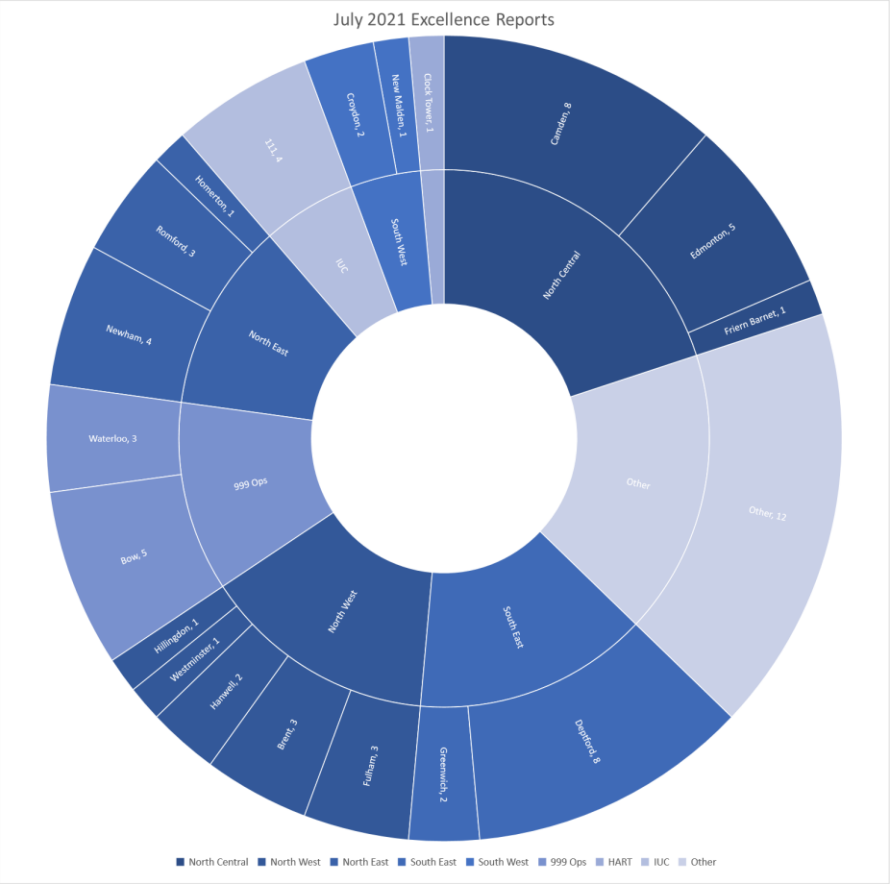
This crew were fantastic in assisting with managing the influx of patients and helping to maintain patient and crew safety. This private ambulance crew assessed and managed multiple low acuity patients allowing the LAS crew to focus on their P1 patient. The crew was responsive and supportive towards the senior clinician managing the scene and communicated any changes and priorities they noticed. This crew deserves the recognition of the fantastic work they do and fantastic display of professionalism they bring to their own service and company. It was an absolute pleasure to work with them on this case.

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.

Excellence reporting and themes are monitored at the Safety Investigation Assurance and Learning Group (SIALG). The Group examines excellence reports alongside themes from serious incidents, complaints, legal cases, patient experiences, and audits to see where learning can be extracted and shared throughout the organisation.

Excellence reports are shared via the following local and Trust wide routes:

- All Excellence reports are shared with individuals, teams and sectors within 48 hour of being reported.
- Used in the Learning events such as the monthly SI learning meeting and the quarterly learning from experience group.
- INSIGHT magazine edition 8 was developed by the Quality Improvement and Learning Team and was released in February 2021. This included 11 key topic areas which were supported by case studies from SIs, incidents and also *Excellence Reports*.



Some further examples of excellence reports from July:

Maternity Care –
When attending what appeared to be a routine obstetric pain call, the crew correctly predicted an early delivery despite history and appearance of the patient suggesting otherwise. They calmly set up a resus area in limited space and demonstrated a great understanding and clear experience in post delivery assessment.

End of Life Care –
I attended an elderly male with dementia who had unfortunately passed away at home. He had a DNAR in place and was on appropriate pain medications with anticipatory medicines should he need them. He had been attended to on the Wednesday prior by this crew and referred to a hospice who was able to provide this. He was unwell and septic on their attendance. The crew had obviously taken the time, involving the family in what can often be a difficult conversation in order to come up with the above plan and allow him to pass away at home with his family in his own bed with his daughter who had taken on his care. The family spoke highly of the above crew who apparently spent some time with them. The process of his passing and indeed our attendance and role procedure was I'm sure helped by whatever conversations they had.

Public Value Scorecard

July 2021

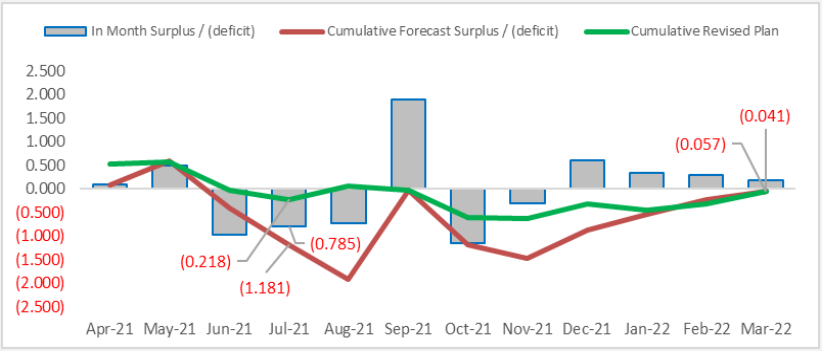
Indicator (KPI Name)	Basis	Data From Month	Target Status	Current Perfomance: Target and Type (Internal / Contractual / National / All)		Latest Month Actual	Latest Month Plan	YTD Actual	YTD Plan	Rolling 12 Months	Outturn: FY21/22 Forecast	FY21/22 Plan	Benchmarking: National Data	Best In Class	Ranking (out of 11)
Adjusted Financial Performance Total (Deficit)/Surplus	£m	Jul-21		0.000	A	(0.782)	(0.176)	(1.161)	(0.200)		0.002	0.000			
Performance Against Adjusted Financial Performance Plan	£m	Jul-21		>=0	A	(0.606)	0.000	(0.961)	0.000		0.002	0.000			
Use of resources index/indicator (Yearly)	Rating	Jul-21		1	A										
% of Capital Programme delivered	%	Jul-21		100%	A	11%	15%	33%	58%		122%	100%			
Capital plan	£m	Jul-21		21.442	A	2.382	3.261	7.118	12.340		26.242	21.442			
Cash position	£m	Jul-21		15.1	A	31.4				60.2					
% spend against Agency Ceiling	%	Jul-21			A	4%	8%	18%	33%		28%	100%			
CIP Savings YTD	£m	Jul-21			A	0.803	0.849	2.094	2.297		9.696	9.700			
	%	Jul-21			A	8%	9%	22%	24%		100%	100%			
CIP Savings achieved - % Recurrent	£m	Jul-21			A										
	%	Jul-21			A										
Commercial income generation	£m	Jul-21		1	I	0.02	0.02	0.07	0.07	1.6	0.4	1			
Corporate spend as a % of turnover	%	Jul-21		<7.0%	I	7.4%		8.4%			9.5%				
Cost per incident (measures to be confirmed in light of COVID)	£	Jul-21			I										
Average Jobs per shift	%	Jul-21		5.3	I	5.0		4.9		4.7					

- 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

Trust Financial Position and Contract Position

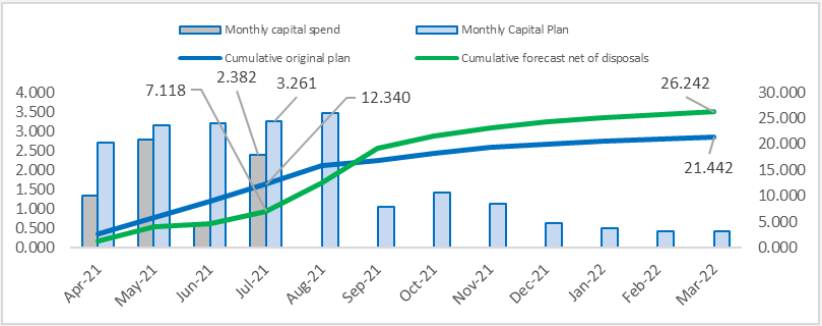
The Trust's month 4 YTD position was a £1.181m deficit (£1.161m deficit on an adjusted financial performance basis), and the month end cash position of £31.4m.

YTD outturn vs budget



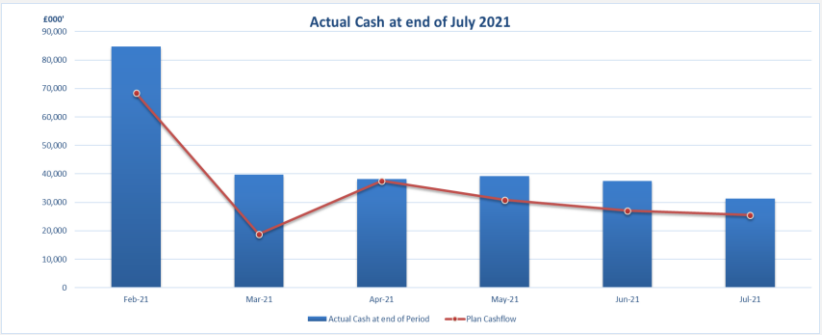
- **YTD Position:** a deficit of £1.181m YTD (£1.161m deficit on an adjusted financial performance basis which is currently behind plan. The position incorporated £19.6m of costs in relation to the Trust's response to COVID-19 primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, as well as associated operational support services.
- **Full year Forecast:** The full year position is forecast to be a £0.041m deficit (£0.002m surplus on an adjusted financial performance basis) which is in line with budget, however funding arrangements for the second half of the year are yet to be confirmed.

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**: Month 4 YTD capital spend (excl donated assets) was £7.1m YTD (£7.1m YTD net of disposals), the bulk of which comprised of spend on ongoing property projects. The Trust capital plan currently incorporates full year capital spending of £26.2m, and increase from the plan of £21.4m due to additional CRL identified through NW London partners. The CRL transfer is still to be completed by NHSI.

Cash position



- **Cash:** Cash was £31.4m as at 31 July 2021. Cash balances have decreased after February 2021 due to the cessation of payment of block contract income in advance.
- **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 2021 YTD was 88.1% and 92.4% respectively. The Trust has a high volume of overdue invoices waiting to be approved and Directorate managers and staff are regularly sent lists of invoices that are outstanding and 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 2021)

	Month 4 2021-22 £000			YTD Month 4 2021-22 £000			Full Year 2021-22 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance to budget fav/(adv)
Income									
Income from Activities	43,825	43,911	86	175,063	175,608	545	522,969	527,671	4,702
Other Operating Income	511	251	(260)	2,025	1,996	(30)	5,003	5,488	484
Total Income	**44,337**	**44,163**	**(174)**	**177,089**	**177,604**	**516**	**527,973**	**533,159**	**5,186**
Operating Expense									
Pay	(30,677)	(31,934)	(1,257)	(122,170)	(124,163)	(1,993)	(365,333)	(367,749)	(2,416)
Non Pay	(11,782)	(11,231)	550	(47,176)	(47,482)	(306)	(137,207)	(139,939)	(2,732)
Total Operating Expenditure	**(42,459)**	**(43,165)**	**(706)**	**(169,346)**	**(171,645)**	**(2,299)**	**(502,540)**	**(507,688)**	**(5,148)**
EBITDA	**1,878**	**997**	**(880)**	**7,742**	**5,959**	**(1,783)**	**25,433**	**25,471**	**39**
EBITDA margin	4.2%	2.3%	(2.0%)	4.4%	3.4%	(1.0%)	4.8%	4.8%	(0.0%)
Depreciation & Financing									
Depreciation & Amortisation	(1,581)	(1,327)	254	(6,075)	(5,318)	758	(19,682)	(19,769)	(86)
PDC Dividend	(463)	(463)	0	(1,853)	(1,853)	0	(5,558)	(5,558)	0
Finance Income	0	0	0	0	0	0	0	0	0
Finance Costs	(14)	7	22	(32)	29	61	(249)	(188)	61
Gains & Losses on Disposals	0	1	1	0	2	2	0	2	2
Total Depreciation & Finance Costs	**(2,058)**	**(1,782)**	**276**	**(7,961)**	**(7,140)**	**820**	**(25,489)**	**(25,513)**	**(24)**
Net Surplus/(Deficit)	**(181)**	**(785)**	**(604)**	**(218)**	**(1,181)**	**(963)**	**(57)**	**(41)**	**15**
NHSI Adjustments to Fin Perf									
Remove Asset Donations I&E Impact	5	3	(2)	19	20	1	57	43	(14)
Adjusted Financial Performance	**(176)**	**(782)**	**(606)**	**(199)**	**(1,161)**	**(962)**	**0**	**2**	**1**
Net margin	(0.4%)	(1.8%)	(1.4%)	(0.1%)	(0.7%)	(0.5%)	(0.0%)	(0.0%)	0.3%

Year to Date Position

The YTD position is a £1.181m deficit (£1.161m deficit on an adjusted financial performance basis) which is adverse to plan due to significant additional overtime and secondee expenditure to respond to operational pressures in Ambulance Services and the Trust's 111 Integrated Urgent Care Service being partially offset by lower than planned recruit numbers and vacancies.

Forecast Full Year Position

The full year position is forecast to be a £0.041m deficit (£0.002m surplus on an adjusted financial performance basis) which is in line with budget. Current levels of Ambulance Service and IUC pay and non pay resourcing have not been forecast forward at this point due to COVID surge uncertainty.

Key Drivers of Position

Income:

- Income from activities was £175.6m YTD (£527.7m full year forecast) and is primarily comprised of the Trust's block contract income under the current financial arrangements, along with standard top up and fixed COVID income. An additional £2.7m income has been recognised in the H1 forecast in respect of COVID surge costs, H2 forecast COVID income assumes sufficient funding to break even on an adjustment financial performance basis but is unconfirmed.
- Other operating income is £2m YTD (£5.5m full year forecast) which is slightly ahead of budget full year due to staff recharge income (£0.8m favourable full year forecast) partially offset by lower education and training income (£0.5m full year forecast). Other Operating Income is mainly comprised of education and training income (£1.4m YTD, full year forecast £3.6m) from Health Education England and apprenticeship income.

Pay Expenditure:

- Pay expenditure is £2m over budget YTD (forecast to be £2.4m over budget full year) due to significant additional resource usage in Ambulance Services and IUC partially offset by vacancies, lower than expected trainee numbers and unallocated reserves in Central Corporate.

Non-Pay Expenditure:

- Non pay expenditure (excl depreciation and finance costs) was £0.3m adverse YTD (full year forecast £2.7m adverse) due to overspends in IUC for additional resourcing in response to higher COVID related activity and is offset by underspends in Programmes and Projects and Strategy & Transformation due to project delays, and People and Culture and Quality and Assurance due to lower recruit numbers than planned.
- Depreciation and finance costs are £0.8m favourable to budget YTD and forecast to be in line with budget for the year with differences due to current forecast timelines for project completion.

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 2021)

	Apr-21 Actual £000	May-21 Actual £000	Jun-21 Actual £000	Jul-21 Actual £000	Jul-21 YTD Move £000
Opening Cash Balance	**39,788**	**38,267**	**39,262**	**37,537**	**39,788**
Operating Surplus	1,755	2,393	816	997	5,961
(Increase)/decrease in current assets	(616)	(901)	(763)	(3,151)	(5,431)
Increase/(decrease) in current liabilities	6,987	971	1,181	(1,123)	8,016
Increase/(decrease) in provisions	(140)	(37)	(7)	124	(60)
Net cash inflow/(outflow) from operating activities	7,986	2,426	1,227	(3,153)	8,486
Cashflow inflow/(outflow) from operating activities	**7,986**	**2,426**	**1,227**	**(3,153)**	**8,486**
Returns on investments and servicing finance	0	0	0	(1)	(1)
Capital Expenditure	(9,507)	(1,431)	(2,952)	(3,009)	(16,899)
Dividend paid	0	0	0	0	0
Financing obtained	0	0	0	0	0
Financing repaid	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(9,507)**	**(1,431)**	**(2,952)**	**(3,010)**	**(16,900)**
Movement	(1,521)	995	(1,725)	(6,163)	(8,414)
Closing Cash Balance	**38,267**	**39,262**	**37,537**	**31,374**	**31,374**

Operating Position

There has been a net outflow of cash to the Trust of £8.4m. Cash funds at 31 July stand at £31.4m.

The operating surplus is £6.0m.

Please note: At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6. This process has not yet included detailed cash flow planning, and as such, no detailed cash flow plan figures are included.

Current Assets

- The movement on current assets is (£5.4m).
- The movement is due to trade receivables (£4.7m), inventories (£0.7m), accrued income £1.6m and prepayments (£1.6m).

Current Liabilities

- The movement on current liabilities is £8.0m.
- The movements are due to deferred income £0.2m, accruals £9.3m and payables (£1.5m).

Dividends

- N/A

Provisions

- The movement on provisions was (£0.1m), this relates to legal and international student payments.

Capital Expenditure

- Capital cash movement was a net outflow of £16.9m.

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.

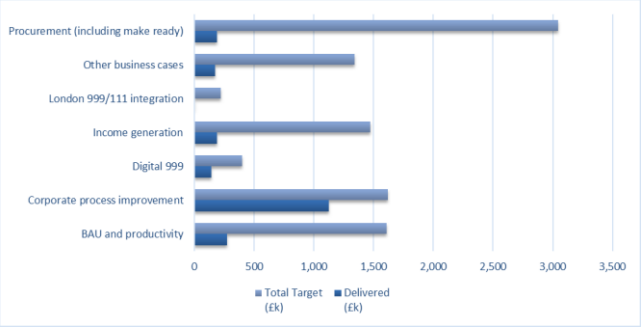
Cost Improvement Programmes (CIPS)

- The Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6 which incorporates the requirement for Cost Improvement Programmes.
- Projects have been developed to deliver £9.7m of efficiency savings and as of M4 achievement overall was in line with plan at £2.1m YTD.

CIP Savings

YTD: £2.1m

FY Target: £9.7m



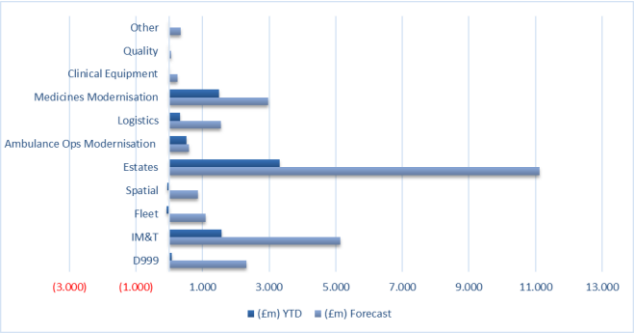
Capital Plan

- YTD capital expenditure net of disposals is £7.1m YTD (£7.1m before disposals) compared to planned YTD capital expenditure of £12.3m (£5.2m behind plan net of disposals). This comprised predominately property projects and programmes.
- Full year forecast capital expenditure net of disposals is £26.2m, £4.8m higher than plan reflecting the increase in CRL identified through NW London partners.

Capital Plan Breakdown

YTD: £7.1m

FY: £26.2m

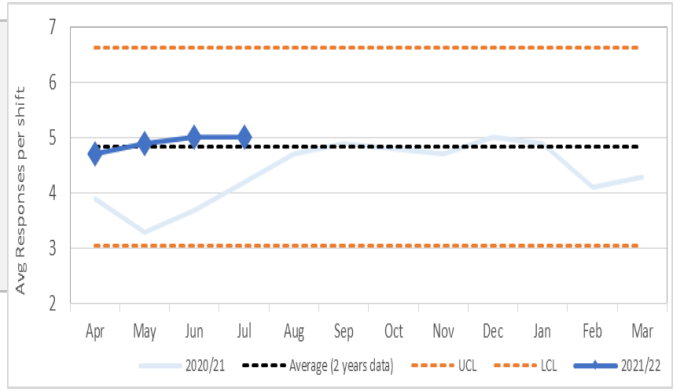


Jobs per shift (DCA)

Average jobs per 12 hour shift

Actual: 5.0

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 2021

Indicator (KPI Name)	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	Benchmarking (Month): National Data	Benchmarking (Month): Best In Class	Benchmarking (Month): Ranking (out of 11)
Hospital handover	minutes	Jul-21	R	18.0	I	23.3	20.9	21.3			
Post-handover (Handover 2 Green)	minutes	Jul-21	G	15.5	I	15.1	15.1	14.9			
See and Convey – to ED (Contractual Position) *	%	Jul-21	G	57.0%	C	47.9%	50.5%	51.3%	51.0%	46.9%	4
Hear and Treat % **	%	Jul-21	G	8.39%	I	16.5%	13.7%	11.7%	11.5%	16.5%	1
Hear and Treat (n) **	%	Jul-21	G	108,073	I	19,006	**61,602**	151,280			

Benchmarking Key
Top 3
Ranked 4-7
Ranked 7+

Please note: 999 performance data is correct as at 16/08/21 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

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 16/08/21 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We saw an increase in hospital delays in July in comparison to June, with the overall number at 2,613 hours lost from our arrival to patient handover over 30 mins. Queens Romford, King Georges, and North Middlesex had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the had the highest number of lost hours over 30 minutes, at 391 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	1,401	1,299	456	35%	237.7	34.8
	North Middlesex	2,309	2,112	885	42%	228.7	30.2
	Royal Free	1,462	1,265	373	29%	111.0	28.2
	University College	1,470	1,362	89	7%	16.0	16.7
	Whittington	1,322	1,163	347	30%	108.1	27.9
North East	Homerton	1,281	1,124	77	7%	9.7	17.5
	King Georges	1,161	1,007	657	65%	224.1	**40.9**
	New ham	1,595	1,351	420	31%	54.9	26.1
	Queens Romford	2,513	2,186	1,316	60%	390.9	37.8
	Royal London	1,812	1,575	189	12%	22.7	22.0
	Whipps Cross	1,482	1,246	297	24%	133.3	27.1
North West	Charing Cross	1,272	1,171	8	1%	1.3	12.2
	Chelsea & West	1,305	1,141	32	3%	8.1	16.8
	Ealing	1,349	1,295	95	7%	31.2	15.2
	Hillingdon	1,821	1,653	274	17%	122.9	21.7
	Northw ick Park	3,218	3,035	538	18%	286.5	22.3
	St Marys	1,719	1,595	224	14%	37.7	20.1
	West Middlesex	2,133	2,007	185	9%	41.6	18.2
South East	Kings college	1,905	1,697	477	28%	97.9	26.4
	Lew isham	1,428	1,199	185	15%	54.6	21.8
	Princess Royal	1,769	1,455	284	20%	184.2	26.3
	Queen Elizabeth II	2,286	1,981	78	4%	45.0	14.7
	St Thomas'	2,085	1,874	217	12%	36.0	20.1
South West	Croydon	2,067	1,870	130	7%	55.3	20.1
	Kingston	1,582	1,372	77	6%	10.9	19.7
	St Georges	1,852	1,500	268	18%	35.3	21.7
	St Helier	1,228	1,086	103	9%	27.7	20.8
	TOTAL	46,827	41,621	8,281	20%	**2,613**	23.3

Max average breach value

Value >10 mins per breach

Patient Handover to Green

In July, we saw handover to green performance within the target, with 15.1, consistent with recent months. However, over 3,600 hours were lost due to patient handover to green exceeding the 14 minute threshold. Handover to Green received organizational focus through the Covid response team and will receive renewed focus as part of planning and recovery.

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	1,937	1,188	61%	226.1	16.5	32.6	11.4
	Edmonton	2,543	1,478	58%	241.2	15.9	30.6	9.8
	Friern Barnet	1,704	1,047	61%	157.6	15.8	28.8	9.0
North East	Homerton	2,181	1,309	60%	228.5	15.4	30.8	10.5
	New ham	2,557	1,580	62%	310.7	16.1	32.8	11.8
	Romford	2,829	1,711	60%	241.7	14.9	28.4	8.5
North West	Brent	3,531	2,102	60%	282.2	15.5	27.5	8.1
	Fulham	2,254	1,394	62%	212.8	16.1	29.9	9.2
	Hanw ell	2,893	1,693	59%	214.7	15.3	25.7	7.6
	Hillingdon	1,661	919	55%	108.4	14.6	25.3	7.1
	Westminster	1,334	871	65%	134.4	16.8	29.7	9.3
South East	Bromley	2,133	1,258	59%	157.6	13.6	26.6	7.5
	Deptford	3,518	2,091	59%	274.8	14.8	27.2	7.9
	Greenw ich	2,303	1,336	58%	138.0	13.8	24.2	6.2
South West	Croydon	1,915	1,184	62%	149.6	15.1	26.8	7.6
	New Malden	1,512	935	62%	116.6	15.3	27.3	7.5
	St Helier	1,467	930	63%	116.1	15.3	26.5	7.5
	Wimbledon	1,061	693	65%	109.0	12.8	29.7	9.4
Other	NULL	312	245	79%	44.9	14.0	31.8	11.0
	IRO	9	5	56%	2.1	20.2	57.7	**25.2**
	Other	769	436	57%	61.8	13.1	27.8	8.5
	Training	1,198	616	51%	88.2	13.8	28.0	8.6
	TOTAL	41,621	25,021	60%	3617.0	**15.1**	**28.5**	**8.7**

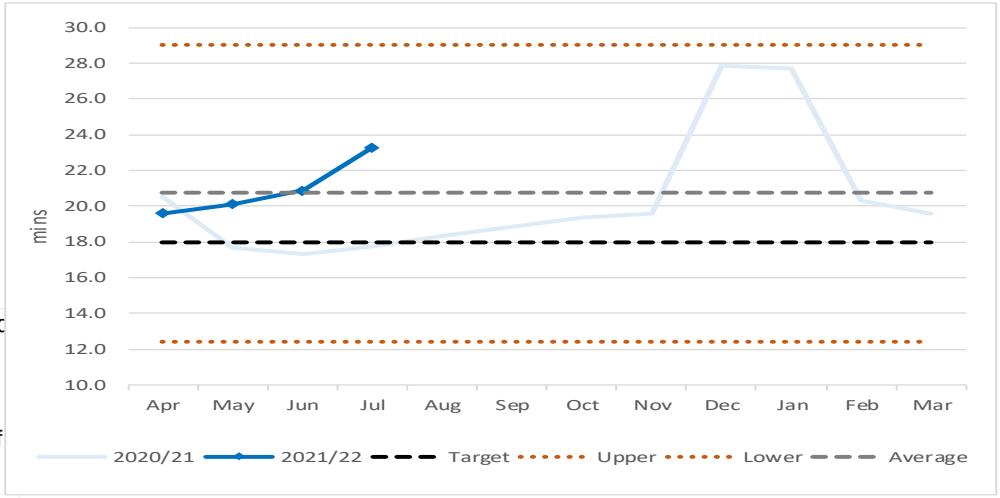
Max average breach value

Value >7 mins per breach

Arrive at Hospital to Patient Handover (**Emergency Departments only & Excluding blue calls)

	May-21	Jun-21	Jul-21	Year-end Target
Arrive at Hospital to Patient Handover (mins)	20.1	20.9	23.3	18.0

Hospital Handover performance remains outside of target, despite an improvement compared to the winter months. Since June 2020 we have been seeing a steady worsening of performance on this metric, due to increasing overall demand and pressure on the hospitals as a result, impacting LAS teams ability to hand patients over. After January, which was a particular outlier due to operational pressures on the EDs stemming from the second wave of Covid, July figures significantly worse than June performance as some of the pressure remains, particularly in NE and NC.

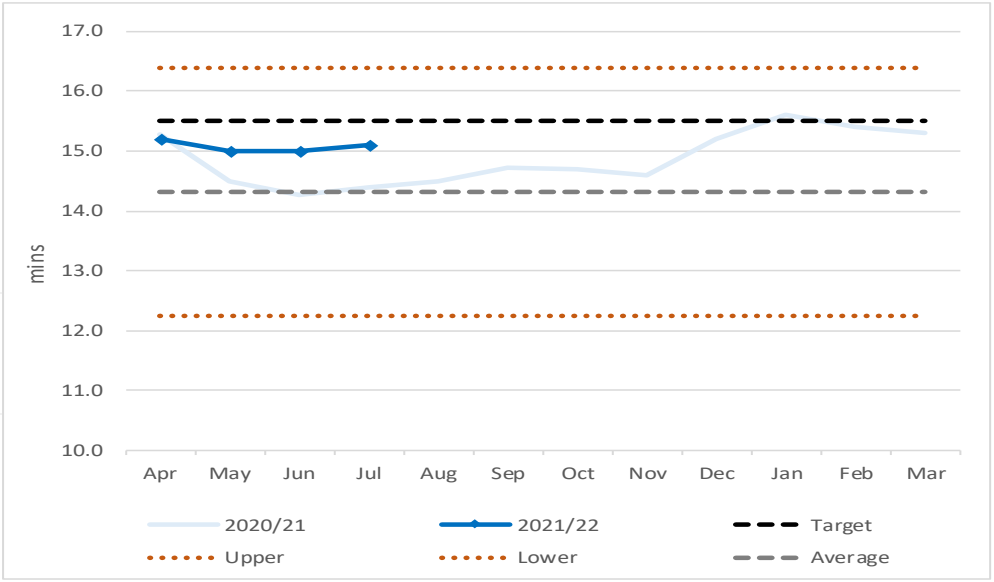


Patient Handover to Green (**Emergency Departments only & Excluding blue calls)

	May-21	Jun-21	Jul-21	Year-end Target
Patient Handover to Green (mins)	15.0	15.0	15.1	15.5

Handover to Green YTD performance has been within target, but above the 19/20 average since April 2020. In June 2021 we are seeing performance continuing within the target after a deterioration in performance following operational pressures in December and January.

Please note: 999 performance data is correct as at 16/08/21 and is subject to change due to data validation processes

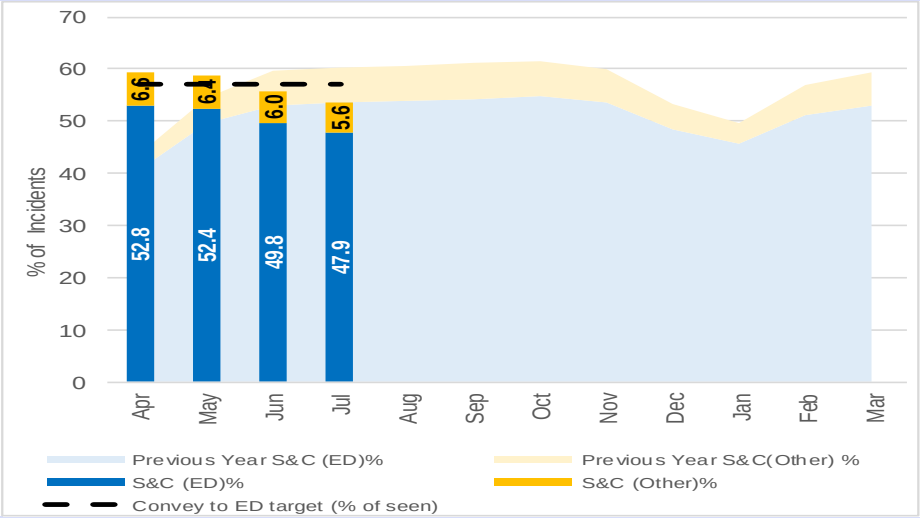


Maximising safe non-conveyance to ED

See and Convey to Emergency Department

		Jul-21	Year To Date	Year-end Target
See & Convey ED %	LAS	47.9%	50.5%	
	Target			57.0%

The conveyance to emergency departments target (57.0%) was delivered in July (47.9%). A steady profile of demand has allowed us to achieve this metric month on month. LAS ranked 4th nationally as the Covid profile demand changed, with a rising proportion of patients where the best clinical decision was to not convey and be overseen by the clinical hub.

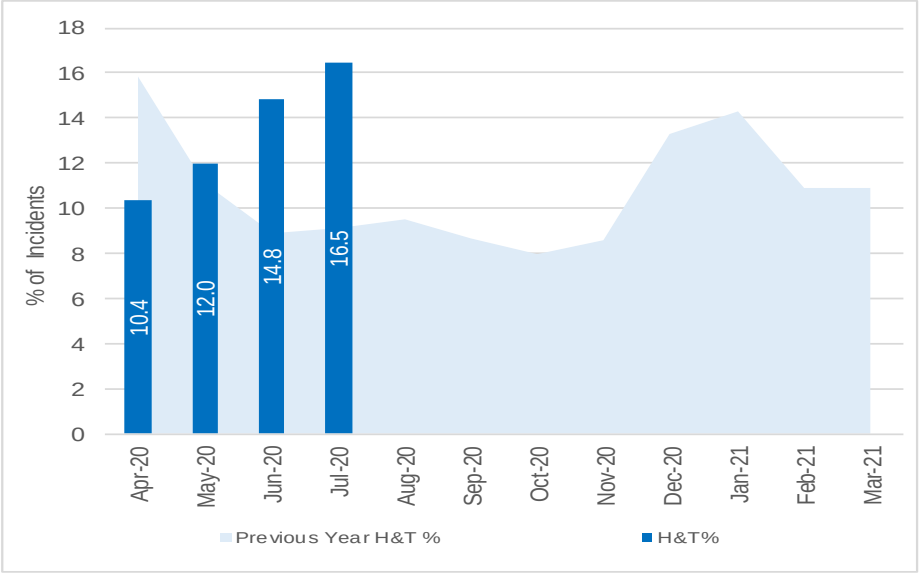


Hear and Treat %

		Jul-21	Year To Date	Year-end Target
Hear & Treat %	%	16.5%	13.7%	
	(n)	19,006	61,602	TBC

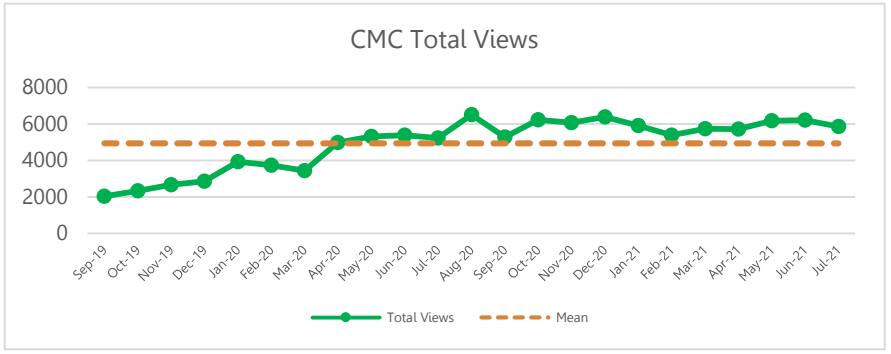
Hear and treat delivered 16.5% in June, being the best nationally. In 2020/21 year to date, the performance in the metric has been strongly within the 2019/20 target (7.9%) and continue to outperform last year's benchmark of 8%. Hear & Treat remains a key focus for the Trust, allowing robust delivery on our conveyance rates and keeping frontline resources available for our most critically ill patients.

Please note: 999 performance data is correct as at 16/08/21 and is subject to change due to data validation processes



4. Our Partners

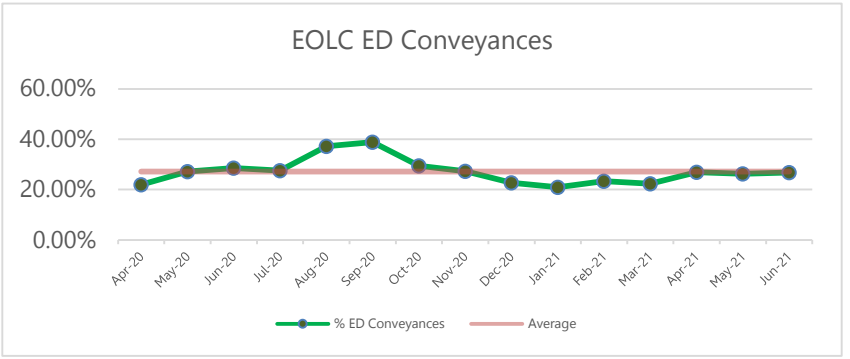
End of Life Care & Mental Health



ED Conveyance

Latest Month (Jun):

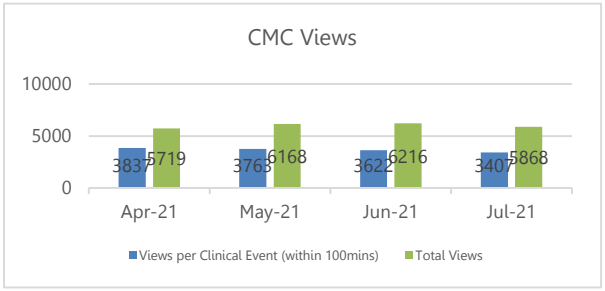
26.8%



The Macmillan Programme won NHS Parliamentary Award in Urgent & Emergency Care

ED conveyance for EoLC patients remains below average

CMC Views



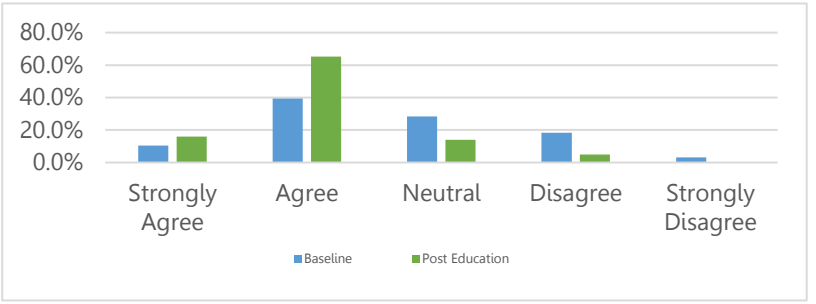
July:
Total views: 5868

Views per clinical event: 3407

Staff Confidence

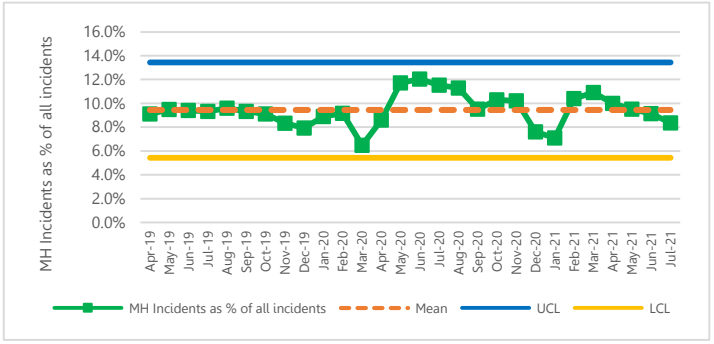
82% staff post education felt confident

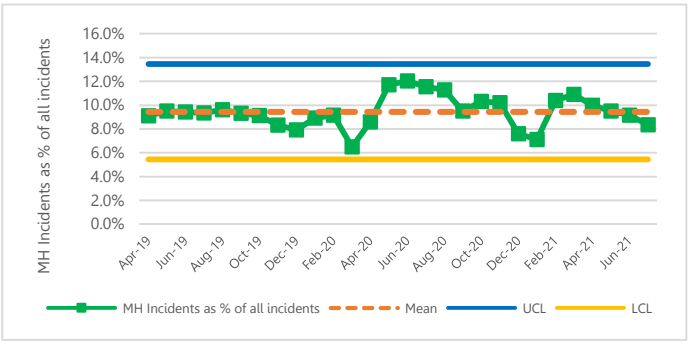
32% increase from baseline

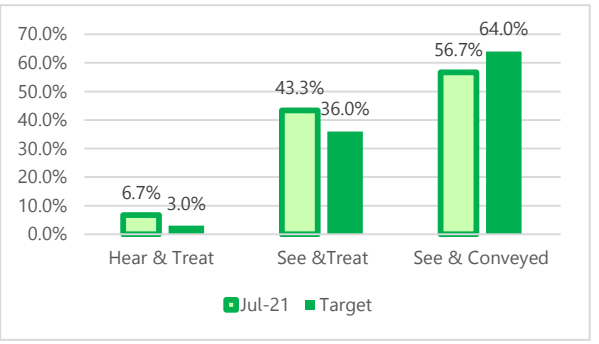


111 IUC CMC data exploration underway

First Team Time ™ hosted at LAS with EoLC Coordinators







We are maximising patient facing time to support REAP 4 within the Trust. Overtime incentives have been offered to CHUB trained mental health nurses to support hear and treat.
We continue to work with our commissioning team to agree the service specification for the MHJRC

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Quality Priorities Update			
Agenda item:	8.1			
Report Author(s):	Jeni Mwebaze, Head of Quality Assurance Systems Amy Pitcher, Quality Compliance Manager			
Presented by:	John Martin, Chief Paramedic and Quality Officer			
History:	N/A			
Purpose:	☒	Assurance	☐	Approval
	☒	Discussion	☐	Noting

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

This paper outlines the progress in Quarter 1 against the 10 quality account priorities agreed by the Board for 2021/22:

- Implementation of the Patient Safety Incident Response Framework (PSIRF) as a pioneer in the new process for other Ambulance Trusts.
- Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services – (front end, CAS and management – including CHUB/ ECAS).
- Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment which is enshrined in policy.
- The Trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation.
- Patient & Communities engagement & involvement.
- Continued delivery of the Clinical Strategy (2016/17-2022/23 2019 Refresh)
- Integrating the 999 and 111/ IUC CAS systems to provide seamless care for patients regardless of access point.
- Implementing the station/service quality accreditation programme
- Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy.
- Continue to invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.

Recommendations for the Board:
The Trust Board is asked to note progress on the 2021/22 Quality Account Priorities.

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

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Quality Priorities Report
July 2021 Update

Author – Jeni Mwebaze, Head of Quality Assurance Systems
Amy Pitcher, Quality Compliance Manager

	Quality Priority - Overview	Status
1.	Implementation of the Patient Safety Incident Response Framework (PSIRF) as a pioneer in the new process for other Ambulance Trusts.	
2.	Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services – (front end, CAS and management – including CHUB/ ECAS).	
3.	Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment which is enshrined in policy.	
4.	The Trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation.	
5.	Patient & Communities engagement & involvement.	
6.	Continued delivery of the Clinical Strategy (2016/17-2022/23 2019 Refresh)	
7.	Integrating the 999 and 111/ IUC CAS systems to provide seamless care for patients regardless of access point.	
8.	Implementing the station/service quality accreditation programme	
9.	Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy.	
10.	Continue to invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.	

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
Not assessed

London Ambulance Service NHS Trust

Quality Priorities from Quality Account	KPI	Status	July Update
Implementation of the Patient Safety Incident Response Framework (PSIRF) as a pioneer in the new process for other Ambulance Trusts.	*Development & delivery of effective QI projects to address findings from PSIRF thematic reviews*		The team continues to work with key stakeholders to develop QI projects in key incident themes such as delayed defibrillation, medicine management and obstetric emergencies. However, the Trust went to REAP 4 in early June 2021 and this has impacted on the ability to meet and progress these ideas into projects at present. The Quality Improvement and Learning team continue to review incidents on a daily basis and support the Trust is its management of patient safety.

<table>
<tr><th>Quality Priorities from Quality Account</th><th>KPI</th><th>Status</th><th>July Update</th></tr>
<tr><td rowspan="2">Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment which is enshrined in policy.</td><td>Medical devices policy and appropriate governance in place by end of Q2, 2021/22.</td><td>●</td><td>On track, medical device policy in draft, and consultant contracted to provide advice. Formal role included in the business plans for recruitment.</td></tr>
<tr><td>Reduction in incidents relating to clinical equipment from baseline Q4 of 2020.</td><td>●</td><td>
<table>
<tr><th></th><th>Q4</th><th>Q1</th></tr>
<tr><td>Total incidents</td><td>446</td><td>446</td></tr>
</table>
<table>
<tr><th></th><th>Q4</th><th>Q1</th></tr>
<tr><td>Failure of device / equipment</td><td>279</td><td>248</td></tr>
<tr><td>Lack / unavailability of device / equipment</td><td>149</td><td>172</td></tr>
<tr><td>User error</td><td>11</td><td>22</td></tr>
<tr><td>Wrong device / equipment used</td><td>7</td><td>4</td></tr>
</table>
The Trust has procured an central asset management system (CAMS). This is to be introduced and trialed at Ilford from the 28th June 2021 which will see the systematic tagging of all medical equipment with passive RFID tags. The process will be tested to identify any gaps in the process and standard operating procedures will be produced to manage the tracking, inventory, storage and maintenance of all medical devices. This will then be rolled out across the Trust.

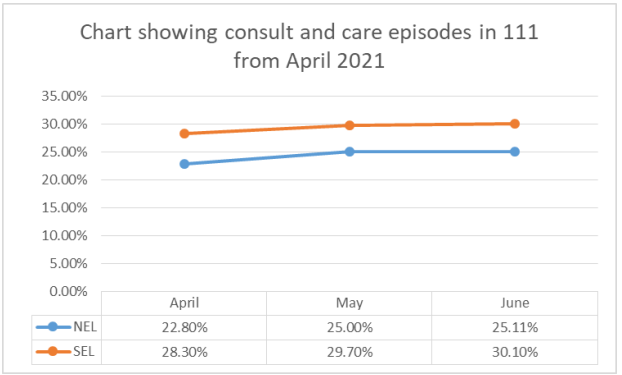
The Trust has also commenced a programme of work to further develop the management of medical devices including the appointment of a Supply Chain Specialist responsible for overseeing where all the devices are and for ensuring they are brought in for scheduled maintenance/servicing and ensuring all ambulances have the equipment they need.</td></tr>
</table>

Quality Priorities from Quality Account	KPI	Status	July Update
The Trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation.	*100% roll out of the inventory management system in phase 1 (April 2021)*	🟡	Work is on-going to achieve 100% roll out of the inventory management system. The original deadline was July 2021 however due to pressures this has been moved to Sept/Oct.
	70% automated temperature monitoring system roll out in phase 2 (2021/22)	🟢	All sites have had the system installed. We are now awaiting training for all staff to complete and implementation of the system.
	100% medicines packing unit complete by December 2021	🟢	On track - expected completion of construction is 23rd August. IMT and snagging expected to be completed by 6th September and a transitioned move by 4th October.
	Recruitment of pharmacy technicians & integration of the relevant logistics staff into the pharmacy team by the end of 2021	🟡	Ongoing, delayed due to competing demands within the pharmacy job sector during COVID. During the interim, we have bolstered the workforce with light duties staff.
Continued delivery of the Clinical Strategy (2016/17-2022/23 2019 Refresh)	*Reduced number of outstanding strategy deliverables from April 2021 baseline.*	🟢	April: 141 deliverables June: 101 deliverables July: 97 deliverables A reduction of 44 deliverables in Q1.

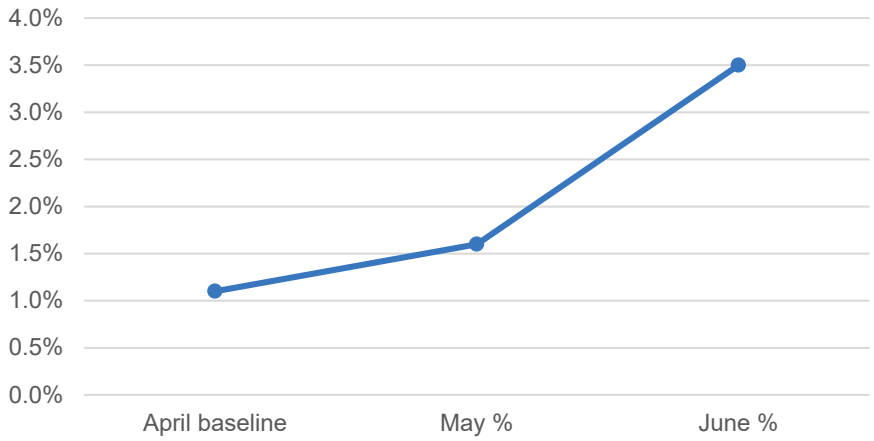
Quality Priorities

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
Not assessed

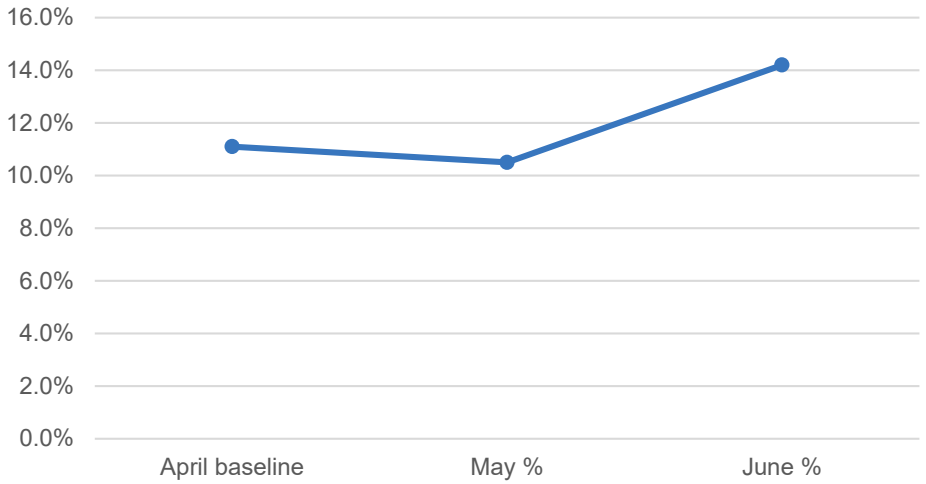
NHS London Ambulance Service NHS Trust

Quality Priorities from Quality Account	KPI	Status	July Update
Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services – (front end, CAS and management – including CHUB/ ECAS).	*Standardisation of both the front end and CAS staffing and outcomes.*	●	Awaiting update
	Appropriate rota fill for the expected establishment as per contract or local plans	●	Awaiting update
Patient & Communities engagement & involvement.	*Implementation of the patient and communities engagement and involvement strategy plan*	●	Over the last few months we have: • Appointed Michael Bryan as Co-Chair for the LAS Public and Patients Council (LASPPC) • Established two new LASPPC 'working groups', rising to 10 - the new groups are focused on patient safety and infection control • Co-created with LASPPC members, Healthwatch representatives and LAS staff, early plans for a visits programme Established a dedicated LASPPC sub-group focused on the Ambulance Operations Modernisation Programme, which will support this major modernisation scheme and help us track progress in the way we engage patients, carers and communities.
Integrating the 999 and 111/ IUC CAS systems to provide seamless care for patients regardless of access point.	*Increased consult and complete episodes in 111 from April 2021 baseline & meeting Hear & Treat KPIs*	●	Consult & Complete:  Hear & Treat (no agreed KPI yet): See next slide

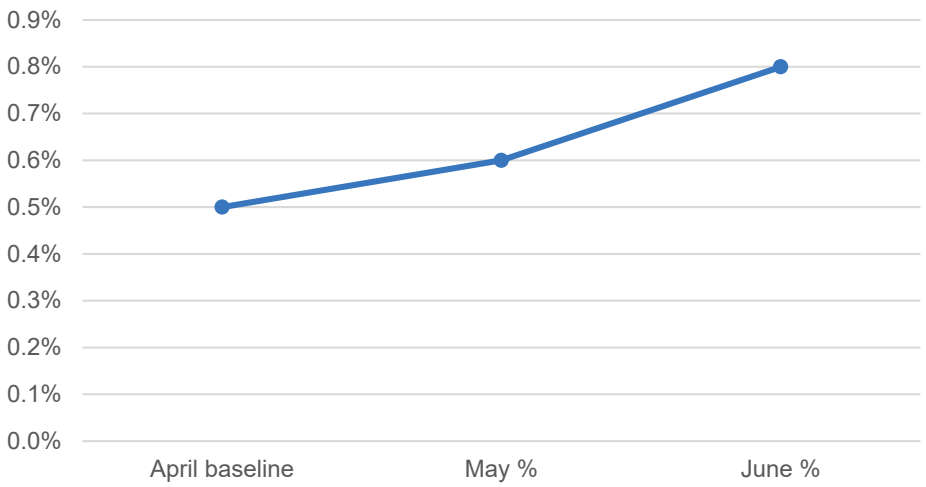
Cat 2 - Hear & Treat



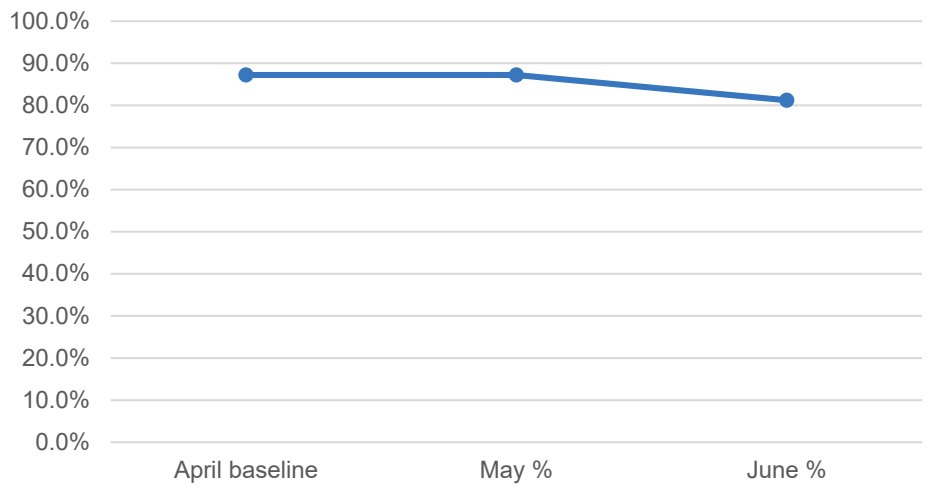
Cat 3 - Hear & Treat



Cat 4 - Hear & Treat



Cat 5 - Hear & Treat



Quality Priorities from Quality Account	KPI	Status	July Update
Implementing the station/service quality accreditation programme	*Supporting 100% of stations/service who volunteer to take part in the programme*		6 stations are participating in the Station Accreditation Programme: Brent / Edmonton / Friern Barnet / Oval / Brixton / Croydon Baseline audits have been completed and action plans created. Assessments were due July/August 2021, however due to REAP 4 being implemented in June 2021, all Station Accreditation work has been suspended. A plan has been developed for re-starting once in REAP 3 and QGAMs have been asked to identify further stations to participate in the programme once it restarts. Station Accreditation Frameworks are being developed for R&SA, EOC & IUC.
Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy	*CDI Strategy developed and implementation plan deployed.*		The People & Culture Directorate will be resetting the cultural transformation priorities at an away day scheduled during the summer. Further update will be available in September '21.
Continue to invest in health and wellbeing of staff, to ensure that they feel supported and are able to do their job and deliver the service.	*Completion of various actions in the implementation plan.*		27 actions in progress 40 actions are completed / or ongoing 9 actions are yet to be started
	Improvement in score for the 2021 national staff survey questions relating to staff wellbeing		See appendix B for full details of 2020 scores.

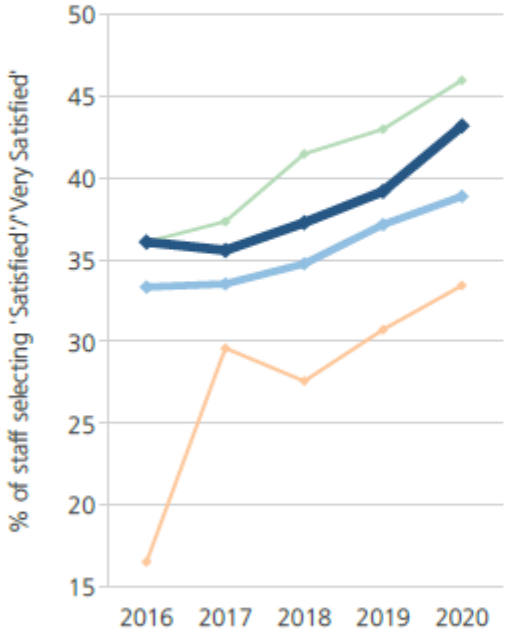
Appendix B

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Health & wellbeing 1/2

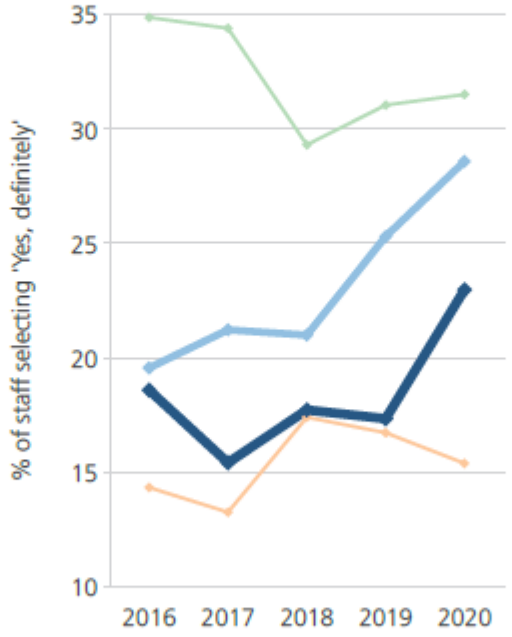
NHS England

Q5h
The opportunities for flexible working patterns



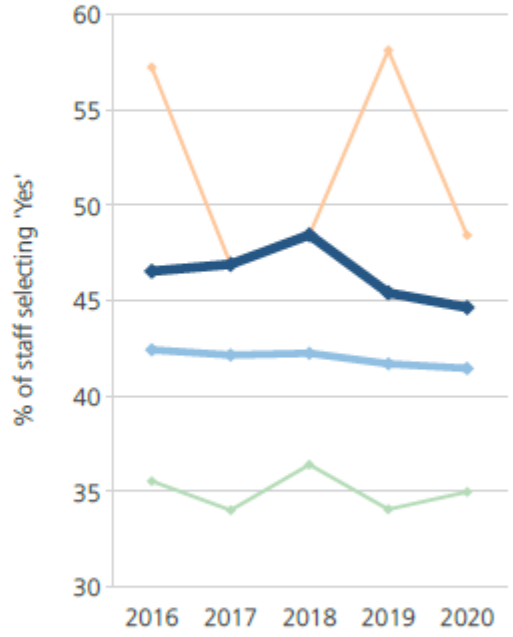
	2016	2017	2018	2019	2020
Best	36.1%	37.3%	41.5%	43.0%	46.0%
Your org	36.1%	35.6%	37.3%	39.2%	43.2%
Average	33.3%	33.5%	34.7%	37.1%	38.9%
Worst	16.5%	29.6%	27.6%	30.7%	33.4%

Q11a
Does your organisation take positive action on health and well-being?



	2016	2017	2018	2019	2020
Best	34.9%	34.4%	29.3%	31.0%	31.5%
Your org	18.6%	15.4%	17.7%	17.3%	23.0%
Average	19.6%	21.2%	21.0%	25.3%	28.6%
Worst	14.3%	13.2%	17.4%	16.7%	15.4%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



	2016	2017	2018	2019	2020
Worst	57.2%	46.9%	48.4%	58.1%	48.4%
Your org	46.5%	46.9%	48.4%	45.4%	44.6%
Average	42.4%	42.1%	42.2%	41.7%	41.4%
Best	35.5%	34.0%	36.4%	34.0%	35.0%

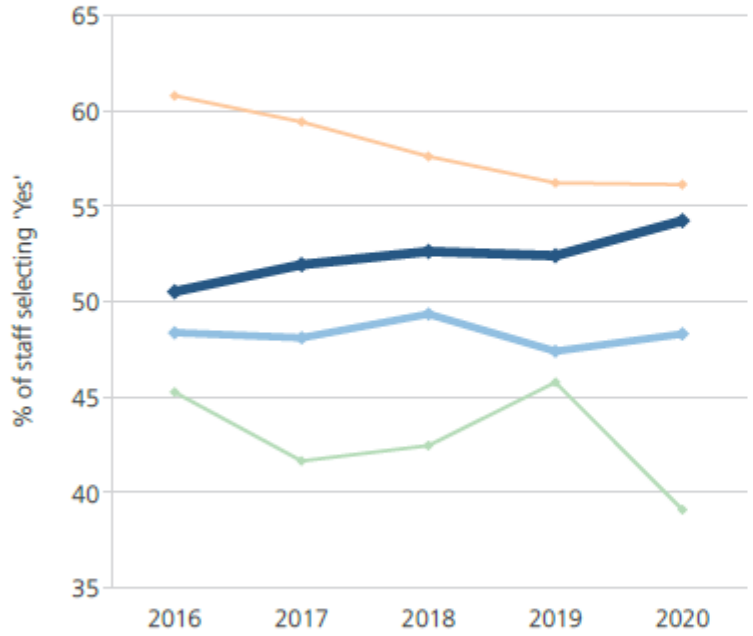
Appendix A

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Health & wellbeing 2/2

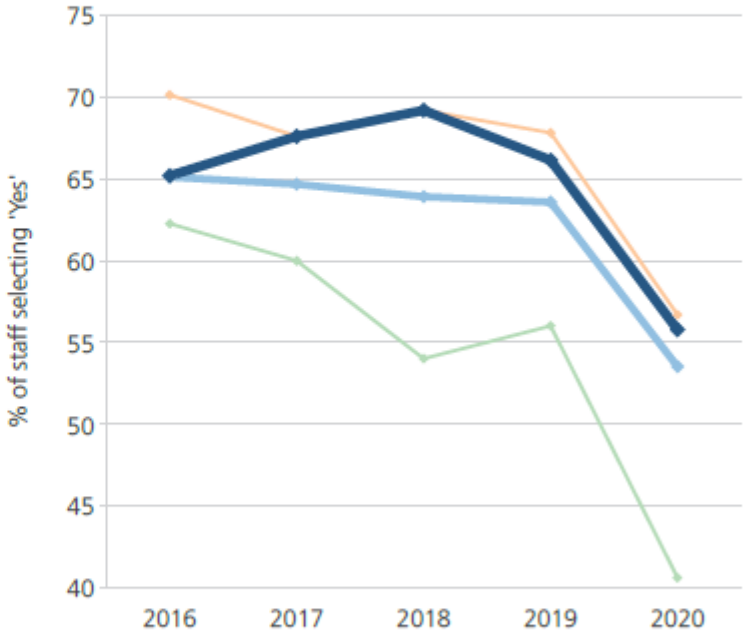
NHS England

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



	2016	2017	2018	2019	2020
Worst	60.8%	59.4%	57.6%	56.2%	56.1%
Your org	50.5%	51.9%	52.6%	52.4%	54.2%
Average	48.4%	48.1%	49.3%	47.4%	48.3%
Best	45.2%	41.6%	42.4%	45.8%	39.1%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2016	2017	2018	2019	2020
Worst	70.1%	67.6%	69.2%	67.8%	56.7%
Your org	65.2%	67.6%	69.2%	66.1%	55.8%
Average	65.1%	64.7%	63.9%	63.6%	53.5%
Best	62.3%	60.0%	54.0%	56.0%	40.6%

London Ambulance Service NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

Report of the Chief Paramedic and Quality Officer (CP&QO)

The directorate incorporates quality assurance, quality improvement, safeguarding and the Clinical Education and Standards department (CES).

This report summarises the directorate activity referencing the Integrated Performance Report (IPR) and Quality Report for the July 2021 reporting period.

Regulatory Update

In March 2020, the Care Quality Commission (CQC) suspended their routine inspection programme in response to COVID-19 and developed their ability to monitor services using a mix of on-site and off-site methods. In July 2021, they piloted further changes to their Emergency Support Framework with the aim of rolling it out further to services over the next couple of months. The developments focus on three key areas:

- improving their ability to monitor risk to help them be more targeted in their regulatory activity
- bringing information together in one place for inspection teams, presented in a way that supports inspectors with their decision making
- testing elements of how they want to work in the future, including how they provide a more up-to-date view of risk for people who use services.

The CQC will carry out regular reviews that will help support their ability to monitor risk. Where the information they have does not find evidence that tells them they need to re-assess the rating or quality at a service, they will publish a short statement on their website. This will inform the public and people who use services that a review has taken place and that they had no concerns based on the information they held at that time.

In cases where the information review indicates that they may need to re-assess a rating or the quality of care, inspectors may want to gather more evidence. For services where they believe people may be at an increased risk of poor quality care, they may undertake an immediate on-site inspection and this may happen at any time.

The Trust recently carried out CQC self-assessments to reflect the impact that REAP 4 has had on quality at a local level. This work will continue Quarters 3 & 4 to enable quality focussed recovery plans to be developed.

CQC engagement

The Trust continues to meet with the CQC through routine virtual engagement meetings as well as responding to requests for information. The last meeting took place on the 13th July 2021 and included discussions on senior management changes, hospital turnaround times, clinical audits, inquests, safeguarding, incidents and risks. The next meeting is due to take place on 12th October 2021.

Quality Account & Quality Priorities

The 2020/21 Quality Account, previously approved at Board was published on the 30th June 2021 as per regulations. The Trust has set ten priorities for the 2021/22 year and the directorate has being undertaking a baseline assessment. The status of the priorities as at July 2021 is follows:

The following seven priorities are assessed as being on plan:

- Implementation of the Patient Safety Incident Response Framework (PSIRF) as a pioneer in the new process for other Ambulance Trusts.
- Improving the management of clinical equipment by ensuring a robust and transparent governance process for medical devices and clinical equipment which is enshrined in policy.
- Continued delivery of the Clinical Strategy.
- Patient & Communities engagement & involvement.
- Development of the Trust's Culture Diversity and Inclusion (CDI) Strategy.
- Integrating the 999 and 111 clinical assessment systems to provide seamless care for patients regardless of access point.
- Continue to 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 following 2 priorities are off target due to operational pressures but require no escalation:

- The Trust must ensure medicines are correctly stored, in line with recommendations made from the CQC and current legislation.
- Implementing the station service quality accreditation programme.

The following priority is currently being assessed:

- Analysis of staffing levels, productivity and efficiency across Integrated Patient Care services.

There is a risk that delivery of this year's quality priorities will be impacted by sustained operational demand, particularly if we encounter a further COVID-19 wave. We will continue to monitor the priorities bi-monthly and have conversations at the Quality Oversight Group and Quality Assurance Committee, where we will consider the impact on the priorities.

Quality Assurance - Trust wide (see Quality Report)

The following are the key points based on quality data analysis and intelligence collated during July 2021:

- The Trust continues to see consistent incident reporting which indicates a good reporting culture as well as a culture of openness (see quality report page 9). The number of incidents graded moderate harm and above has increased due to the high levels of demand being experienced. Delays identified undergo a Structured Judgement Review (SJR) to look at the impact this had on care and treatment.
- There continues to be assurance that there is an effective system for identifying drugs retained off duty and resolving issues promptly. The new Medicines packing unit is nearing completion which will provide enhanced security and oversight.
- Hand Hygiene compliance for July 2021 is at 96%. Compliance exceeds the expected Trust target of 90% for the group stations that submitted data. Of note, 14 out of 18 group stations submitted Operational Workforce Review (OWR) data for July 2021. Overall submissions totalled 51 during July, this decrease is expected as the quarterly targets have been met. Vehicle preparation deep clean compliance remains positive at the Trust's expected target of 95%. Premises cleaning for 15 Group Stations/Services who submitted data for analysis provides a Trust compliance of 96%. This score continues to exceed the Trust performance target of 90%. Stations that failed to achieve 90% are escalated to the facilities manager to establish why and ensure remedial actions are put in place (see quality report page 21).
- Overall Compliance with the Medical Priority Dispatch System (MPDS) protocols is positively at 92% and the Trust continues to operate within Centre of Excellence standards with high levels of compliance, resulting in appropriate triage and in turn patient care (see quality report page 34).
- The public engagement team held eleven events in July which reached an approximate audience of 2,617 on a variety of topics including drugs and alcohol, choose well, knife crime and assemblies for primary schools about what the Ambulance Service does and how to use our service appropriately. The virtual Junior Citizen's Scheme has now concluded, with a total of 14,341 Year 6 students across London watching our video on how to approach and assess a casualty and call 999 for an Ambulance (see quality report page 44).
- 70 excellence reports were submitted with themes of outstanding patient care, working above and beyond and scene management (see quality report page 46).

Current areas of focus:

- There are 1022 incidents (as of 13/08/2021) which have been opened on the system longer than 35 working days (this excludes SIs, PSIIs and COVID19 reviews). This is a 10% increase from June 2021 where there were 928 overdue incidents. 86% of overdue incidents have been labelled as No Harm and 13% as Low Harm. All incidents continue to be monitored daily by the Incident and Risk Hub. The Quality Governance and Assurance Managers (QGAMS) also work with the services to ensure incidents are investigated in a timely manner (see quality report page 11).
- Medical Equipment continues to be one of the highest reported categories of patient safety incidents. The majority of these are failure of devices rather than missing devices which had previously been seen over the course of the year. Actions being taken include recruiting the supply and distribution leadership team including the new

Medical Equipment Specialist who will be responsible for overseeing where all the devices are and for ensuring they are brought in for scheduled maintenance/servicing and ensuring all ambulances have the equipment they need.

- Safeguarding level 2 & 3 training is below the target of 90%. There are sufficient places on training courses throughout 2021/22 and work is ongoing to ensure staff are released to attend training, alongside the demand pressures (see quality report page 19).
- Statutory & mandatory training is below the 85% target at 82% (see quality report page 25). Regular reports are sent to mangers and individuals of when training is due.
- 70 policies are currently under review.
- We have maintained a level of quality assurance during REAP 4 despite suspension of some activities to support operational delivery. The team has taken a risk based approach to quality governance and assurance, meaning that activities have been prioritised due to the sustained operational pressures.

Clinical Education and Standards (CES)

Recruitment to core management and support positions continue. A positive recruitment trajectory is now evident and we are progressing with adverts and offers, we have a new Clinical Education Manager joining the senior team in November. The team has innovatively flexed to ensure that the training capacity to deliver the ambitious 2021/22 workforce plan continues to be met. To support organisational resilience and the provision of quality patient care over the winter period, the department has also developed and rolled out a training package for 162 third year Higher Education students with further courses planned.

CES delivers a range of externally regulated awards. These include the Level 4 Diploma for Associate Ambulance Practitioners (L4DAAP), Level 3 Certificate in Emergency Response Ambulance Driving (L3CERAD) and the Level 4 Diploma in Emergency Response Ambulance Driving Instruction (L4DERADI). The Level 3 Diploma in Ambulance Emergency and Urgent Care Support (L3DAEUCS), undertaken by Assistant Ambulance Practitioners (AAPs) is subject to review by Future Quals and is envisaged to become an addition to the suite of regulated awards.

Uptake to the AAP course was lower than anticipated, with a total of 239 starting the programme from its inception; this is potentially attributable to the preference for the Trainee Emergency Ambulance Crew (TEAC) apprenticeship programme. To bridge this educational gap, CES collaborated with MediPro, co-creating a TEAC upskilling course for AAPs, assuring access, diversity and professional mobility within the paramedic pipeline. The first cohort of 50 is due to start the bridging course in February 2022.

Section 19 of the Road Safety Act 2006, is set to become effective from January 2022. A review is underway of the impact of this to the Trust. CES is collaborating with other departments to facilitate the associated driving education requirements.

The new education centres at Newham Dockside and Brentford are now operationally, but some further work is required to complete these facilities including:

- Simulation-based learning technology
- Simbulance fit outs
- Electric vehicle charging points
- Peripheral building infrastructure
- UPS to communications rooms

Each year the Trust provides updates for those in post using the Core Skills Refresher (CSR) programme. Due to COVID-19 a delay has occurred in the face to face delivery of CSR. A review has now been undertaken and the following agreed the topics will be delivered:

- Supraglottic Airways (SGA)
- Conflict Resolution Training
- Information Governance
- Infection Prevention & Control
- Fire Safety
- Prevent Level 2
- Frailty (including medicines management)
- Resuscitation
- Moving and Handling
- EPRR Incident Response & JESIP
- Safeguarding

The delivery of the programme will commence at the beginning of September within the new education centres.

Safeguarding

Specialist safeguarding provision continues within the Trust with 15-20 adult and 30-40 child referrals received each day. Strong links continue across London support the protection of people when concerns are raised.

Safeguarding is available at all levels virtually, compliance is improving but is still only at 55.5% for level 3.

The Trust has been invited to present on best practice at a national CQC event on sexual safety in September. The LAS is also holding its own safeguarding conference in October covering; youth violence, safeguarding children in care, mental capacity assessments, stalking & coercion, safeguarding & learning disabilities, female genital mutilation and the use of internet in radicalisation.

Quality Improvement and Learning

The Quality Improvement & Learning team continue to maintain oversight of patient safety incidents Trust wide ensuring a safety net for quality. The team have developed processes to

review 999 data to identify any delayed cases that require further review. The team use the structured judgement review for delays, developed during the COVID-19 waves, to review these cases. The findings produce both an organisational learning report as well as individual reports ensuring duty of candour is also maintained, where appropriate. The team are working with IUC colleagues to develop a similar process for 111 data.

The team have recently published its Quarter 1 incident thematic report which outlines that a total of 2,282 patient safety incidents were reported on the Trust's Risk Management system, Datix. Of the 2,282 patient safety incidents reported in Q1, a total of 158 reported incidents were assessed under the Patient Safety Incident Response Framework (PSIRF) and against the Trusts Patient Safety Incident Response Plan (PSIRP) for an enhanced level of investigation. Of these, 69 were declared as follows:

National Priority – Patient Safety Incident Investigation (PSII)

- 1 incident met the national defined priority requiring an external investigation by the Health Safety Investigation Branch (HSIB)
- 10 incidents met the national defined priority requiring an internal investigation where a death was clinically assessed as more likely than not being due to problems in care. These cases had been first reviewed by the Trust's Learning from Death process.

Local Priority – PSII

- 1 incident met the Trusts PSIRP under the Local Priority of Clinical Assessment of Spinal Injuries and is being investigated as a PSII.
- 1 incidents met the Trusts PSIRP under the Local Priority of Medication error and is being investigated as a PSII.

Patient Safety Review (PSR) (Non PSII) including Thematic Review

- 30 incidents are being investigated as a thematic are incidents identified from the re-contact audit which occurred during the Winter Peak of COVID-19.
- A further 26 incidents were assessed against the Trusts PSIRP and were agreed to be investigated as PSRs.

Local Review

- The remaining 89 incidents were referred to Sector/Department management teams for a local investigation to be completed.

A number of activities continue to occur across the Trust such as Learning Briefings to provide staff with up to date information regarding current incident themes, learning from closed investigations as well as embedding human factor principles including psychological safety and just culture. The team are working on creating recordings to ensure that learning continues to be shared with as many staff as possible during REAP 4.

Key themes from PSIIs and PSRs reveal that 20 of the 39 incidents (51.2%) met the Trusts Local Priorities categories while 14 of the 39 incidents (35.9%) were known themes including delayed defibrillation and delays. This suggests that the PSIRP accurately reflects the Trusts incident and risk profile. A number of actions are being taken to address these themes including a number of quality improvement initiatives being developed.

In regards to Quality Improvement, the team alongside the wider quality and clinical directorates, launched a collaborative enquiry into clinical contact on scene. This approach used QI methodology and sought feedback from our frontline clinicians into frustrations and areas of waste, generating ideas to be taken forward for improvement. The feedback received supported by data analysis has seen ideas taken forward including an electronic Patient Care Record (ePCR) guide to support staff and improved access for referrals.

Leadership

During the last two months the CP&QO has undertaken the following activities to support visible leadership:

- 5th July – attended NHS celebration at St Paul's Cathedral
- 9th July – Clinical shift at Barnehurst
- 15th July – Advanced Paramedic shift at Brent
- 22nd July – Clinical shift at Greenwich
- 23rd July – visit to Brentside education centre to meet students
- 26th July – directorate wide engagement event
- 29th July – Advanced Paramedic shift at Brent
- 6th August – Clinical shift at Barnehurst
- 12th August – Clinical shift at Isleworth (with incoming CEO)
- 19th August – Clinical support in Waterloo EOC

London Ambulance Service
NHS Trust

PUBLIC BOARD MEETING

23 September 2021

Report of the Chief Medical Officer Officer

Maintaining Safety at times of increased demand

The volume of patients accessing urgent and emergency care has continued to be very high and clinical safety. As a provider of 999 and 111 IUC services across London, it is necessary that when demand exceeds resources, clinically supported and governed decisions are made to ensure the sickest and most seriously injured patients are prioritised and other patients who do not require an emergency ambulance are given advice about where to access Healthcare. There continues to be a significant work across the London Health system to ensure LAS continue to reduce avoidable conveyance to hospital in order to reduce the demand on the busy emergency departments. This means that patients, whose health and social care needs could be safely and effectively met in a community setting, within or close to their home, are not conveyed to hospital but instead receive an enhanced telephone clinical assessment or assessment on scene by the highly skilled ambulance clinicians before being given self-care advice, receiving an onward referral to a community team or advised to make their own way to an urgent treatment pathway. We have continued, through social media and other communication, to advise patients on where best to access care for their health need to ensure those with emergency needs eg signs of a stroke can access a 999 response without delay.

Oversight of safety at times of surges in demand is maintained through careful implementation of the Clinical Safety Escalation Plans in both the 999 and 111 IUC systems. These plans have been reviewed, in preparation for winter, through a series of cross-directorate workshops to reflect learning from COVID-19 pressures and better understand the impact of individual and multiple actions on the LAS and system-wide pressure. The refreshed plans systematically reflect increasing levels of demand pressure and suggest associated actions for the strategic and tactical management of patient safety. They align to the recently produced national clinical safety plan recommendations and advice which allows better comparison of pressures across the whole English ambulance sector. The plans were approved through the LAS Clinical Advisory Group and Quality Oversight Group and shared for noting at the Quality Assurance Committee. A series of clinically led briefings were held prior to implementation.

Over the past two months the Clinical Directorate have continued to provide additional senior clinical support both with the Emergency Operations Centre, Tactical Operations Centres and as frontline ambulance clinicians to provide support and advice for both our patients and our staff and volunteers.

Strategic and Transformation development

Internally the Right Care Right Place (RCRP) programme has been being developed as one of the LAS transformation programmes. The RCRP programme, represents an opportunity to improve the care that Londoners receive, and the settings in which they receive it.

LAS has accelerated the transition from a traditional ambulance service provider to a key system partner involved in delivering integrated care across London, and with growing influence over the shape of urgent and emergency care at both a regional and national level. This shifting system-focus has supported a safe reduction in ED conveyances of about 4.9% since the Trust strategy was agreed in 2018.

Clinical Digital Transformation

The work of the OneLondon regional team (that includes the LAS) has been recognised at the HSJ Value Awards for digital innovation. This award recognises the Health Secretary's NHS digital programme to fast track digital and technological transformation to make patient information more accessible. Work continues to ensure that the pan London Clinical records are 'mobile'-friendly, in line with today's technological standards. The award reflects the clinical information team's continued hard work in improving how information is managed and stored throughout the LAS. Acting on staff feedback, the Chief Clinical Information Officer and team have made further improvements to Special Care Records (SCRa) and electronic patient care records (ePCR). They also ensure that training opportunities are available for staff members who are not as familiar with the fast-paced changes in technology.

As the organisation has undertaken a Digital Strategy Refresh, work has been conducted to ensure that it aligns with the vision for the Clinical Strategy and programmes of work within it. This ensures that collaborative approaches are undertaken and that we keep Clinical Transformation at the forefront of development within LAS.

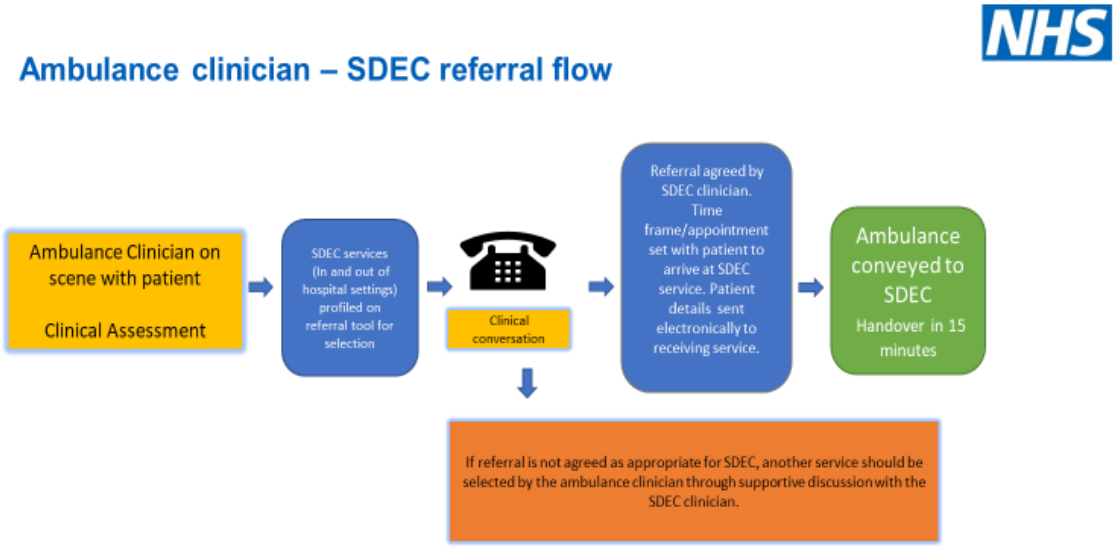
System-Wide Collaboration

Developing improved models of care

As the NHS moves towards the Autumn and Winter a significant amount of work is on-going to ensure that expected increases in demand for emergency care does not, where possible, impact on the delivery of the elective pathways for the many patients who have had their care delayed. London Ambulance Service has an important role in ensuring that alternative, high quality and easily accessible pathways are available for ambulance clinicians to refer patients to thus avoiding unnecessary conveyance but ensuring patients receive the right care in a clinically appropriate timeframe. The patient's transfer of care experience should be considered a key component of developing streamlined pathways.

Significant progress is being made on the development of the Same Day Emergency Care (SDEC) pathways which have been co-designed with partners across London for 'Hear & Treat' (Clinical Hub, 111 Clinical Assessment Service) and 'See & Treat' (clinicians based on ambulances). SDEC utilises a multi-disciplinary approach to assess, treat and discharge patients with appropriate follow up on the same day. This provides an alternative to Emergency Department attendance and hospital admission by removing delays for patients requiring further investigation or treatment and improving patient experience by reducing the number of clinical contacts. It will also help reduce the risk of nosocomial infection. LAS senior clinicians have been involved in the development of the SDEC pathways which have

been ratified at the NHSE London Clinical Advisory Group (CAG) and approved for implementation by the London Ambulance Service CAG. The Clinical Directorate is overseeing the guidance for LAS clinicians to ensure there is clarity about the referrals into SDEC and will be closely monitoring the pathway use to understand their efficiency and effectiveness for treating patients across London.



Alternative Care Pathways

Additional work is on-going to create more clinical pathways for patients across London to ensure they receive the right care in the right place. The Urgent Crisis Response (UCR) appropriate care pathway (ACP) which has now been implemented across all South East London providers has been designed to reduce the health inequalities in the local population by increasing access to care for patients where the emergency departments or 999 services may not best meet their needs. These 2-hour crisis response services accept referrals from NHS111 and 999 and provide assessment, treatment and support to patients in their usual place of residence who are experiencing a health or social care needs and who might otherwise be admitted to hospital. Additionally, they review population, service data and patient feedback and act on this insight with referrers, to ensure all local communities use and benefit from this service when needed. Ambulance clinicians can refer in to the UCR and paramedics have been listed as potential community crisis response team members, a good reflection of the professions skillset. All ICSs in England have been requested to deliver a two-hour response by 31 March 2022 and so that it can be expected that UCR pathways will be in all sectors in London by this date.

The physician response unit (PRU) is a rapid response emergency service, staffed by a senior emergency medicine doctor and ambulance clinician and despatched by LAS. It aims to 'take the emergency department to the patient' and thus reduce avoidable conveyance was highly commended in the recent Health Service Journal (HSJ) value awards.

Patient Outcomes

Mental health illness is the primary reason for approximately 2% of all calls received by UK Ambulance Services. The Ambulance service is often the first point of contact for people experiencing a mental health crisis. Calls of this nature can be complex, with many alternative care pathways. These can be difficult to access and navigate, which can result in lengthy on-scene times and frequently an inequity of access to care. Mental health care was

identified as one of five areas where patients would be offered a specialised response as part of the 2018-2023 London Ambulance Service NHS Trust (LAS) Clinical Strategy. As a result, the Mental Health Joint Response Car (MHJRC), staffed by a Paramedic and Mental Health Nurse, was introduced in November 2018 to increase a specialised response and reduce conveyance to EDs. The MHJRC initiative was initially introduced to serve the South East of London. However, it was expanded in 2020 to cover all areas of London to create parity of esteem. A clinical audit was undertaken in August 2021 to determine whether patients attended by the Mental Health Joint Response Car (MHJRC) receive appropriate care, according to local and national guidelines and that, where a remote assessment occurs, any telephone advice was documented according to local guidelines. Many patients were assessed and treated to a high standard by the MHJRC with almost all patients had their mood, thoughts, and perception evaluated as part of the mental state examination (MSE). Furthermore, most patients had a management plan and details of their current care person recorded. Areas of excellence highlighted in the audit allowed further adjustments to be made to local guidelines to ensure best practice in mental health care. Additionally, performance indicators were reviewed to ensure they incorporate the relevant aspects of care and allows for continuous clinical audit of the MHJRC – a national clinical quality indicator (CQI) is now being considered which LAS are contributing to. The MHJRC was recently highly commended in the HSJ awards.

Despite the increased demand LAS has experienced the sickest patients are continuing to receive a fast response. In June 2021 data showed that patients presenting the a ST elevation myocardial infarction (heart attack) received an ambulance response within 29 minutes of their 999 call and were at hospital in an average of 85 minutes. The target time from call to angiography target is 130 minutes so an arrival time of 85 minutes allows time for the hospital to undertake the clinical procedures within the timeframe. The stroke data for July 2021 shows that the average 999 call to ambulance on scene time for a stroke patient was 35 minutes and those patients who were identified as having time critical symptoms were in hospital in an average of 78 minutes – well within the London target time for thrombolysis of 4.5 hours.

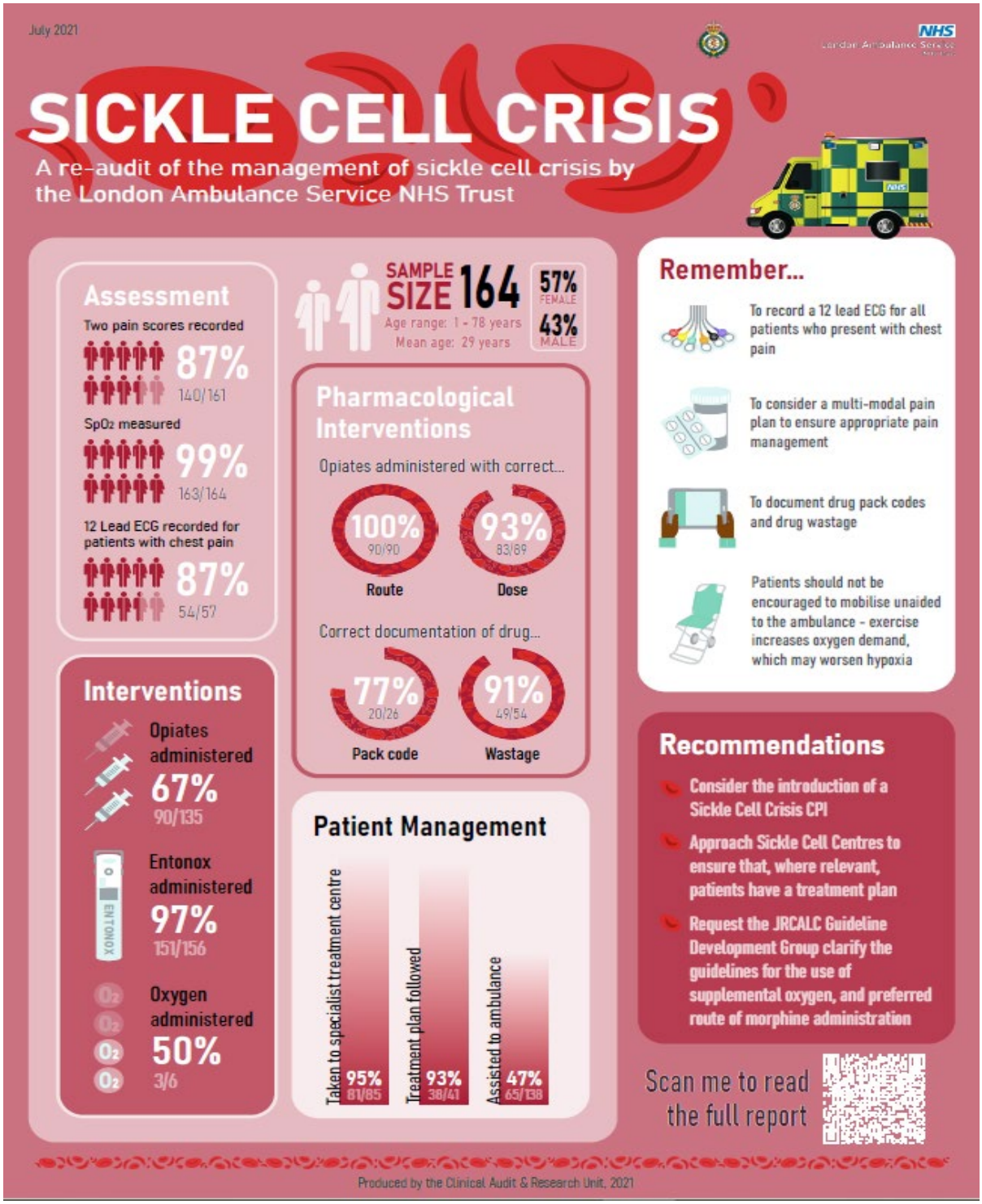
Regional and National Research

We have made considerable progress in managing clinical conditions that affect the BAME population of London. A re-audit of the care we provide to Sickle Cell Crisis patients has recently been published. The re-audit aimed to determine whether the documented care provided to patients in sickle cell crisis meets the standard outlined in UK Ambulance Service Clinical Practice Guidelines. It also assessed whether care has further improved since the last re-audit in 2016 which took place after the Chief Medical Officer joined a Patient feedback meeting to hear about the experience of these patients.

Since the initial clinical audit in 2004, the care provided to patients in sickle cell crisis has improved. This re-audit, along with those undertaken in previous years, has allowed us to demonstrate areas of excellence, such as drug administration, and areas in need of improvement, such as using equipment to assist patients to the ambulance.

The findings have been shared with clinicians via posters and articles, highlighting the importance of pain assessments and providing pain management. A national sickle cell group has recently been set up with ambulance representation on it and our audit findings will be shared to ensure that, were relevant, patients have a treatment plan.

LAS will also consider introducing a Sickle Cell Crisis Clinical Performance Indicator (CPI) to allow continuous monitoring and individualised feedback to clinicians who attend to patients in sickle cell crisis.



Development of Clinical Workforce

The Association of Ambulance Chief Executives (AACE) Strategy released in November 2020 aspired to the continuous advancement of the Ambulance Service to improve care delivery, including clinical development of the workforce. Embodying this, a clinical development programme was implemented to allow the opportunity to refresh some of the advanced clinical skills expected of the clinical leaders within LAS. For some leaders, this will be an update to their training. For those more recently recruited, it will provide additional training which had been disrupted due to the pandemic.

Training has also been developed for the newly formed St. Johns Ambulance (SJA) Falls Community First Responders (CFRs) ahead of their go-live date. LAS will be working with SJA to deploy volunteers to patients who have experienced a non-injurious fall and require assistance to get up. This pilot involves a group of selected CFRs, who have received additional clinical training and have additional equipment to attend to patients that require assistance to get up from the ground.

Infection Prevention and Control (IPC)

Healthcare-Associated Infections (HCAIs) continue to represent a threat to patient safety and safe care delivery. As such, all NHS providers have a duty of care to reduce the risk of HCAIs by providing safe, efficient and effective care. Infection prevention and control is a crucial aspect of HCAI reduction as set out in The Health and Social Care Act: code of practice on preventing and controlling infections (Department of Health, 2008; revised (2015)).

Consequently, the Internal Outbreak Management Procedure has been updated and approved by the Trust Board. It sets out the procedure for managing incidents and outbreaks of infections, in addition to ensuring staff are aware of the actions and precautions required to minimise the risk of epidemics or incidents occurring. This procedure also provides a framework for the identification and control of outbreaks within LAS healthcare premises.

The Internal Outbreak Management Procedure will assist in staff health and well-being and the safety of our patients across London.

London Ambulance Service
NHS Trust

PUBLIC BOARD MEETING
23 September 2021
Executive Director Report: People and Culture

1. Executive Summary

Covid-19 vaccinations; We are reporting Covid-19 vaccinations at (89%) first vaccination and (83%) double vaccinated. Work continues to increase this number - including webinars and training up peer vaccine advocates. In addition, a LAS representation is on the national group reviewing future vaccination programmes. It has been confirmed that eligible LAS staff and volunteers will be able to get their booster at local vaccination centres and hospital hubs as with the first two vaccinations. The flu programme is now being planned with a start date from mid-September.

Isolation Guidance; As of August 16th the Government's isolation guidance changed for NHS workers and all staff and volunteers have been informed of this change. Anyone who is fully vaccinated and 14 days after their second vaccine will be exempt from isolation, including if someone in the household is positive with Covid-19. A PCR is only advisory. For NHS staff to come to work this is slightly different and a negative PCR must be returned followed by 10 days of documented LFT testing. This only applies to fully vaccinated staff 14 days post second vaccination. If a household contact is positive, they are unable to come to work. Anyone partially or unvaccinated must isolate in line with government guidance.

Well-being; There are now three main support groups for colleagues who are affected by a variety of conditions, either directly or indirectly – for menopause, cancer or post covid syndrome. These groups give colleagues the opportunity to talk about anything they feel might improve their working lives with subject matter experts invited along to answer questions. In August the Tea Trucks will be distributing the new "cool bags" out to staff, which were paid for in conjunction with the LAS Charity, GMB and Unison and carry the three logos. Weekly deliveries of sandwiches continue to be sent to the four control rooms.

Absence; Remains extremely challenging with July reporting (7.3%), driven by short term MSK absence (24 to 37 episodes) and gastrointestinal problems (159 to 196 episodes). Proactively the P&C Business Partners and HR Managers have reviewed all staff with over 100 days absence and are working to have an action plan in place in order to resolve all cases by September. They are also working with their respective teams to review trends and develop strategies to reduce absence with a specific focus on MSK (musculo-skeletal) cases.

Recruitment & Retention; Frontline new starters are 68 FTE behind plan to July 2021, but an additional 100 TEAC places have been added in Q4 meaning the Trust should recover in year. Turnover has remained stable in July (9.4%) which is positively below our set KPI.

2. P&C Operations

Recruitment

The recruitment team continue to work with Ambulance Services and Clinical Education to deliver a strong pipeline of registered and non-registered staff. Frontline new starters are 68 FTE behind plan to July 2021, but an additional 100 TEAC places have been added in Q4 meaning the Trust should recover in year. If all remaining course places are filled, Ambulance Ops will close the year 11 FTE below establishment.

We have recruited 144 UK graduates to date and we will be advertising again in November to recruit any further candidates who may have had to retake their exams. We are working closely with the LAS link tutors to identify any other opportunities. Due to the number of partner students graduating at the current time, a high number have been assigned to International Paramedic courses to fill these spaces and to ensure these candidates do not apply elsewhere before more Partner Student Courses become available.

The AAP recruitment pipeline remains challenged due to continued competition with the TEAC course. A task & finish group has been established to review options for a unified non-registrant pathway from next year. All surplus driving course places which were assigned to AAPs have been filled by NQPs and iparas from the waiting list and the driving backlog has now been reduced to almost zero for the first time in recent years. UK NQP recruitment has so far been unaffected by the reduction in the welcome incentive and the Recruitment team is confident all course places will be filled to October. A kick-off meeting with MSI International, the Trust's new international recruitment partner, will take place on 10th August to ensure there is a healthy pipeline of candidates from the end of 2021.

The overall vacancy rate has increased during Quarter and Quarter 2 1 due to the establishment increases in Ambulance Operations (+200fte) but remains below target at 4.6%. Recruitment continues for the 999 call handling which is fully established and is forecast to reach above establishment to provide the additional resilience required given the CAD / Bow changes and the potential for a third wave of Covid-19. CHUB staffing levels have improved in July with rolling recruitment for permanent positions in place. The team remain heavily reliant on secondments from Ambulance Services. The call handling establishment in IUC is on track to be fully delivered by October and course fill rates remain positive. In total there were 69 starters in July. 58% were from a BAME background covering roles in 111, 999 and Ambulance Services.

Retention

Turnover has remained stable in July (9.4%) which is below our set KPI. The stability rate, which measures the % of staff in post for > 1 year, has positively remained above 90% and the number of frontline leavers remains below plan.

To support this work, we have appointed a Head of Retention who will lead on a number of activities, focusing initially on the 'quick wins' identified from the recent international paramedic survey and focus groups. These include streamlining the process for bursary funding, shared relief bags and opportunities to standardise secondment and development opportunities across all Groups.

Staff Absences

The monthly Trust wide sickness has increased from (6.5%) to (7.3%). Episodes of anxiety/stress/depression and back problems have remained at similar levels to June although

there were increases in short term MSK absence (24 to 37 episodes) and gastrointestinal problems (159 to 196 episodes).

Proactively the P&C Business Partners and HR Managers have reviewed all staff with over 100 days absence and are working to have an action plan in place in order to resolve all cases by September. They are also working with their respective teams to review trends and develop strategies to reduce absence with a specific focus on MSK (musculo-skeletal) cases. The well-being team are working with PAM to improve the access to counselling services and have been heavily promoting 'Keeping Well – NWL'. Work is also on-going to review the number of staff who are in excess of four week's absence and who have not yet been referred – this will provide an earlier opportunity to identify the required support for staff and the potential to reduce the length of absence. The number of staff support groups continues to increase including cancer, post-Covid and menopause support and work is also underway to look at ways to increase the number of peer support workers.

The People and Culture Committee approved an improvement trajectory of absence – reporting at least a (6%) KPI by March 22, which takes into account the significant current pressure and forecasted winter pressures.

	Jan 2021	Feb 2021	March 2021	April 2021	May 2021	June 2021	July 2021
Absence	9.4%	6.7%	6.0%	6.4%	6.7%	6.6%	7.3%

Statutory Mandatory Training/Personal Development Reviews (Appraisals)

As at 31st July 2021, the overall statutory and mandatory training completed is slightly below the 85% target, at 82%. The REAP 4 pressure levels continue to affect performance in July for Stat and Mand training (which has remained stable but below target). Information Governance compliance has been reported at the Senior Leaders Daily Meeting each Friday to ensure it meets its 95% compliance requirement. The Trust is currently running at 92% and this has also been affected by the REAP 4 challenges.

PDR compliance, based on a rolling 12 month period, has decreased in July from 75% to 68%. Weekly reports are being sent out to all Managers highlighting those who have an expired PDR date and those who are due to expire in the next three month period, to aid the effective scheduling of these reviews. As with Information Governance compliance, PDR compliance is now being tracked on a weekly basis to ensure it meets its 85% target. Weekly reports are being sent out to all Managers highlighting those who have an expired PDR date and those who are due to expire in the next three month period, to aid the effective scheduling of these reviews.

Workforce Analytics

Digital Workforce Programme - ESR Manager Self-Service

Our Digital Workforce Programme has delivered a number of important benefits for staff and managers including:

- On-line e-learning (over 400,000 courses completed)
- E-payslips (accessed 330,000 times)
- Weekly payroll (overtime payments reduced from nine to two weeks and over £137,00 paid to staff)
- Digital HR Staff files (over two million scans which can be accessed via an on-line portal)
- Electronic staff changes and leavers forms – streamlined and quicker processing of over 17,000 forms leading to more timely and accurate data in ESR
- Information automatically flowing between ESR and our rostering system GRS

ESR Manager Self-Service go-live with new functionality in our Electronic Staff Record (ESR) was also successfully rolled out, which will enable our managers to be able to view and update information about their teams, including stat and mand training, PDR appraisals, professional registration, DBS, right to work, staff absences. They will also be able to access a suite of workforce intelligence reports and receive important reminder notifications about their staff.

4. Health and Wellbeing

There continues to be a large number of colleagues accessing mental health support via the Trust OH provider or through other internal or external services. In line with the relaxation of lockdown measures, the Wellbeing team guided by the Trust Psychotherapist are now planning for the widespread refresher training of current LINC (peer support) workers and for new recruits to the network. This will be a large programme, aligning with recommendations from the AACE suicide prevention work. Other interventions in development include additional trauma psychotherapy for colleagues with complex mental health needs, supervision sessions for managers and the expansion of Team Time/Schwartz Rounds training. The three support groups aimed at colleagues affected by menopause, post covid syndrome or cancer continue to be well attended, supported by the LAS Wellbeing Hub. The Hub managers have undertaken “train the trainer” sessions on wellbeing conversations provided by NHSE and are now able to pass this learning on to managers.

The Wellbeing team are looking at ways to encourage better physical health and how the provision can move from the current virtual offers such as the VP Go app or online yoga classes to face-to-face activities. The Wellbeing team were pleased to be able to support the recent LAS football tournament and aim to expand this support to other LAS teams and sports groups. The tea trucks continue to operate in some cases 24 hours across the Service offering a range of snacks and drinks to colleagues, with the aim of visiting hospitals with particularly long wait times for ambulances. Provisions are also sent on a weekly basis to the EOCs and IUCs.

National isolation guidance changed for NHS workers in August and fully vaccinated colleagues are now able to return to work following a negative PCR test and with ongoing LFT reporting. The Wellbeing Hub are overseeing the administration of the guidance with support from operational and clinical colleagues that ensures safe decision making. More than 50 colleagues have so far been able to return to work through the new process instead of potentially needing to isolate.

LAS Covid-19 vaccinations, combined with the National Immunisation and Vaccination reports LAS at 89% (first vaccination) and 83% (fully vaccinated) respectively. The focus of the LAS vaccination team is now on the delivery of the 2021/22 flu programme with the first vaccines arriving in the Trust in the second week of September and the Covid-19 booster vaccination programme.

Work on the Occupational Health retender continues, with the programme remaining at a commercially sensitive stage. The specifications for future provision are almost complete and have benefitted from widespread engagement from colleagues across the Trust.

5. Talent Management and Organisational Development

The focus on delivering interventions to support the talent management and organisational development workstreams are continuing. In particular, the following activities are in place:

Redesign of the *Engaging Leader* course: The new programme will be widened to all leaders at Bands 4-7, which currently represents approximately 750 staff. New content is being created on building successful teams and incorporating the use of MBTI to enable rich discussion to enhance both individual leadership skills as well as building team cohesion. Greater focus on pre/post skills evaluation, integrated reflective work and individual action planning to embed organisational change. There will also be a review of ROI and the impact of the programme.

LAS Green Plan will set out LAS's sustainability objectives and describe a range of initiatives to be delivered from April 2022 – March 2025. The LEAP Team will nominate a main point of contact to lead and drive the Green Plan commitments/objectives on behalf of the People and Culture directorate. Agreement of five to 10 P&C commitments over the course of the next three years will be made in terms of accountable deliverables that will enable the overarching LAS Green Plan to succeed.

Ofsted Inspection of LAS direct-delivered Apprenticeship programme: Preparation for the Ofsted inspection is underway. The team is working with the CE&S team and also with other English ambulance services via a new NENAS Ofsted sub group. Inspectors will look at the delivery of the programme and the organisational support provided to the apprentices (TEACs), via observations and interviews with staff at various levels. The week-long visit will conclude with Ofsted grading LAS with a rating and a public report of their findings being published.

Relaunch of Course Catalogue: The LEaP Course Catalogue is being redesigned and is expected to be launched by the end of September. This is a clear portfolio of all professional/personal development opportunities in the Trust for all members of staff. The catalogue also provides further information on other areas to help staff along their employment journey, including staff networks & the Wellbeing Hub.

New Recruitment and Selection Training: The training design has been completed and is ready for launch; awaiting further policy review from CDI colleagues and the recruitment team.

Wellbeing Webinars: These sessions are scheduled to run once a month starting from this month with *Managing Remote Working*. Sessions will continue to run through to December 2021 and will be reviewed again in January 2022.

Interview Skills Recorded Webinar will be launched in October via ESR. This is a one-hour session which will allow staff to access personal development information at any time they wish. It will also be supported by downloadable tools, tips and videos on interview skills.

6. Culture, Diversity & Inclusion

2021 Annual Staff Survey Preparation

The 2021 Staff Survey will run for ten weeks from 20th September until 26th November and the results will be made available to us in January 2022. As in previous years the appointed service provider will be Picker Institute Europe. The following changes have been made to this year's survey:

- 32 new questions will be added and others will be removed or reworded, which will affect how we can reliably benchmark against previous years.
- The results reporting will be based around the seven elements of the NHS People Promise, rather than the ten themes which have been used previously. However, the themes of Staff Engagement and Morale will continue to be reported.
- The eligibility criteria has been extended slightly to include staff on long term sickness absence of more than 90 days and staff on a secondment at an organisation for more than 12 months. We have agreed to sign a three year contract, which comes at a discounted rate.

July People Pulse Survey Results

The results of our first People Pulse survey which ran during July 2021 have been received and the initial analysis has taken place. The People Pulse focuses on Staff Engagement and is run three times a year, supplementing the annual Staff Survey in September. The results reflect the difficulties faced in this month, with the Trust operating at REAP level 4 for the duration of the survey.

We received 434 responses to our initial People Pulse survey, representing 4.8% of our workforce, including bank staff and contractors (compared to the response rate of our annual staff survey which reached 72% of substantive staff last year).

Further analysis is taking place, however at first glance the results represent those of previous national staff surveys.

Women's Staff Network Group

July saw the launch of our new Women's Staff Network Group to bring together women from across the Trust to support and share experiences with each other, as well as to provide feedback and advice on Trust policies and procedures.

Menopause/Andropause Guidance

In collaboration with the Health and Wellbeing team, we have developed guidance for managers in how to best support staff going through the menopause or andropause.

London Ambulance Service NHS Trust

PUBLIC BOARD OF DIRECTORS MEETING

Report of the Chief Finance Officer

The Finance Directorate encompasses financial control and management, procurement, commissioner contracting and costing, commercial, business planning and corporate reporting functions in support of providing the best possible value for the tax paying public.

This report summarises the directorate activity referenced in pages 33 to 37 in the Integrated Performance Report for the reporting period to July 2021 (Month 4).

The Trust continues to operate under an adjusted financial framework from April to September 2021 (H1) in response to the continued impact of the COVID pandemic. The financial framework sets fixed income arrangements funded through block payments via the host NW London Integrated Care System for the first half of the year and is working to a financial plan for the first six months of 2021/22 (H1) to breakeven.

Arrangements for the second half of the year, October to March 2022 (H2) have just been announced nationally and at the time of publishing this report the Trust is working with its host NWL ICS to agree the income envelope for operations by the end of September.

1. **Financial Position – Month 4 2021/22 (page 33)**

Since the last report, the Trust's financial position has been challenged as a result of the significant increase in 999 and 111 service demand reported in the Chief Operating Officer's report.

At the end of July 2021 the key financial highlights are:

- The Trust has a YTD deficit of £1.2m as at 31 July 2021.
- Is currently forecasting a breakeven position to the end of September 2021 however this assumes additional income from NWL ICS of £4.6m for the Trust's share of £55m special funds announced to cover urgent and emergency care demand pressures. The precise quantum is being agreed at time of publication.
- The Trust has delivered £2.1m of efficiency reductions YTD and is forecasting a £3.5m efficiency saving to the end of September 2021 in line with its agreed plan.
- £19.6m of revenue COVID 19 expenditure was incurred year to date.
- The Trust's cash position at the end of July was £31.4m but this is forecast to reduce to £4m with committed revenue and capital expenditure.
- Capital spend excluding donated assets was £7.1m YTD, the majority of which comprised spend on ongoing property projects. The Trust continues to forecast delivery of its capital plan for 2021/22.

Since month 4 the Trust has secured a further £4.8m from the NWL ICS to fund the Newham EOC development and CAD replacement projects which brings the total funded capital programme to £26.2m.

Discussions are underway with NHS partners to increase capital funding available as the Trust's capital requirements exceed this though this will be dependent on the Trust's ability to manage the cash consequences.

2. Financial and Business Planning 2021/22

The normal finance and business planning arrangements were suspended during Covid. In the absence of published national income arrangements the Trust had prepared its budgets based on a normalised cost basis (adjusted for non-recurrent and full year effect adjustments) and the Trust Board approved a financial plan for the first half year in March 2021 on this basis.

On the 25 March 2021 NHS England published the planning guidance and system allocations for the first 6 months (H1) of 2021. Trusts then worked with Integrated Care Systems to develop agreed Provider plans for H1 which were submitted on 6 May 2021. The Finance and Investment Committee received an update on the Trust submission at the meeting on 13 May 2021.

An update of the funding arrangements for H2 was provided at the National CFO meeting on 9 September 2021. Overall funding for H2 is expected to be considerably tighter than H1. The key headlines pertinent to the Trust's plan are as follows:

- H2 system envelopes are based on H1 adjusted for a higher efficiency requirement, capacity funding and inflationary impacts
- H2 envelopes are funded for H1 and H2 impacts of the pay award (3%)
- Block payment arrangements stay in place but will have an 0.83% efficiency applied in H2
- In addition to the general efficiency requirement (0.82%) there will be additional efficiency requirements on system envelopes based on Distance from Target.
- COVID allocations will reduce by 5%
- Overall system requirement does not exceed 3% of controllable system cost base
- NHS provider 'Other Income' support will reduce to 75% of H1 levels.
- H1 and H2 will be treated as a single financial period and organisations required to deliver financial balance for the year as a whole
- Capacity funding included in envelopes for Non elective and Maternity Growth
- Urgent and Emergency Care additional funding (£55m already announced plus additional 111 funding to replace think 111 allocations
- Nationally funded PPE will continue to March 2022
- Testing and Vaccinations will continue to funded outside envelopes

Detailed guidance is expected imminently and once final allocations are issued for H2, the financial plan for the second half of 2021/22 will be brought to the Board for approval in October.

Lorraine Bewes OBE
Chief Finance Officer
September 2021

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Month 4 Finance Report			
Agenda item:	8.3			
Report Author(s):	James Corrigan, Financial Controller			
Presented by:	Lorraine Bewes, Chief Finance Officer			
History:	This paper provides an update on the Trust month 4 financial position.			
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 2021 (month 4)

Key points to note are that the Trust:

- The Trust has a YTD deficit of £1.2m as at 31 July 2021.
- Is currently forecasting a breakeven position to the end of September 2021 however this assumes additional income from NWL ICS of £4.6m due to increased costs required to respond to unprecedented increases in demand.
- The Trust has delivered £2.1m of efficiency reductions YTD and is forecasting a £3.5m efficiency saving to the end of September 2021.
- £19.6m of revenue COVID 19 expenditure was incurred year to date.
- The Trust continues to forecast delivery of its capital plan for 2021/22.

Recommendation for the Board:

The Trust Board is asked to note the financial position and forecast outturn for the Trust for the period ending 31 July 2021.

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

Directorate	Agreed				Relevant reviewer [name]
Quality	Yes		No		
Finance	Yes	x	No		Chief Finance Officer

Chief Operating Officer Directorates	Yes		No		
Medical	Yes		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes		No		

London Ambulance Service NHS Trust

Finance Report

Month 4: July 2021

Summary

This paper updates on the financial position as at the end of July 2021 (month 4, financial year 2021-22).

At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6 including fixed income envelopes which are being managed at STP or ICS level and incorporating Cost Improvement Programmes. Other contracting and commissioning processes (including CQUIN) remain paused.

For the first half of the year the Trust is planning a £25k deficit (breakeven on an adjusted financial performance basis) as agreed with NW London partners, and this planning includes a CIP target of £4.05m.

As of M4, the Trust is reporting a YTD deficit of £1.181m (£1.161m deficit on an adjusted financial performance basis) which is behind plan. Significant additional expenditure is being incurred to respond to operational pressures in Ambulance Services (overtime and secondees), and in the Trust's 111 Integrated Urgent Care Service (external resource, agency and overtime), but is currently partially offset by lower than planned recruit numbers and vacancies. Total COVID costs YTD (excluding centrally provided consumables and equipment) are £19.6m primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, as well as associated operational support services.

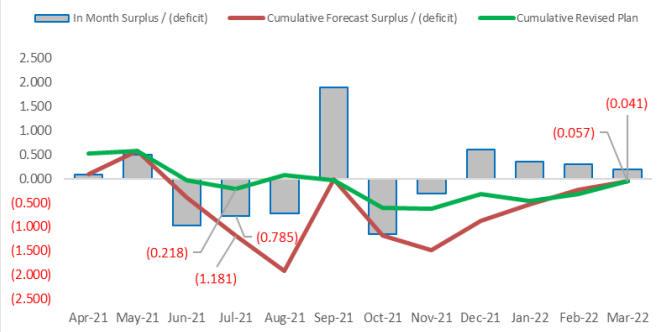
Items of note include:

1. Income is forecast to end the year £5.2m higher than full year draft budgets due to the pass through of inflation funding from NWL STP (£0.5m full year forecast), assumed additional income to support COVID surge resourcing (£4m but likely to increase as more information becomes available), PCN Pilot income (£0.4m favourable full year forecast) and staff recharge income (£0.8m favourable full year forecast).
2. Forecast full year pay expenditure is expected to be £367.7m which is £2.4m higher than full year draft budgets due primarily to the increased resourcing requirements to respond to operational demand and capacity pressures in Ambulance Services and 111 IUC Services partially offset by lower than planned recruit numbers and vacancies across other areas of the Trust.
3. Non pay expenditure (including depreciation and finance costs) is forecast to end the year £2.7m higher than full year draft budgets due to forecast overspends in the Trust's 111 Integrated Urgent Care Service (forecast £3.7m unfavourable) in response to high demand for services partially offset by underspends in People and Culture and Quality and Assurance in relation to lower than planned recruits and thus training costs (£0.6m) and minor underspends in other areas.

The Trust finished the month with a cash position of £31.4m, and capital spend (excl donated assets) was £7.1m YTD (£7.1m YTD net of disposals), the bulk of which comprised of spend on ongoing property projects. The Trust capital plan currently incorporates full year capital spending of £26.2m, however discussions are underway with NHS partners to increase capital funding available.

Key Financial Indicators

Surplus / (Deficit)



M4	YTD	Forecast
AMBER	AMBER	GREEN

- The Trust is reporting a deficit of £1.181m YTD (£1.161m deficit on an adjusted financial performance basis which is currently behind plan.
- The full year position is forecast to be a £0.041m deficit (£0.002m surplus on an adjusted financial performance basis) which is in line with budget, however funding arrangements for the second half of the year are yet to be confirmed.
- The position incorporated £19.6m of costs in relation to the Trust's response to COVID-19 primarily in relation to additional resourcing to meet COVID requirements in Ambulance Services and IUC, as well as associated operational support services.
- The Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6 including fixed income envelopes which are being managed at STP or ICS level and incorporating Cost Improvement Programmes.

Use of Resources Rating

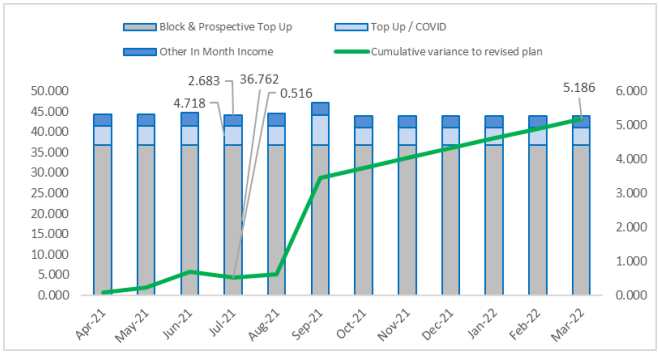
	YTD		Full year	
	Plan	Actual	Plan	Actual
Capital service cover rating				
Liquidity rating				
I&E margin rating				
Variance from control total				
Agency rating				
Overall rating				

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

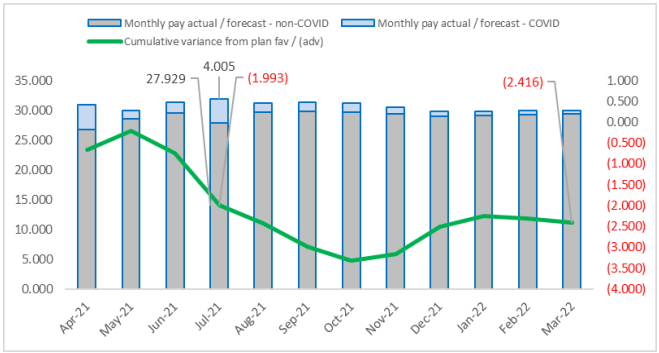
Income



M4	YTD	Forecast
AMBER	GREEN	GREEN

- The Trust continues to operate under an adjusted financial framework which involves pausing contracting and commissioning processes (including CQUIN), the Trust receiving block contract income along with a standard monthly top-up amount and fixed COVID income supplement.
- Block contract income being received totals £34m per month, along with a standard monthly top-up amount and fixed COVID income supplement of £7.3m per month.
- Other Operating Income is £2m YTD (FY forecast £5.5m) which is comprised mainly of Education & Training Income £1.4m YTD (FY forecast £3.6m) and staff recharge income £0.3m YTD (FY forecast £0.9m).
- The total income position is forecast to finish £5.2m higher than plan predominantly due to due to assumed additional income in relation to costs associated with current continuing COVID pressures and the pass through of inflation from NWL STP (£4.6m favourable) and staff recharge income (£0.9m favourable).

Pay Expenditure

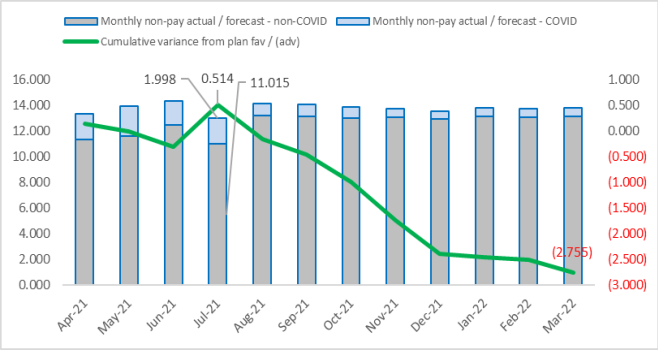


M4	YTD	Forecast
AMBER	AMBER	AMBER

- Pay expenditure is £2m over budget YTD due to significant additional resource usage in Ambulance Services and IUC offset by vacancies, lower than expected trainee numbers and unallocated reserves in Central Corporate.
- Forecast full year pay expenditure is expected to be £367.7m which is £2.4m higher than budget, again driven by Ambulance Services and 111 IUC spend.
- Total COVID pay costs are £11.5m YTD and forecast to be £19.8m full year.
- £2.2m has been recognised YTD (full year forecast £3.4m) for seconded London Fire Brigade and Met Police resources in relation to COVID support provided.

Key Financial Indicators

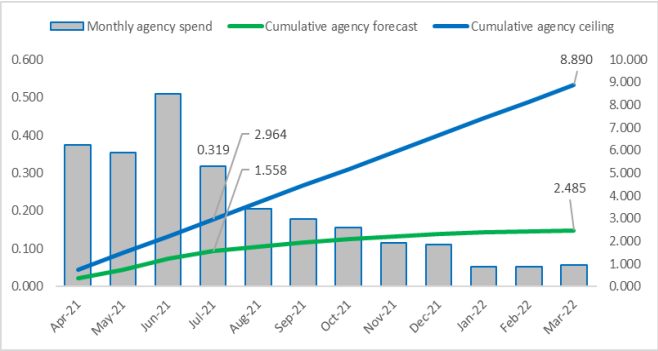
Non-Pay Expenditure



M4	YTD	Forecast
GREEN	GREEN	AMBER

- Non pay expenditure (incl depreciation and finance costs) was £0.5m favourable YTD (full year forecast £2.8m adverse).
- YTD overspends in 111 IUC for additional resourcing in response to higher COVID related activity (£4m) are offset by underspends in Project areas due to timing delays (£2.1m) and underspends on training costs due to lower recruit numbers than planned (£1.7m).
- The worsening between the YTD and forecast positions is largely driven by expectations that project spend delays will be reversed and that some of the underspend in recruitment and training will be reversed via additional recruitment.
- Non pay COVID-19 costs are £8.2m YTD (FY forecast £14.4m) in relation to increased 111 IUC external resourcing, increased fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning, personal protective equipment, medical equipment and operational consumables. Current 111 IUC resourcing pressures are not forecast forward at present due to uncertainty.

Agency Ceiling



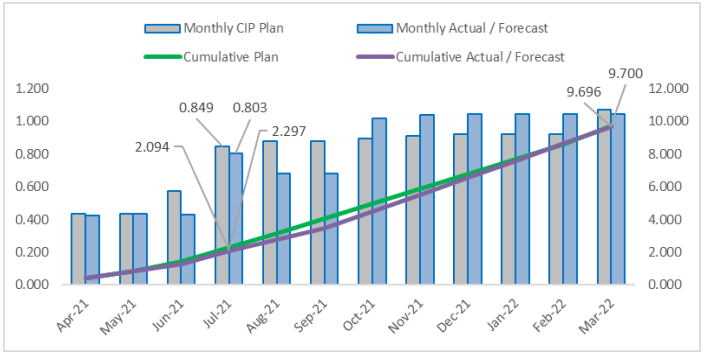
M4	YTD	Forecast
GREEN	GREEN	GREEN

- YTD agency spend is £1.6m compared to the cumulative YTD agency ceiling of £3m.
- Full year agency spend is currently forecast to be £2.5m, which is £6.4m 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, and planned IUC recruitment.

Key Financial Indicators

Cost Improvement Programme

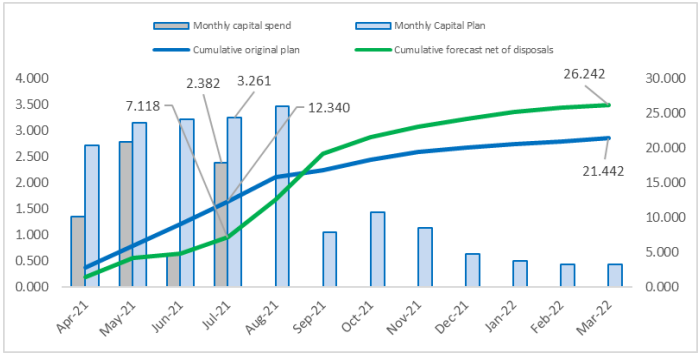
M4	YTD	Forecast
AMBER	AMBER	GREEN



- The Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6 including fixed income envelopes which are being managed at STP or ICS level and incorporating Cost Improvement Programmes.
- Under the financial framework in place, over the first half of the financial year a £4m efficiency is required, with current plans for a further £5.7m over the second half of the year.
- Projects have been developed to meet this need and the Trust is reporting YTD efficiency savings of £2.1m YTD (£3.5m half year forecast, £9.7m full year forecast) which is slightly behind plan YTD (in line with plan full year forecast).

Capital Expenditure

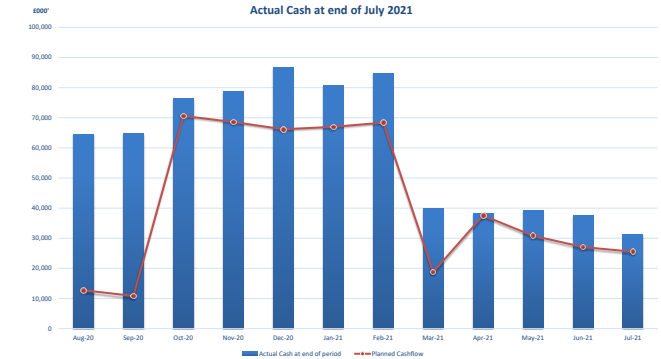
M4	YTD	Forecast
AMBER	AMBER	GREEN



- Capital expenditure net of disposals is £7.1m YTD (£7.1m before disposals) compared to planned capital expenditure of £12.3m (£5.2m behind plan net of disposals).
- Full year forecast capital expenditure net of disposals and donated assets is £26.2m (£26.2m before disposals) £4.8m higher than plan reflecting the increase in CRL identified through NW London partners (CRL transfer by NHSI to be processed).
- Capital spend on the Trust's ongoing property projects and programmes forms the bulk of YTD spend.

Key Financial Indicators

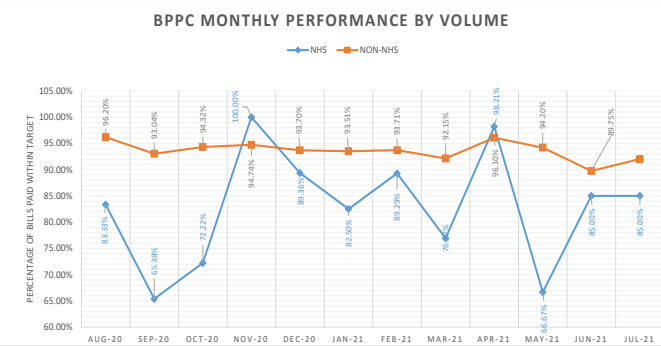
Cash



M4	YTD	Forecast
GREEN	GREEN	GREEN

- Cash was £31.4m as at 31 July 2021.
- The cash balance fell in March 2021 due to the ending of the block contract income being paid one month in advance during the period April 2020 to February 2021.

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 Trust achieved - NHS and Non-NHS performance by volume for July 2021 was 85.0% and 92.0% respectively.
- The Trust achieved – NHS and Non-NHS performance by volume for ytd July 2021 was 88.1% and 92.4% respectively.
- In 2020/21 NHSI the Trust received one months income in advance to support the early payment of suppliers during COVID and we reported against a 7 day payment target. Under this arrangement the LAS paid supplier invoices as soon as the invoice was authorised. NHSI ceased this arrangement in March 2021 and we have gone back to our normal payment terms of 30 days.
- 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.

COVID-19 Response Expenditure (YTD)

	Actual £000 YTD Month 4 2021-22	Actual £000 Apr-21	Actual £000 May-21	Actual £000 Jun-21	Actual £000 Jul-21
Additional Staff Costs (EOC and Ambulance Services)	**9,210**	3,602	853	1,287	3,469
NHS 111 Additional Capacity - Staff	**2,173**	483	588	557	546
NHS 111 Additional Capacity - External Contracts	**3,235**	484	789	970	992
Decontamination Services - Premises	**397**	118	117	32	130
Defibrillators, Medical and Ambulance Equipment	**59**	14	10	18	16
IT Support	**6**	-	2	1	2
Private Ambulance and Managed Operations Services	**1,432**	388	656	193	195
Vehicle Leasing	**16**	18	0	0	2
Telephony, Radio and IT Systems Expansion	**2**	11	6	2	9
Accommodation	**83**	15	22	54	35
Personal Protective Equipment	**331**	70	30	84	146
Fleet Maintenance and Preparation	**1,747**	693	533	265	256
Critical Care Transfer Service	**52**	44	1	7	1
Property Adjustments and Expansions	**344**	94	76	76	98
COVID Asset Depreciation	**332**	83	83	83	83
Other	**235**	59	57	77	42
Total COVID-19 Expenditure	**19,617**	**6,140**	**3,768**	**3,707**	**6,002**

The Trust has incurred £19.6m of COVID 19 costs YTD excluding centrally provided consumables and equipment (M1 £6.1m, M2: £3.8m, M3: £3.7m, M4: £6m) in order to provide significantly expanded resourcing, fleet maintenance preparation support and additional required premises services.

PPE requirement for the Trust has increased significantly compared to BAU however national centralised provision of PPE has continued into 2021-22.

Vehicle deep cleans have continued to be required at a significantly increased level and estate consolidation has been undertaken to consolidate operations and enable a flexible deployment model and improve efficiency across supply chain management.

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.

Significant items of spend are summarised in the table at top left and are detailed below.

- Additional Staff Costs Ambulance Services and EOC (£9.2m YTD) reflecting the cost of additional resourcing to cover increased abstractions, longer job cycle times, higher time off the road and increased resource capacity in control rooms. This includes London Fire Brigade and Met Police support charges of £2.2m YTD (£3.4m FY forecast).
- Personal Protective Equipment (£0.3m YTD) for PPE items not provided through the national supply.
- NHS 111 Additional Capacity Staff (£2.2m YTD) for additional resourcing through internal sources.
- NHS 111 Additional Capacity External Contracts (£3.2m YTD) predominantly for additional clinician resources such as GPs, nurses and advanced practitioners (£1.8m) and additional non-clinical call handling resource support (£1.3m).
- Fleet Maintenance and Preparation (£1.7m YTD) additional external fleet maintenance support, bunkered fuel project costs and preparation resources for cleaning higher numbers of vehicles more frequently.
- Private Ambulance and Managed Operations Services (£1.4m) for additional private ambulance resources and blue light driver services to support front line service provision.
- Decontamination Services - Premises (£0.4m YTD) for increased frequency of premises cleaning.

Movement in Forecast Outturn

Directorate / Division	Full Year 2021-22 £000 Annual Budget	M3 Forecast	M4 Forecast	M3 to M4 Movement fav/(adv)	COVID-19 Total Cost in Positions
Chief Executive	(2,170)	(2,430)	(2,093)	337	0
Chairman & Non-Executives	(226)	(228)	(233)	(5)	0
People & Culture	(13,155)	(12,851)	(12,772)	79	0
Communication & Engagement	(3,323)	(2,653)	(2,672)	(19)	0
Ambulance Services	(243,126)	(249,597)	(253,714)	(4,117)	(21,695)
999 Operations	(39,582)	(39,510)	(38,390)	1,120	(202)
IUC Services	(31,329)	(35,110)	(36,933)	(1,824)	(5,666)
Performance	(1,493)	(1,367)	(1,473)	(106)	0
Programmes & Projects	(12,509)	(11,555)	(11,849)	(294)	0
COO Management	(1,656)	(1,590)	(1,572)	18	0
Corporate Services	(9,435)	(9,491)	(9,489)	2	0
Finance	(4,979)	(4,723)	(4,922)	(199)	0
Strategy & Transformation	(1,016)	(631)	(627)	5	0
IM&T	(18,227)	(18,239)	(18,062)	177	(802)
Medical	(6,926)	(6,304)	(6,025)	279	0
Quality & Assurance	(23,388)	(22,239)	(21,357)	882	0
Strategic Assets & Property	(60,048)	(59,876)	(59,145)	731	(5,483)
Directorate Sub-Total	**(472,588)**	**(478,395)**	**(481,328)**	**(2,933)**	**(35,243)**
Central Income	502,590	506,094	506,816	722	0
Central Depreciation & Fin Charges	(21,285)	(23,227)	(22,928)	299	0
Apprenticeship levy	(1,414)	(1,490)	(1,482)	8	0
Legal Provisions	(945)	(422)	(440)	(18)	0
Other central costs & income	(132)	(18)	(17)	1	0
Net Reserves incl Unallocated CIP	(6,282)	(2,213)	(295)	1,918	0
COVID-19 Income and Central Costs	0	(372)	(368)	3	(368)
Central Sub-Total	**472,531**	**478,353**	**481,286**	**2,934**	**(368)**
Total surplus / (deficit)	**(57)**	**(42)**	**(41)**	**1**	**(35,612)**

Commentary on key forecast movements

1. Ambulance Services

- Increase between M3 forecast and M4 forecast due primarily to increased resource cost forecasts (£3.6m) in response to continuing operational pressures (primarily overtime and incentives) and lower income (£0.8m) in relation to stadia and events, and the cessation of the Physician Response Unit.

2. Central Corporate

- Central Income movement due to the inclusion of assumed additional income in relation to costs associated with current continuing COVID pressures (£1.1m) partially offset by lower education and training income from HEE (£0.4m).
- Net Reserves incl. Unallocated CIP movement driven by budget reserves previously forecast centrally.
- Central Depreciation & Financial Charges movement due to changes in forecast timelines for project completion.

3. IUC Service

- Increase in cost between periods due to higher resourcing costs to respond to current ongoing COVID surge demand pressures.

4. 999 Operations

- Decrease in forecast cost between periods due to delays in recognition of clinical advisor resources to be seconded from Ambulance Services which were previously expected to be in place.

5. Quality & Assurance

- Reduction in forecast cost between periods due to lower than expected recruit numbers and thus training costs in Clinical Education (£0.8m) and delays to recruitment to vacancies in Quality and Assurance Management (£0.1m).

6. Strategic Assets & Property

- Reduction in forecast cost between periods due to fleet repair and maintenance costs (£0.4m) and lower staff costs (£0.5m) due primarily to the transfer of the Pharmacy Team to Medical, partially offset by higher premises costs (£0.2m) for increased cleaning services in relation to COVID.

Supporting Information

SOCI

	Month 4 2021-22 £000			YTD Month 4 2021-22 £000			Full Year 2021-22 £000		
	Budget	Actual	Variance fav/(adv)	Budget	Actual	Variance fav/(adv)	Budget	Full Year Forecast	Variance to budget fav/(adv)
Income									
Income from Activities	43,825	43,911	86	175,063	175,608	545	522,969	527,671	4,702
Other Operating Income	511	251	(260)	2,025	1,996	(30)	5,003	5,488	484
Total Income	**44,337**	**44,163**	**(174)**	**177,089**	**177,604**	**516**	**527,973**	**533,159**	**5,186**
Operating Expense									
Pay	(30,677)	(31,934)	(1,257)	(122,170)	(124,163)	(1,993)	(365,333)	(367,749)	(2,416)
Non Pay	(11,782)	(11,231)	550	(47,176)	(47,482)	(306)	(137,207)	(139,939)	(2,732)
Total Operating Expenditure	**(42,459)**	**(43,165)**	**(706)**	**(169,346)**	**(171,645)**	**(2,299)**	**(502,540)**	**(507,688)**	**(5,148)**
EBITDA	**1,878**	**997**	**(880)**	**7,742**	**5,959**	**(1,783)**	**25,433**	**25,471**	**39**
EBITDA margin	4.2%	2.3%	(2.0%)	4.4%	3.4%	(1.0%)	4.8%	4.8%	(0.0%)
Depreciation & Financing									
Depreciation & Amortisation	(1,581)	(1,327)	254	(6,075)	(5,318)	758	(19,682)	(19,769)	(86)
PDC Dividend	(463)	(463)	0	(1,853)	(1,853)	0	(5,558)	(5,558)	0
Finance Income	0	0	0	0	0	0	0	0	0
Finance Costs	(14)	7	22	(32)	29	61	(249)	(188)	61
Gains & Losses on Disposals	0	1	1	0	2	2	0	2	2
Total Depreciation & Finance Costs	**(2,058)**	**(1,782)**	**276**	**(7,961)**	**(7,140)**	**820**	**(25,489)**	**(25,513)**	**(24)**
Net Surplus/(Deficit)	**(181)**	**(785)**	**(604)**	**(218)**	**(1,181)**	**(963)**	**(57)**	**(41)**	**15**
NHSI Adjustments to Fin Perf									
Remove Asset Donations I&E Impact	5	3	(2)	19	20	1	57	43	(14)
Adjusted Financial Performance	**(176)**	**(782)**	**(606)**	**(199)**	**(1,161)**	**(962)**	**0**	**2**	**1**
Net margin	(0.4%)	(1.8%)	(1.4%)	(0.1%)	(0.7%)	(0.5%)	(0.0%)	(0.0%)	0.3%

YTD Position

The YTD position is a £1.181m deficit (£1.161m deficit on an adjusted financial performance basis) which is adverse to plan due to significant additional overtime and secondee expenditure to respond to operational pressures in Ambulance Services and the Trust's 111 Integrated Urgent Care Service being partially offset by lower than planned recruit numbers and vacancies.

Full Year Forecast Position

The full year position is forecast to be a £0.041m deficit (£0.002m surplus on an adjusted financial performance basis) which is in line with budget. Current levels of Ambulance Service and IUC pay and non pay resourcing have not been forecast forward at this point due to COVID surge uncertainty.

Key items to note in the positions are:

- Income from activities was £175.6m YTD (£527.7m full year forecast) and is primarily comprised of the Trust's block contract income under the current financial arrangements, along with standard top up and fixed COVID income. An additional £2.7m income has been recognised in the H1 forecast in respect of COVID surge costs, H2 forecast COVID income assumes sufficient funding to break even on an adjustment financial performance basis but is unconfirmed.
- Other operating income is £2m YTD (£5.5m full year forecast) which is slightly ahead of budget full year due to staff recharge income (£0.8m favourable full year forecast) partially offset by lower education and training income (£0.5m full year forecast). Other Operating Income is mainly comprised of education and training income (£1.4m YTD, full year forecast £3.6m) from Health Education England and apprenticeship income.
- Pay expenditure is £2m over budget YTD (forecast to be £2.4m over budget full year) due to significant additional resource usage in Ambulance Services and IUC partially offset by vacancies, lower than expected trainee numbers and unallocated reserves in Central Corporate.
- Non pay expenditure (excl depreciation and finance costs) was £0.3m adverse YTD (full year forecast £2.7m adverse) due to overspends in IUC for additional resourcing in response to higher COVID related activity and is offset by underspends in Programmes and Projects and Strategy & Transformation due to project delays, and People and Culture and Quality and Assurance due to lower recruit numbers than planned.
- Depreciation and finance costs are £0.8m favourable to budget YTD and forecast to be in line with budget for the year with differences due to current forecast timelines for project completion.

Financial Position by Directorate

Directorate	Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	COVID	Actual excl COVID	YTD Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	COVID	Actual excl COVID	Full Year 2021-22 £000 Budget	Forecast	Budget Variance fav/(adv)	COVID	Actual excl COVID
Chief Executive	(179)	(180)	(1)		(180)	(739)	(726)	13		(726)	(2,170)	(2,093)	76		(2,093)
Chairman & Non-Executives	(19)	(15)	4		(15)	(74)	(67)	7		(67)	(226)	(233)	(7)		(233)
People & Culture	(960)	(662)	298	0	(662)	(3,896)	(2,758)	1,137	0	(2,758)	(13,155)	(12,772)	383	0	(12,772)
Communication & Engagement	(279)	(238)	41		(238)	(1,146)	(835)	311		(835)	(3,323)	(2,672)	652		(2,672)
Ambulance Services	(20,342)	(23,047)	(2,706)	(3,692)	(19,355)	(81,327)	(90,286)	(8,960)	(10,674)	(79,613)	(243,126)	(253,714)	(10,588)	(21,695)	(232,019)
999 Operations	(3,298)	(2,960)	338	(8)	(2,952)	(13,237)	(12,197)	1,040	(154)	(12,043)	(39,582)	(38,390)	1,192	(202)	(38,188)
IUC Services	(2,607)	(3,862)	(1,254)	(1,606)	(2,256)	(10,346)	(15,178)	(4,832)	(5,666)	(9,512)	(31,329)	(36,933)	(5,604)	(5,666)	(31,268)
Performance	(150)	(99)	51		(99)	(508)	(370)	138		(370)	(1,493)	(1,473)	20		(1,473)
Programmes & Projects	(1,189)	(556)	632		(556)	(4,711)	(2,271)	2,440		(2,271)	(12,509)	(11,849)	660		(11,849)
COO Management	(149)	(141)	7		(141)	(539)	(516)	24		(516)	(1,656)	(1,572)	84		(1,572)
Corporate Services	(786)	(786)	(0)		(786)	(3,145)	(3,069)	76		(3,069)	(9,435)	(9,489)	(54)		(9,489)
Finance	(469)	(439)	30		(439)	(1,923)	(1,804)	119		(1,804)	(4,979)	(4,922)	58		(4,922)
Strategy & Transformation	(83)	(56)	27		(56)	(350)	(191)	158		(191)	(1,016)	(627)	389		(627)
IM&T	(1,616)	(978)	639	(57)	(921)	(6,108)	(5,916)	193	(259)	(5,656)	(18,227)	(18,062)	165	(802)	(17,260)
Medical	(610)	(412)	198	0	(412)	(2,253)	(1,527)	726	0	(1,527)	(6,926)	(6,025)	901	0	(6,025)
Quality & Assurance	(2,025)	(1,434)	591		(1,434)	(7,971)	(5,638)	2,333		(5,638)	(23,388)	(21,357)	2,031		(21,357)
Strategic Assets & Property	(5,029)	(5,155)	(126)	(610)	(4,545)	(20,633)	(20,026)	607	(2,732)	(17,294)	(60,048)	(59,145)	903	(5,483)	(53,662)
Directorate Sub-Total	**(39,791)**	**(41,021)**	**(1,230)**	**(6,109)**	**(35,047)**	**(158,907)**	**(163,376)**	**(4,468)**	**(19,889)**	**(143,891)**	**(472,588)**	**(481,328)**	**(8,740)**	**(35,243)**	**(447,480)**
Central Income	42,363	42,018	(345)	6,139	35,879	169,478	169,319	(159)	20,021	149,297	502,590	506,816	4,227	35,612	471,205
Central Corporate	(2,753)	(1,782)	971	(29)	(1,753)	(10,789)	(7,124)	3,665	(132)	(6,992)	(30,058)	(25,530)	4,528	(368)	(25,162)
Total	**(181)**	**(785)**	**(604)**	**0**	**(921)**	**(218)**	**(1,181)**	**(963)**	**0**	**(1,586)**	**(57)**	**(41)**	**15**	**0**	**(1,437)**

Ambulance Services

- Overspend YTD of £9m (FY forecast £10.6m) primarily due to increased resourcing costs to respond to operational pressures.
- COVID-19 costs are £10.7m YTD (FY forecast £21.7m) primarily in relation to overtime resourcing and LFB/Met Police support costs (£2.2m YTD, £3.4m FY forecast) to respond to the current COVID surge, partially offset by vacancies.

IUC Services

- YTD position is £4.8m over budget (FY forecast overspend of £5.6m) due primarily to current increased resourcing levels in response to high demand for services.
- COVID-19 IUC costs are £5.7m YTD (£5.7m FY forecast) primarily in relation to increased call handling and clinical resourcing.
- This resourcing has not yet been forecast forward due to uncertainty over activity forecasts.

Programmes & Projects

- YTD position £2.4m favourable to budget (FY forecast £0.7m underspend) driven by project delays and timing differences in Medicines Modernisation, Ambulance Operations Modernisation, Logistics, D999 and IM&T programmes, along with cost Programmes and Projects team vacancies.

People & Culture

- YTD underspend of £1.1m (FY forecast £0.4m favourable) due to lower recruit numbers and thus lower relocation support costs with some recovery expected later in the year.

Strategic Assets & Property

- £0.6m favourable to budget YTD (£0.9m favourable FY forecast) primarily due to lower operational PPE & equipment costs YTD due to continuation of national stock pile provision.
- COVID-19 costs of £2.7m YTD (FY forecast £5.5m) relate primarily to fleet maintenance and vehicle preparation services through external suppliers, increased vehicle and premises cleaning and clinical waste costs.

Quality & Assurance

- £2.3m favourable to budget YTD (FY forecast £2m favourable) due to lower recruit numbers than expected in the early part of the year resulting in reduced training costs, and vacancies in Q&A teams.

Medical

- Favourable variance of £0.7m YTD (FY forecast £0.9m) driven by management and pharmacy team vacancies.

Communications & Engagement

- £0.3m favourable YTD (FY forecast £0.7m favourable) due to vacancies and lower event costs due to COVID adjustments.

IM&T

- YTD favourable variance of £0.2m (FY forecast £0.2m favourable) primarily in relation to net vacancies.
- COVID-19 costs of £0.3m YTD (FY forecast £0.8m) relate primarily to depreciation on IT equipment and system assets procured in response to COVID.

Income

Income by Type	Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	YTD Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	Full Year 2021-22 £000 Budget	Forecast	Budget Variance fav/(adv)
Patient Care Income									
Commercial Service Income	114	248	134	455	608	153	2,713	2,552	(161)
Emergency & Urgent Care Income	41,432	41,472	40	165,687	165,888	201	493,063	497,650	4,587
Emergency Bed Service Income	0	8	8	0	31	31	0	93	93
Injury Cost Recovery Income	81	105	25	323	280	(44)	970	927	(44)
Neonatal Service Income	0	0	0	0	0	0	0	0	0
Non-Contract E&UC Income	16	14	(2)	62	59	(3)	186	183	(3)
Other Patient Care Income	55	55	(1)	221	453	232	700	971	271
Patient Transport Service Income	0	0	0	0	0	0	0	0	0
Specialist Service Income	670	586	(84)	2,483	2,483	0	7,842	7,882	40
Telephone Advice Service Income	1,458	1,424	(33)	5,832	5,807	(25)	17,496	17,414	(82)
Centrally Paid Pension Income	0	0	0	0	0	0	0	0	0
Total Patient Care Income	**43,825**	**43,911**	**86**	**175,063**	**175,608**	**545**	**522,969**	**527,671**	**4,702**
Other Operating Income	**511**	**251**	**(260)**	**2,025**	**1,996**	**(30)**	**5,003**	**5,488**	**484**
Total Income	**44,337**	**44,163**	**(174)**	**177,089**	**177,604**	**516**	**527,973**	**533,159**	**5,186**

At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves pausing contracting and commissioning processes (including CQUIN), the Trust receiving block contract income as determined by NHSE/I, along with a standard monthly top-up amount and fixed COVID income supplement.

Patient Care Income

Emergency & Urgent Care Income

- E&UC income is £0.2m favourable YTD (£4.6m favourable full year) due to assumed additional income in relation to costs associated with current continuing COVID pressures and the pass through of inflation from NWL STP.
- Block contract income is reported under the emergency and urgent care heading with £34m being received each month.
- Monthly top up and fixed COVID support income (£7.3m per month) is also included here.

Telephone Advice Service Income

- This is limited to 111 First programme and NW London 111 IUC Service income due to the adjusted financial framework in place, and is in line with budget YTD (£0.1m adverse full year forecast, broadly in line with plan).

Commercial Service Income

- Commercial income is £0.2m favourable YTD (£0.2m unfavourable full year forecast). YTD variance is due to additional one off income in relation to Wimbledon, however the forecast going forward is for lower income levels and this is partially offset by higher Heathrow service income.

Specialist Service Income

- Specialist Service income is in line with budget YTD and full year with favourable variances for Primary Care Network service pilots offset by the cessation of PRU.

Other Operating Income

Staff Recharges

- Staff recharge income is £0.3m favourable YTD (£0.8m favourable full year forecast) in relation to seconded staff across the Trust.

Education & Training

- Education and Training funding is £0.4m adverse to budget YTD (£0.2m adverse full year forecast) due to lower apprenticeship income and lower training & development funding.

Pay Expenditure

Pay Expenditure by Type	Month 4 2021-22 £000			YTD Month 4 2021-22 £000			Full Year 2021-22 £000		
	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Substantive									
Corporate & Support Staff	(3,606)	(2,784)	821	(14,462)	(11,144)	3,319	(43,147)	(37,338)	5,810
Directors And Senior Managers	(1,781)	(1,445)	336	(7,002)	(5,493)	1,510	(21,083)	(18,531)	2,552
Frontline Control Staff	(2,640)	(2,560)	80	(10,508)	(10,217)	291	(31,495)	(32,826)	(1,330)
Frontline Ops Staff	(15,915)	(15,528)	387	(62,981)	(61,975)	1,006	(189,666)	(187,955)	1,711
Med, Nursing & Clin Adv Staff	(772)	(603)	169	(3,094)	(2,511)	583	(9,250)	(8,061)	1,189
Non-Emergency Control Staff	(15)	(15)	0	(59)	(59)	0	(178)	(178)	0
Non Emergency Ops Staff	(442)	(288)	154	(1,767)	(1,171)	596	(5,300)	(3,477)	1,824
Ops Management & Team Leaders	(3,009)	(2,846)	163	(12,040)	(11,324)	716	(36,063)	(34,570)	1,493
Other Pay Costs	(898)	(125)	773	(3,786)	(483)	3,303	(8,222)	(3,960)	4,263
Overtime & Incentives	(1,218)	(4,688)	(3,470)	(4,919)	(14,620)	(9,700)	(16,451)	(31,485)	(15,033)
Total Substantive	**(30,295)**	**(30,882)**	**(588)**	**(120,620)**	**(118,997)**	**1,623**	**(360,857)**	**(358,379)**	**2,478**
Agency	(41)	(319)	(278)	(167)	(1,558)	(1,391)	(412)	(2,485)	(2,073)
Bank	(327)	(292)	35	(1,323)	(1,338)	(15)	(3,884)	(3,200)	684
Seconded	(15)	(441)	(426)	(60)	(2,271)	(2,211)	(179)	(3,684)	(3,505)
Total Pay Expenditure	**(30,677)**	**(31,934)**	**(1,257)**	**(122,170)**	**(124,163)**	**(1,993)**	**(365,333)**	**(367,749)**	**(2,416)**

Pay Expenditure by Directorate	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	(898)	(127)	771	(3,786)	(507)	3,280	(8,204)	(3,983)	4,221
Chief Executive	(141)	(196)	(55)	(587)	(667)	(81)	(1,714)	(1,936)	(222)
People & Culture	(455)	(450)	5	(1,818)	(1,699)	119	(6,313)	(6,472)	(159)
Communication & Engagement	(244)	(207)	37	(977)	(802)	175	(2,930)	(2,630)	300
Ambulance Services	(19,288)	(22,361)	(3,073)	(77,188)	(86,380)	(9,192)	(232,118)	(243,069)	(10,951)
999 Operations	(3,179)	(2,866)	312	(12,759)	(11,794)	964	(38,145)	(37,120)	1,026
IUC Services	(1,690)	(1,913)	(223)	(6,679)	(7,603)	(924)	(19,914)	(21,838)	(1,924)
Programmes & Projects	(302)	(142)	160	(1,161)	(598)	563	(3,675)	(2,780)	895
COO Management	(124)	(83)	41	(465)	(330)	134	(1,450)	(1,065)	385
Corporate Services	(222)	(182)	40	(887)	(750)	137	(2,661)	(2,482)	180
Finance	(377)	(356)	20	(1,509)	(1,470)	39	(4,378)	(4,190)	188
Performance	(109)	(81)	28	(435)	(317)	118	(1,305)	(1,264)	41
Strategy & Transformation	(39)	(36)	3	(172)	(192)	(20)	(482)	(488)	(5)
IM&T	(463)	(362)	101	(1,871)	(1,519)	352	(5,563)	(5,288)	274
Medical	(565)	(418)	146	(2,160)	(1,539)	621	(6,697)	(5,800)	898
Quality & Assurance	(1,823)	(1,440)	382	(6,573)	(5,103)	1,470	(20,521)	(19,047)	1,474
Strategic Assets & Property	(760)	(712)	48	(3,143)	(2,894)	249	(9,259)	(8,295)	963
Total Pay Expenditure	**(30,677)**	**(31,934)**	**(1,257)**	**(122,170)**	**(124,163)**	**(1,993)**	**(365,333)**	**(367,749)**	**(2,416)**

Year to Date Position

YTD pay expenditure is £124.2m which is £2m overspent due to additional overtime and incentives, seconded external resources and agency in Ambulance Services and 111 IUC Services, partially offset by vacancies and lower recruit numbers than planned.

Full Year Position

Pay expenditure is currently forecast to be £367.7m for the year which is £2.4m adverse to budget, again driven by Ambulance Services and 111 IUC spend. Current levels of Ambulance Service and IUC pay resourcing have not been forecast forward at this point due to COVID surge uncertainty.

Key items to note in the positions are:

- COVID-19 response costs of £11.5m YTD (£19.8m full year forecast) are primarily in relation to additional resourcing across Ambulance Services and IUC Services with significant operational pressure in both areas.
- Overspend in Ambulance Services (£9.2m YTD, full year forecast £11m) is driven by overtime and incentives, as well as seconded support from the London Fire Brigade and Met Police partially offset by Frontline, Non Emergency Transport Service and Management and Team Leader underspends. Current forecasts reflect a reduction in resourcing going forward.
- Overspend in 111 IUC (£0.9m YTD, full year forecast £1.9m) is primarily driven by agency and overtime use, and forecast recruitment going forwards, though current resourcing pressures are not forecast forward at present due to uncertainty.
- These are partially offset by favourable variances in Programmes and Projects (£0.6m YTD, full year forecast £0.9m) due to capitalisations and delays in projects, Quality and Assurance (£1.5m YTD and full year) due to lower numbers of recruits in training than planned, reserves in Central Corporate and vacancies across other areas.

Non Pay and Financial Charges

Non Pay by Type	Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	YTD Month 4 2021-22 £000 Budget	Actual	Budget Variance fav/(adv)	Full Year 2021-22 £000 Budget	Forecast	Budget Variance fav/(adv)
Non Pay Expenditure									
Establishment Expenses	(828)	(743)	85	(3,397)	(2,888)	509	(10,451)	(10,367)	83
General Supplies & Services	(1,908)	(1,495)	413	(8,107)	(7,428)	679	(22,639)	(23,310)	(670)
Technology & Communications	(1,307)	(1,198)	109	(5,093)	(4,809)	284	(15,010)	(15,574)	(563)
Operations Supplies & Services	(3,753)	(4,860)	(1,107)	(15,069)	(18,577)	(3,508)	(44,896)	(47,526)	(2,629)
Premises & Fixed Plant	(1,984)	(1,193)	791	(7,101)	(5,759)	1,341	(20,034)	(18,531)	1,503
Transport	(2,002)	(1,742)	259	(8,409)	(8,020)	389	(24,176)	(24,631)	(455)
Total Non Pay Expenditure	**(11,782)**	**(11,231)**	**550**	**(47,176)**	**(47,482)**	**(306)**	**(137,207)**	**(139,939)**	**(2,732)**
Financial Charges									
Depreciation & Amortisation	(1,581)	(1,327)	254	(6,075)	(5,318)	758	(19,682)	(19,769)	(86)
Other Financial Charges	(478)	(455)	22	(1,885)	(1,822)	63	(5,807)	(5,744)	63
Total Financial Charges	**(2,058)**	**(1,782)**	**276**	**(7,961)**	**(7,140)**	**820**	**(25,489)**	**(25,513)**	**(24)**
Total Non Pay & Financial Charges	**(13,840)**	**(13,013)**	**827**	**(55,136)**	**(54,622)**	**514**	**(162,696)**	**(165,452)**	**(2,755)**

Non Pay by Directorate	Budget	Actual	Budget Variance fav/(adv)	Budget	Actual	Budget Variance fav/(adv)	Budget	Forecast	Budget Variance fav/(adv)
Central Corporate	(1,855)	(1,655)	200	(7,003)	(6,618)	385	(21,854)	(21,548)	306
Chief Executive	(39)	7	46	(156)	(68)	88	(466)	(173)	293
Chairman & Non-Executives	(19)	(15)	4	(73)	(67)	6	(222)	(229)	(7)
People & Culture	(545)	(337)	208	(2,434)	(1,478)	957	(8,088)	(7,857)	231
Communication & Engagement	(47)	(49)	(3)	(188)	(127)	60	(576)	(329)	247
Ambulance Services	(1,344)	(1,108)	235	(5,104)	(5,218)	(114)	(15,646)	(15,665)	(19)
999 Operations	(120)	(94)	26	(478)	(403)	76	(1,437)	(1,270)	167
IUC Services	(2,388)	(3,416)	(1,028)	(9,549)	(13,523)	(3,975)	(29,060)	(32,805)	(3,744)
Programmes & Projects	(928)	(428)	499	(3,714)	(1,805)	1,909	(9,325)	(9,514)	(189)
COO Management	(25)	(59)	(34)	(75)	(185)	(111)	(206)	(507)	(301)
Central Income	0	0	0	0	0	0	0	0	0
Corporate Services	(564)	(605)	(40)	(2,258)	(2,319)	(61)	(6,774)	(7,007)	(234)
Finance	(176)	(91)	86	(498)	(342)	156	(1,362)	(1,247)	116
Performance	(41)	(18)	23	(74)	(54)	20	(188)	(209)	(21)
Strategy & Transformation	(44)	(30)	15	(178)	(31)	146	(534)	(208)	326
IM&T	(1,153)	(616)	537	(4,237)	(4,471)	(234)	(12,664)	(12,848)	(184)
Medical	(67)	(31)	36	(177)	(95)	82	(479)	(475)	5
Quality & Assurance	(216)	(26)	189	(1,451)	(676)	775	(3,025)	(2,700)	326
Strategic Assets & Property	(4,269)	(4,443)	(174)	(17,490)	(17,142)	348	(50,789)	(50,861)	(71)
Total Non Pay & Financial Charges	**(13,840)**	**(13,013)**	**827**	**(55,136)**	**(54,622)**	**514**	**(162,696)**	**(165,452)**	**(2,755)**

Year to Date Position

YTD non pay expenditure including financial charges is £54.6m which is £0.5m over budget. Overspends in 111 IUC for additional resourcing in response to higher COVID related activity (£4m) are offset by underspends in Programmes and Projects (£1.9m) due to project delays, People and Culture and Quality and Assurance (£1.7m combined) due to lower recruit numbers than planned and other more minor areas.

Full Year Forecast Position

Non pay expenditure including financial charges is forecast to finish the year at £166.5m which would be £2.8m unfavourable to current draft budgets. Current levels of IUC resourcing have not been forecast forward at this point due to COVID surge uncertainty.

Key items to note in the positions are:

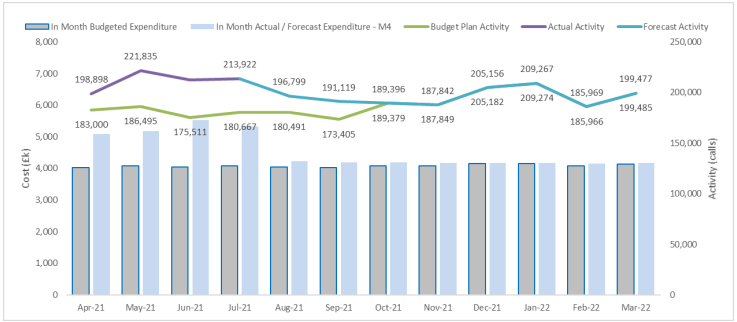
- Transport is underspent by £0.4m YTD (forecast full year overspend £0.5m) with the full year overspend being driven by vehicle movements contract costs budgeted to finish but awaiting contract end confirmation due to delays in Make Ready contract finalisation.
- Operational Supplies and Services are overspent by £3.5m YTD (forecast full year overspend £2.6m) with the YTD and full year overspend due primarily to IUC resourcing for high activity levels partially offset by the receipt of PPE from the national stockpile which was budgeted locally and lower operational equipment costs. The current forecast position improves as the increased IUC resourcing has not yet been forecast across the full year due to uncertainty.
- General Supplies and Services is underspent by £0.7m YTD (full year forecast overspend £0.7m). Full year overspend is predominantly due to professional services costs within the Chief Operating Officer directorate for projects and management support, and are partially offset by pay underspends.
- Premises expenses are underspent by £1.3m YTD (full year forecast underspend £1.5m) due primarily to project delays.
- Technology and Comms is underspent by £0.3m YTD (full year forecast overspend £0.6m) with the forecast position due primarily to updated project spend expectations.
- Depreciation and finance costs are £0.8m favourable to budget YTD and forecast to be in line with budget full year due to current forecast timelines for completion of project related assets.
- COVID-19 response costs are £8.2m YTD (full year forecast £14.4m), primarily in relation to 111 IUC and Ambulance Services external resourcing, external vehicle maintenance and prep services, increased vehicle and premises cleaning, and depreciation impacts in respect of assets purchased.

IUC / 111 Services

	111 IUC Total YTD M4 2021-22 £000			111 IUC Total FY Forecast M4 2021-22 £000		
	Budget	YTD	Variance fav/(adv)	Budget	Full Year Forecast	Variance fav/(adv)
Income						
Income from Activities	5,882	5,948	67	17,646	17,709	64
Other Income	0	0	0	0	0	0
Total Income	**5,882**	**5,948**	**67**	**17,646**	**17,709**	**64**
Pay						
Substantive Staff	(6,552)	(6,584)	(32)	(19,563)	(20,751)	(1,188)
Agency	(3)	(679)	(676)	(8)	(679)	(671)
Bank	(124)	(319)	(195)	(343)	(340)	3
Total Pay Expenditure	**(6,679)**	**(7,582)**	**(904)**	**(19,914)**	**(21,770)**	**(1,856)**
Non Pay						
Establishment Expenses	(6)	(4)	2	(17)	(12)	5
General Supplies & Services	(281)	(373)	(91)	(904)	(879)	24
Technology & Communications	(449)	(531)	(82)	(1,344)	(1,617)	(273)
Operations Supplies & Services	(8,094)	(11,807)	(3,713)	(24,645)	(28,031)	(3,386)
Premises & Fixed Plant	(609)	(681)	(72)	(1,824)	(1,860)	(37)
Transport	(2)	(1)	1	(5)	(5)	0
Depreciation & Amortisation	(107)	(126)	(19)	(322)	(401)	(79)
Total Non Pay	**(9,549)**	**(13,523)**	**(3,975)**	**(29,060)**	**(32,805)**	**(3,744)**
Net Surplus/(Deficit)	**(10,346)**	**(15,157)**	**(4,812)**	**(31,329)**	**(36,866)**	**(5,537)**

Key points to note:

- The current financial arrangements mean that funding for NE and SE London contracts are predominantly covered by block contract arrangements, however specific income is received for 111 First (£0.4m per month) and NW London IUC (£1m per month).
- YTD activity was around 17% higher than the budget plan due to COVID, event and weather impacts. Compounding this, calls requiring transfer to a clinician have increased by 29% and 31% YTD for SE and NE London respectively, along with an increase in clinician call time of 38% and 40% in SE and NE London respectively.
- Significant quantities of additional resource have been engaged in the early part of the year to manage activity - COVID-19 response costs are £5.7m YTD.
- The overall IUC position includes £11.7m of managed service and GP Service costs YTD (£27.8m FY forecast) to deliver stable clinical services and respond to COVID-19 demand levels, the 111 First programme and to provide the NW London 111 service.



Capital Investment

	Actual (£m) Apr-21	Actual (£m) May-21	Actual (£m) Jun-21	Actual (£m) Jul-21	Forecast (£m) Aug-21	Forecast (£m) Sep-21	Forecast (£m) Oct-21	Forecast (£m) Nov-21	Forecast (£m) Dec-21	Forecast (£m) Jan-22	Forecast (£m) Feb-22	Forecast (£m) Mar-22	Total
Monthly capital spend	1.346	2.786	0.605	2.382									**7.118**
Original plan	2.712	3.151	3.216	3.261	3.478	1.048	1.435	1.137	0.636	0.498	0.434	0.436	**21.442**
Forecast	1.346	2.786	0.605	2.382	5.487	6.579	2.354	1.526	1.193	0.910	0.632	0.442	**26.242**
Disposals													**0.000**
Forecast net of disposals	1.346	2.786	0.605	2.382	5.487	6.579	2.354	1.526	1.193	0.910	0.632	0.442	**26.242**
Cumulative actual	1.346	4.131	4.736	7.118	7.118	7.118	7.118	7.118	7.118	7.118	7.118	7.118	
Cumulative original plan	2.712	5.863	9.079	12.340	15.818	16.866	18.301	19.438	20.074	20.572	21.006	21.442	
Cumulative forecast net of disposals	1.346	4.131	4.736	7.118	12.605	19.184	21.538	23.065	24.258	25.168	25.800	26.242	

Programme	(£m) YTD (excl Disposals)	(£m) Forecast (excl Disposals)	YTD as % of forecast
D999	0.073	2.307	3%
IM&T	1.569	5.132	31%
Fleet	(0.077)	1.082	-7%
Spatial	(0.062)	0.862	-7%
Estates	3.314	11.124	30%
Ambulance Ops Modernisation	0.513	0.585	88%
Logistics	0.317	1.551	20%
Medicines Modernisation	1.490	2.965	50%
Clinical Equipment	0.000	0.242	0%
Quality	(0.012)	0.059	-21%
Other	(0.007)	0.333	-2%
Total	**7.118**	**26.242**	**27%**

The Trust's capital plan submitted in conjunction with NW London partners provides for £21.4m worth of capital investment. As of M4, the Trust has also been advised that an additional request for £4.8m of non-cash backed CRL for transformation projects has been approved and this has now been included in forecasts. The forecast £26.2m capital programme is expected to be funded from:

- Internally generated capital (£24.8m); and
- RAAC Plank and Diagnostic Equipment PDC (£1.4m).

YTD and Full Year Position

- YTD capital expenditure net of disposals is £7.1m YTD (£7.1m before disposals) compared to previously planned capital expenditure of £12.3m (£5.2m behind plan net of disposals).
- Full year forecast capital expenditure net of disposals and donated assets is £26.2m (£26.2m before disposals) £4.8m higher than plan due to additional CRL identified by NW London partners.
- Capital spend on the Trust's ongoing property projects and programmes forms the bulk of YTD spend.

Cash Flow Statement

	Apr-21 Actual	May-21 Actual	Jun-21 Actual	Jul-21 Actual	Jul-21 YTD Move
	£000	£000	£000	£000	£000
Opening Cash Balance	**39,788**	**38,267**	**39,262**	**37,537**	**39,788**
Operating Surplus	1,755	2,393	816	997	5,961
(Increase)/decrease in current assets	(616)	(901)	(763)	(3,151)	(5,431)
Increase/(decrease) in current liabilities	6,987	971	1,181	(1,123)	8,016
Increase/(decrease) in provisions	(140)	(37)	(7)	124	(60)
Net cash inflow/(outflow) from operating activities	7,986	2,426	1,227	(3,153)	8,486
Cashflow inflow/(outflow) from operating activities	**7,986**	**2,426**	**1,227**	**(3,153)**	**8,486**
Returns on investments and servicing finance	0	0	0	(1)	(1)
Capital Expenditure	(9,507)	(1,431)	(2,952)	(3,009)	(16,899)
Dividend paid	0	0	0	0	0
Financing obtained	0	0	0	0	0
Financing repaid	0	0	0	0	0
Cashflow inflow/(outflow) from financing	**(9,507)**	**(1,431)**	**(2,952)**	**(3,010)**	**(16,900)**
Movement	(1,521)	995	(1,725)	(6,163)	(8,414)
Closing Cash Balance	**38,267**	**39,262**	**37,537**	**31,374**	**31,374**

At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6. This process has not yet included detailed cash flow planning, and as such, no detailed cash flow plan figures are included.

Summary
There has been a net outflow of cash to the Trust of £8.4m.

Cash funds at 31 July stand at £31.4m.

Operating Surplus
- The operating surplus is £6.0m.

Current Assets
- The movement on current assets is (£5.4m).
- The movement is due to trade receivables (£4.7m), inventories (£0.7m), accrued income £1.6m and prepayments (£1.6m).

Current Liabilities
- The movement on current liabilities is £8.0m.
- The movements are due to deferred income £0.2m, accruals £9.3m and payables (£1.5m).

Dividends
- N/A

Provisions
- The movement on provisions was (£0.1m), this relates legal and international student payments.

Capital Expenditure
- Capital cash movement was a net outflow of £16.9m.

Statement of Financial Position

	Mar-21 Act £000	Apr-21 Act £000	May-21 Act £000	Jun-21 Act £000	Jul-21 Act £000
Non Current Assets					
Property, Plant & Equip	194,033	194,040	195,441	195,275	196,632
Intangible Assets	13,109	13,154	13,180	12,612	12,311
Trade & Other Receivables	0	0	0	0	0
Total Non Current Assets	**207,142**	**207,194**	**208,621**	**207,887**	**208,943**
Current Assets					
Inventories	6,440	6,469	6,818	6,756	7,180
Trade & Other Receivables	28,598	29,185	29,737	30,562	33,289
Cash & cash equivalents	39,788	38,267	39,262	37,537	31,374
Non-Current Assets Held for Sale	0	0	0	0	0
Total Current Assets	**74,826**	**73,921**	**75,817**	**74,855**	**71,843**
Total Assets	281,968	281,115	284,438	282,742	280,786
Current Liabilities					
Trade and Other Payables	(80,553)	(79,752)	(82,631)	(81,928)	(80,641)
Provisions	(7,557)	(7,958)	(7,966)	(8,041)	(7,540)
Borrowings	0	0	0	0	0
Working Capital Loan - DH	0	0	0	0	0
Capital Investment Loan - DH	0	0	0	0	0
Total Current Liabilities	**(88,110)**	**(87,710)**	**(90,597)**	**(89,969)**	**(88,181)**
Total Assets Less Current Liabilities	**193,858**	**193,405**	**193,841**	**192,773**	**192,605**
Non Current Liabilities					
Trade and Other Payables	0	0	0	0	0
Provisions	(8,381)	(7,840)	(7,780)	(7,692)	(8,309)
Borrowings	(107)	(107)	(107)	(107)	(107)
Working Capital Loan - DH	0	0	0	0	0
Capital Investment Loan - DH	0	0	0	0	0
Total Non Current Liabilities	**(8,488)**	**(7,947)**	**(7,887)**	**(7,799)**	**(8,416)**
Total Assets Employed	**185,370**	**185,458**	**185,954**	**184,974**	**184,189**
Financed by Taxpayers Equity					
Public Dividend Capital	77,840	77,840	77,840	77,840	77,840
Retained Earnings	60,043	60,131	60,627	59,647	58,862
Revaluation Reserve	47,906	47,906	47,906	47,906	47,906
Other Reserves	(419)	(419)	(419)	(419)	(419)
Total Taxpayers Equity	**185,370**	**185,458**	**185,954**	**184,974**	**184,189**

At the commencement of 2021-22 the Trust continues to operate under an adjusted financial framework which involves limited business planning up to M6. This process has not yet included detailed Statement of Financial Position planning, and as such, no detailed plan figures are included.

Non Current Assets

- Non current assets stand at £208.9m, £1.8m movement in year.

Current Assets

- Current assets stand at £71.8m.
- Cash position as at 31 July is £31.4m, (£8.4m) movement in year.
- Within Trade & Other Receivables at £33.3m, is £4.7m movement. The movement is due to receivables at £6.5m, is a £4.7m movement, accrued income at £18.1m, is a (£1.6m) movement and prepayments at £8.7m is a £1.6m movement.

Current Liabilities

- Current liabilities stand at (£88.2m), (£0.1m) movement in year.
- Within Trade and Other Payables at £80.6m, is a (£0.1m) movement. The movement is due to accruals at £58.9m, is a £9.3m movement, payables at £21.3m, is a (£9.4m) movement.
- Current provisions at £7.5m, no movement in year.

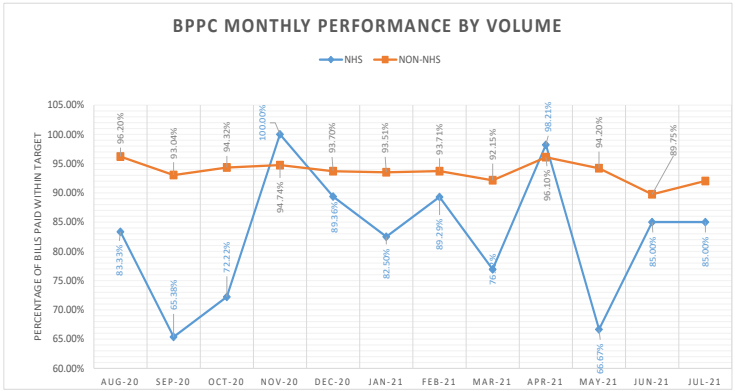
Non Current Liabilities

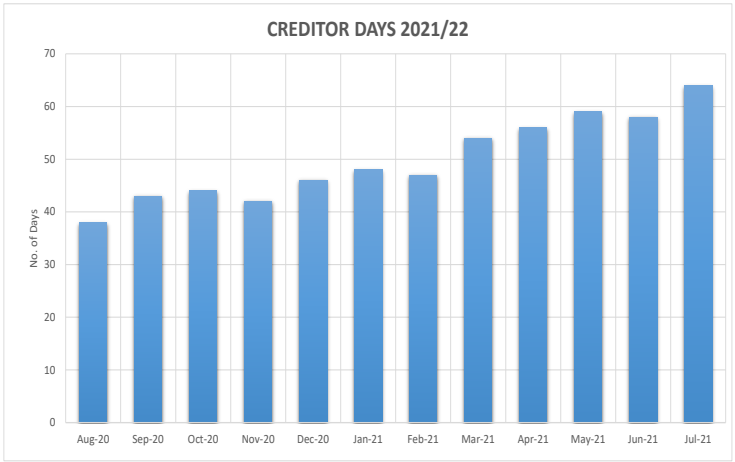
- Non current provisions at £8.3m, £0.1 movement in year.
- Borrowings at £0.1m, no movement in year.

Taxpayers Equity

- Public Dividend Capital stands at £77.8m, no movement in year.
- Revaluation Reserve stands at £47.9m, no movement in year.
- Retained Earnings stands at £58.9m, (£1.2m) movement in year.
- Taxpayers Equity stands at £184.2m, (£1.2m) 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. BPPC performance for July 2021 was 92.0% and 85.0% for Non-NHS and NHS respectively.
- BPPC performance ytd for July was 92.4% and 88.1% for Non-NHS and NHS respectively.
- 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 paid for the 4 months to the end of July 2021 is 14,877 and 185 for Non-NHS and NHS respectively.

Creditor Days

- The increase in creditor days in March 21 to Jul 21 was due to an increase in accruals. The main increases are in the following areas SEL and NEL 111 managed costs, AA services, Interserve and London Fire Brigade.

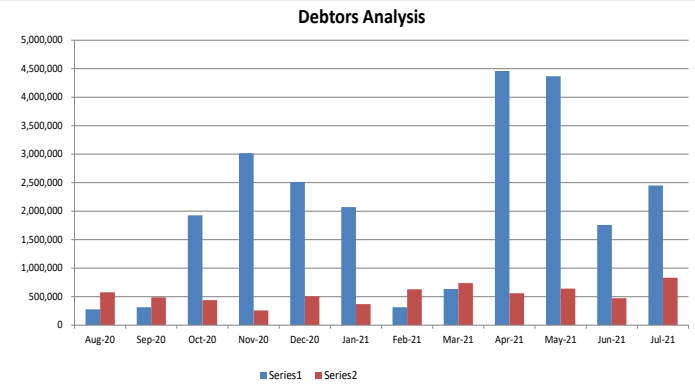
Debtors Analysis

Debtors:

Aged Debtors Summary 31st July 2021

	Note	Total	Days Overdue			
			0 - 30	31 - 60	61 - 90	Over 91 days
		£'000	£'000	£'000	£'000	£'000
NHS Debtors						
Nhs North East London Ccg	1	1,631	957	-	-	674
Nhs North West London Ccg	1	210	-	-	-	210
Barts Health Nhs Trust	1	136	115	7	-	14
West Midlands Ambulance Service Univ. Nhs Ft	1	110	110	-	-	-
Nhs South East London Ccg	1	95	35	18	35	7
North East London Csu	1	72	31	-	-	41
<£5,000	1	193	117	34	0	46
NHS Debtors		**2,447**	**1,364**	**58**	**35**	**993**
Non-NHS Debtors						
Heathrow Airport Ltd	2	290	290	-	-	-
All England Lawn Tennis Club	3	105	105	-	-	-
University Of Cumbria	4	82	82	-	-	-
Wanstead & Woodford Pcn	5	17	17	-	-	-
University Of West London	6	17	5	12	-	-
<£15,000	7	320	66	22	29	202
Total Non NHS Debtors		**831**	**566**	**34**	**29**	**202**
TOTAL DEBTORS 30th Febuary 2021		**3,278**	**1,930**	**93**	**64**	**1,195**

Source: Debtors Ledger 31st July 2021



Debtors Position: 31st of July 2021

Total outstanding NHS and Non-NHS debtors as at 31st July 2021 amounted to £3.3m. The NHS over 60 day's debt stands at £1.03m.

1. NHS Debtors.
   - 3 x NHS North East London invoices for £957k not due for payment, £674k paid in August.
   - 2 x NHS North West London invoices for £210k is due for payment but PO expected to be rasied by the supplier, delay due to merger of organisations.
   - 28 x Barts Health NHS Trust Invoices £136k. £21k Invoices relate to ongoing issues the Trust have had in respect of Barts raising the required purchase orders. £115k not due for payment. We have now managed to locate the correct senior finance managers for each case and are now liaising directly with finance, so expect resolution for all these invoices in the coming weeks.
   - West Midlands Ambulance Service for £8k not due for payment, £102k paid in August.
   - 2 x NHS South East London CCG Invoices £35k not due for payment, £53k payment expected in Aug 2021, £7k is being disputed.
   - North East London Csu for £31k not due for payment, £41k payment expected in August.
2. 4 x Heathrow Airport Ltd invoices for £290k payment not due.
3. All England Lawn Tennis Club invoice for £105k payment not due.
4. 2 x University of Cumbria invoices for £82k payment not due.
5. Wanstead & Woodford Pcn invoice for £17k payment not due.
6. University of West London invoice for £5k payment not due. £12k payment expected in August.
7. Non-NHS Debtors <£13k - £320k consists of; £200k of salary overpayments made to employees, the individuals are paying us on a monthly basis based on their financial status, £47k of stadia events, the stadiums are being chased for payment on a regular basis. The remaining £73k is due from local Government bodies and other miscellaneous organisations.

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

London Ambulance Service
NHS Trust

Assurance report:	Audit Committee (AC)	Date:	15/09/2021

Summary report to:	**Trust Board**	**Date of meeting:**	**23/09/2021**
Presented by:	**Rommel Pereira, Chair of AC**	**Prepared by:**	**Rommel Pereira, Chair of AC**

Matters for escalation:

Culture of control

The Committee discussed the need for an agile mindset, flexible processes, data driven risk assessments and the need for a trusting/low blame culture that embraces risk management and internal controls.

Annual Report & Accounts lessons learned

The Committee examined actions to improve process, production, matrix team working (including matters to be addressed by HR, the People & Culture and Remuneration Committees), prompter identification of control issues and Directors Assurance Statements which would be put into place in support of the Annual Governance Statement and addressing external auditor requirements. The CFO would be the lead accountable Director going forward with regular progress updates to AC in preparation for next year.

Business Continuity Planning/Emergency Preparedness, Resilience and Response (EPRR)

With the background of ongoing REAP4 pressures, AC reviewed BC/DR and EPRR readiness and recommends a strategic discussion at Board, closing self-assessment gaps and prioritising investment and funding needs. The team will revert to AC later this year on actions to be addressed before Board EPRR assurance at its January meeting.

Governance review

The Committee supported prompt commissioning of this important review, also in concert with any changes the new CEO would be proposing, the Assurance Map that AC had requested, recommendations from the recent AC effectiveness review (in particular, increasing NED membership to ensure quoracy, reduce the burden on existing members and provide stronger linkage to other committees) and best practice to nominate Counter Fraud champions at ED and NED levels (other than the CFO and Chair of AC).

Health Sector Counter Fraud – C-19 post event assurance (PEA)

As with centralised spend by government and the wider public sector, the NHS CFA have been tasked by the Health Sector Counter Fraud Board to lead on a similar PEA exercise for COVID-19 spend across NHS Trusts. An extensive set of responses is required. AC was reassured that there were no items of concern but requested sight of final numbers (eg. purchase order versus non purchase order spend).

Other matters considered:	**Counter Fraud** The Committee requested a triage process between the CFO, COO and PCC Director prior to the initiation of counter fraud investigations to ensure appropriate delineation between fraud and performance management issues. **Single Tender Waivers** AC questioned several retrospective waivers and did not agree to the creation of an exemptions list to be included in Standing Financial Instructions. It was agreed that the CEO will sign off all STW going forward. **Losses & Special Payments** AC requested thematic explanations of an increased number of employment tribunals. **SIRO & DSPT** AC noted ongoing progress by the Trust's nominated SIRO, Data Protection Officer, Caldicott Guardian and Chief Information Officer exercising their oversight responsibilities through the Information Governance Group, which reports to the Executive Committee. While our DSPT assessment for 2020/21 did not meet mandatory assertions, an implementation plan for the outstanding requirements is being overseen weekly by the CIO and a consensual audit is being completed by a digital security specialist prior to a DSPT compliance internal audit in Q4 for the 21/22 submission. **Standing Financial Instructions & Scheme of Delegation** AC noted changes following the restructure of reporting and assurance fora for capital expenditure, but requested a root and branch review, taking account of any proposed changes the new CEO may want to make and the proposed Governance Review, before recommending these to the Board.
Key decisions made / actions identified:	**New Internal Audit and Counter Fraud providers** Subject to the inclusion of matters noted elsewhere, the Committee approved BDO and RSM's work plans for the rest of this year, asking that the plans remain flexible to address the changing needs of the Trust. **AC Terms of Reference** No immediate changes proposed but asked that the Trust Board be advised of Committee members' feedback. **Fit and Proper Person (FPPR) and Conflict of Interest** FPPR and Conflict of Interest policies approved, but AC noted this does not only apply to Board members and requested FPPR coverage of senior interims/contractors and assurance that employment agencies are conducting full pre-employment checks.
Risks:	**Board Assurance Framework and corporate risks** AC commended a visual probability and impact heat map presentation by BDO of BAF and Corporate risks. This highlighted a very significant number of red risks and several tolerated risks with a score of 20 (linked to the Trust's risk appetite).

	The Committee welcomed the new CEO's objective to bring the BAF and Corporate risks (previously managed by different directorates) together under Corporate Affairs and agreed to management's request to undertake a stocktake and refresh and that a Risk Maturity internal audit would follow on from that.
Assurance:	**Internal Audit Reports** The Committee received significant assurances on Workforce Planning (with minor improvements), Infection Protection Control (with some improvement, asking that QAC oversee that feedback on safety from more junior staff is respected), CIP/Benefit Realisation (with improvement required, noting that dependencies on analytical consultancy support would be mitigated soon with new permanent appointments) and partial assurance with improvement required on Equality & Diversity (reflecting more work that is required in this important area). Disappointed to note significant delays in the audits of Recruitment & Retention, Rostering and IR35 from the outgoing internal auditors. AC asked BDO to complete the IR35 review as part of their program. **Counter Fraud** AC did not agree to the recommendation to exclude a 111 IUC timesheet verification from the CF plan and reinstated the review with RSM. AC further requested assurance that Supplier Relationship Management and Contract Management processes had been strengthened following the completion of a fraud investigation and interview under caution that indicated a contract monitoring failure.

London Ambulance Service
NHS Trust

Assurance report: Logistics and Infrastructure Committee

Date: 13/09/2021

Summary report to:	**Trust Board**	**Date of meeting:**	**23/09/2021**
Presented by:	**Sheila Doyle, Non-Executive Director, Logistics and Infrastructure Committee Chair**	**Prepared by:**	**Sheila Doyle, Non-Executive Director, Logistics and Infrastructure Committee Chair**

Matters for escalation:

Newham EOC

Newham EOC is delayed to Feb/Mar due to national and international supply chain challenges in the construction industry. Project dependencies and key milestones will be reviewed to ensure the optimum delivery plan.

Hub 1

The Hub 1 business case is being refreshed. The whole life costs will exceed the board's delegated limit and will need to be approved by NHSE. The business case refresh will include a comprehensive options appraisal as part of the economic evaluation.

One London Integration Engine

The committee received and supported the outline business case for the One London Integration and Analytics Engine. LAS is asked to host this system for the London region. The system will provide opportunities for LAS to enable digital transfer of patient care and for direct admission workflows to be developed.

Revised Terms of Reference

The revised Terms of Reference is presented to the Trust Board for approval.

Other matters considered:

Fleet Modernisation

The committee received a briefing paper outlining options to obtain Ultra Low Emissions Zone (ULEZ) and Zero Emissions Zone (ZEZ) compliance for Double Crew Ambulance (DCA). Members recommended that the options paper is expanded to include Fast Response Units (FRU) & vans and sought assurance that the recommendations are aligned with the Trust Fleet strategy. An updated paper will be provided at the next meeting.

Infrastructure Modernisation Priorities

The committee received a verbal update on the recent CAD outage and the complexity of the existing Telephony systems. The Infrastructure Modernisation program, already underway, will address many of the current technical issues. Members noted and supported the

	prioritisation of investment and resources to address critical infrastructure projects. **UPS** The committee received an update on the ongoing work to resolve Uninterruptible Power Supply (UPS) issues at HQ, Bow, Newham, and Maritime House. The replacement work at Bow is on hold due to the planned move to Newham. The Estates team has developed a contingency plan in the event of UPS failure and are exploring alternative options to manage / mitigate this risk.
Key decisions made / actions identified:	Noted in previous section.
Risks:	**Board Assurance Framework and Corporate Risks** Members reviewed BAF risks and requested that BAF risk 58 and 45 are updated to provide a clearer outline of the actions underway to mitigate these risks. Development of the Trusts risk approach to transformation is progressing. The proposal is expected to be formalised by the Executive Committee in September.
Assurance:	Estates has achieved 100% statutory compliance. The committee welcomed the work to: 1) Develop an integrated program plan, outlining project inter dependencies and building blocks, and, 2) Continued focus on prioritization of investment and resources to address technical infrastructure challenges, build resilience, and mitigate BAF and corporate risks.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	London Ambulance Service Public and Patient Council notes – August			
Agenda item:	9			
Report Author(s):	Antony Tiernan, Director - Communications and Engagement			
Presented by:	Antony Tiernan, Director - Communications and Engagement			
History:	n/a			
Purpose:	☐	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

The London Ambulance Service Public and Patients Council (LASPPC) was established in 2020 and is one of many ways in which LAS engages patients and local communities with its work.

To help keep the Trust Board and Executive Committee informed of the work of the LASPPC, the notes and actions from meetings are presented for information at Board and ExCo meetings for information. Having been approved at its August meeting, the notes of the May LASPPC meeting are attached.

Also attached is the agenda for the August LASPPC meeting. The notes will follow once they are approved.

Recommendation for the Board:

The Board is asked to note the contents of this paper.

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

Directorate	Agreed				Relevant reviewer [name]
Quality			No		
Finance			No		
Chief Operating Officer Directorates			No		
Medical			No		
Communications & Engagement	-		-		
Strategy			No		
People & Culture			No		
Corporate Affairs			No		

London Ambulance Service NHS Trust

Meeting of the London Ambulance Service Public and Patients Council on Tuesday 10 August 2021, at 10:00am – 12.00pm, via Microsoft Teams

Agenda

Item		Owner		Time
1.	**Welcome** **Apologies:** **David Elliman** **Heather Lawrence, Chair, LAS** **Patrick Burns – second hour** **Observer:** **Simba Tome, Head of Quality, NWL ICS** **Ruth Sheridan, Head of Quality, SEL ICS** **Jenny Singleton, Head of Quality, NEL ICS** **Nicola Bamford, Senior Quality Manager, SWL ICS** **Emma Casey, Clinical Governance & Quality Assurance Lead, NCL ICS**	Dame Christine Beasley, Co-Chair	Verbal	10.00
2.	**Notes and actions of the last meeting**	Dame Christine	Papers – attached Notes (001) Actions (002) Public perceptions data (003)	10.05
3.	**Declarations of Interest – not previously declared or pertinent to the agenda**	Dame Christine	Verbal	10.05
4.	**LAS executive changes**	Antony Tiernan, Director of Communications and Engagement	Verbal	10.10
5.	**COVID-19/demand/winter update**	Pauline Cranmer, Director of Ambulance Services	Verbal/ presentation (004)	10.15
6.	**Non-conveyance and quality strategy refresh**	John Martin, Chief Paramedic	Presentation (005)	10.25

Item		Owner		Time
	Additional (optional) reading: **Non-conveyance:** https://bmjopen.bmj.com/content/8/8/e021732 **Quality strategy:** https://www.londonambulance.nhs.uk/wp-content/uploads/2018/05/Quality-Strategy-Vision-2020-and-Annual-Quality-Account-2018-2019.pdf https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021 https://www.ncbi.nlm.nih.gov/books/NBK222265/#ddd00039	and Quality Officer		
7.	**Mental health team – update**	Carly Lynch, Consultant Nurse for Mental health	Presentation (006)	10.45
8.	**Delivering a Greener LAS**	Ant Scott, Head of Strategic Development	Presentation (007)	11.00
9.	**Ambulance Operations Modernisation Programme sub-group – Hub1 update**	Antony Tiernan and Ian Buckmaster, LASPPC member	Presentation (008)	11.10
10.	**Sub-group – update**	Antony Tiernan	Paper (009)	11.25
11.	**End of life care team – update**	Dr Diane Laverty Macmillan Nurse Consultant: Palliative Care and Georgina Murphy-Jones, Macmillan Paramedic Lead, Palliative and End of Life Care	Presentation (010)	11.40
12.	**AOB**	All	Verbal	11.55
	Meeting ends			12.00

Next meeting:

24 November, 11am to 1pm

Future dates:

23 February, 11am – 1pm

25 May, 1pm – 3pm
24 August, 12:30pm – 2pm

London Ambulance Service NHS Trust

Meeting of the London Ambulance Service Public and Patients Council (LASPPC) on Tuesday 4th May 2021, at 10:00am – 12.00pm, via Teams Video Conference

Summary

Attendees

Council
Dame Christine Beasley, Co-Chair (CB); Dora Dixon-Fyle MBE (DD); Audrey Lucas; Lynne Strother; David Law; Laura Bennett; Angela Cross-Durrant; Glenda Bonde; Michael Bryan, Co-Chair; Mary Leung; Patrick Burns (PB); Ian Buckmaster (IB); Oonagh Heron; David Elliman.

London Ambulance Service
Antony Tiernan. Director of Communications and Engagement (AT); Robert Bowen, Programme Director – Ambulance Operations Modernisation Programme (RB); Lee Hyatt-Powell, Quality Governance and Assurance Manager (LHP); Chris Rutherford, Next Generation Ambulance Programme Lead (CR); Philippa Keir, Senior Stakeholder Manager (PK); Amy Pitcher, Quality Compliance Manager (AP); Antony Scott, Head of Strategy (AS); Helen Woolford, Head of Quality Improvement and Learning (HW).

Observers
Jill Anderson, Non-Executive Director; Alvin Kinch, Volunteering and Regional Network (London) Manager, Healthwatch England.

Apologies
Rommel Pereira, Non-Executive Director, LAS; Moh Okreson (LASPPC), Jacqui Morrissey (LASPPC); Heather Lawrence OBE (Chair, LAS); Dr Mark Spencer, Non-Executive Director (LAS); Dr Kathy French (LASPPC); Amit Khutti, Non-Executive Director (LAS).

1. Welcome

CB welcomed members.

2. Notes of the last meeting

The draft notes of the last meeting were agreed as a true and accurate account. No amendments were required. The actions are in hand. Mental Health team not able to join this meeting but will join in August.

CB – One of the actions from the last meeting was that MB (Co-Chair) was to introduce himself and give an overview of his background.

3. Michael Bryan – introduction

Michael shared that he is currently a medical student with an interest in emergency paediatric medicine. He is also a Special Constable with the Metropolitan Police Service. As

well as being the Co-Chair, Michael will support AT with the development of the LASPPC sub-groups.

4. Consultations

AS stated that a number of consultations have come out over the past few weeks and he updated the LASPPC on three. The first is a Government consultation on proposed changes to the Mental Health Act. The second is an NHS England consultation on a proposed provider selection regime and the third was a commentary by the Association of Ambulance Chief Executives (AACE) and Public Health England on the role of ambulance services in promoting public health.

Mental Health Act

Consultation followed an independent review in 2018. This review set out a list of what needed to change in law and practice to deliver services which respect the patient's voice so as to allow them to shape their own treatment.

AS shared the topics which were covered: patient detention period; strengthen the patient voice; and, to legislate that people having learning disabilities and autism are not grounds for detention. First, the White Paper ensures that people are transported by ambulance and not police so that they do not feel like a criminal. Second, the paper proposed to extend the powers of detention within A&E. AS explained that LAS's response supported the proposals. Expressed five key messages – need to address legislative gaps, shared view around vehicle specification, supported that the ambulance should convey the patient when in crisis, raised issue with variation in ambulance service access to funding to deliver additional mental health services and, finally, the importance of getting ambulance specific guidance to be able to apply the act effectively.

AS answered questions.

NHS England consultation on proposed provider selection regime

AS explained this consultation is about the removal of competition rules in tendering for new health services. By removing the competitive process, providers are encouraged to be more collaborative and less competitive with each other. The removal of the bid process reduces the time in which health managers have to input in developing the bid responses thus freeing up more time for patient facing activities.

LAS response was broadly supportive of the new regime as it reduces the procurement barriers which LAS currently face in implementing the vision of being the primary integrator of urgent and emergency care and by allowing commissioners to award 111 services to LAS with the long procurement process.

AS answered questions.

Association of Ambulance Chief Executives (AACE) and Public Health England on the role of ambulance services in promoting public health

AS explained that this was more a commentary on the role that ambulance services play in public health. Broad areas covered – how ambulance data can be valuable when combined with other health and care data sets on managing the health of the population and how ambulance services can play a vital role in providing different prevention initiatives.

We welcomed from the paper in five key areas:

- The role that paramedics play in primary care networks to deliver public health interventions.
- We supported the case around sharing data for the purpose of public health and perhaps be the integrator of the data.
- To play an expanded role in delivering public health initiatives we would need to change our organisational structure – increasing the capacity to be represented at public health forums.
- Increased training.
- Opportunities within 111 which were missed.

AS answered questions.

5. Station (Quality) Accreditation Programme

AP gave update on the Station (Quality) Accreditation Programme.

AP focused on the learning from the pilot, current position and support that is required.

Explained that the programme was very successful. Four stations came in at Gold and one as Silver. Because of COVID-19, all assessments were virtual. This summer we are including 'ride outs'. More focus on patient feedback which links in to the Care Quality Commission key lines of enquiry. Looking at the complaints process, looking at the complaint journey as a whole. Focus on staff survey results and making sure there are action plans in place and they are met.

AP explained that if stations now provide the narrative and the answer, then they will now score higher – that's what they would expect from a Gold standard. Just one of either would now score lower points. Each station had to provide evidence. The programme has been extended from eight to 12 weeks.

For those that participated in the programme, they have developed a monitoring system with the quality team able to monitor all the 'Gold' standards – personal development reviews (PDRs), mandatory and statutory training, clinical performance indicators, auditing at the correct level. Extending further to include key quality indicators.

AP confirmed that the data pack was well received but needed a few changes – to include more trends and key analysis, examples of complaints and incidents including the investigation and the learning, more commentary and context.

Current position – fully launched in April. A quality priority for the LAS. Running assessments throughout the year at staggered times. Ensure that it is suspended during winter pressures. Currently have six stations participating across the Trust with Brixton going for reassessment due to coming out as Silver.

AP asked the group if they would like to participate as an assessor. She explained that they would have the opportunity to have a 'ride out' with the staff, have a briefing before the assessment day, get a quality visit and go around the station, speak with the Local General Manager and the Clinical Team Manager. They will be given a set of standard questions to ask. At the end of the assessment day, they will have a collaboration session to discuss their day. Then to decide if the station comes out as Gold, Silver or Bronze. Explained it runs over 1 ½ days. That all stations are different and what they need to focus on.

MB explained that he was part of this programme for Camden.

Questions asked.

6. Patient Safety Incident Response Framework (PSIRF)

HW explained that LAS is an early adopter of the PSIRF and asked for support. Explained the strategy was refreshed in 2019 looking at patient safety. It came with three aims – insight; involvement; and, improvement.

Explained we need to involve the public to improve patient safety. To make sure it informs and engages patients, family and carers.

Stated that only went live 1 April due to COVID-19. To ensure that we are looking at themes and trends and then driving improvements. Making sure that as we are the only ambulance trust, we develop these standards.

HW says that aim is to feedback October. Asked for support to help design the systems. Looking for four or five members to join the quality team. To support patients, getting feedback from the LASPPC, to develop a questionnaire to send back to patients who have been involved. To ensure new standards of the framework are achieved.

HW answered questions.

7. Next Generation Ambulance (NGA)

CR explained why we need the next generation ambulance (NGA). We need a zero emission option due to the zero emission zone. Wanted a lightweight vehicle so it does not need a C1 licence. More accessible vehicle to reduce MSK injuries in staff/volunteers and finally a digitally enabled vehicle for the future.

CR explained they have a working group, including colleagues and LASPPC members. Stated this is now a national project and not just London.

CR explained who the groups were on his slide – all organisations which provide funding and who develop low emissions vehicles.

Gave a summary from the project board last month. Staff/volunteer survey to get views of what they would like to see in the NGA. Getting Greener NHS aligned with our targets. Had some design days including two LASPPC members.

Shared staff/volunteer survey – one of which was digital. Staff/volunteers requested docking station to integrate their phones. To also have Wi-Fi in the vehicle for video triage etc.

Accessibility – staff/volunteers were not happy with the loading mechanism. Looking at a self-loading trolley. Working with St John Ambulance and looking at their vehicles.

Lightweight – discussion about medical equipment and we are now comparing with other trusts. London carries 30kg more gas and we need to learn from other services.

Zero emission – positive but anxiety around charging and range. CR confirmed that the distance we covered during the day can be completed on a zero emission vehicle.

LASPPC members gave an insight into the NGA design day at North Kensington Ambulance Station.

8. Ambulance Operations Modernisation

RB and PK introduced themselves to the group.

RB has taken over from Ross Fullerton, Director of Strategy and Transformation and is leading on the Ambulance Operations Modernisation (AOM) business case and Hub1 project.

Explained that the AOM business case covers all of the estates work – trying to consolidate all the older estates around London to make them into a smaller number of Ambulance Deployment Centres. RB went on to explain that the LAS wants to provide its staff/volunteers with modern, fit for purpose facilities and to make sure all the processes for getting the ambulance ready for dispatch is happening efficiently. Stated by consolidating the estates, this will allow all of this to happen.

Hub 1 – RB stated LAS has now reached a decision where the location of the first hub will be (Wantz Road, Dagenham). Explained that it is confidential as it is currently 'owned' by BT but we are in negotiations with them. Hoping to have this concluded over the next few weeks. Will be going out to seek planning permission in the Summer.

Stated the location of the site gives us good access to the hospitals and standby points. There is more construction work than anticipated which has pushed back the date.

RB answered questions regarding costs.

PK updated the group with key messages as to why we are creating these Hubs.

PK asked for recommendations as to how the LAS can involve patients and public more in the process. CB asked for any responses.

9. Sub-groups

AT updated on sub-groups and asked for expressions of interest in new groups. CB has asked for this to move up the agenda to allow more time to talk about the subject. AT thanked members that have been working on other sub-groups.

10. AOB

None.

Next meeting: Tuesday 10 August 2021, 10am to 12noon

London Ambulance Service
NHS Trust

Report to:	**Trust Board**			
Date of meeting:	23 September 2021			
Report title:	Board Assurance Committee Terms of Reference and Membership			
Agenda item:	10.1			
Report Author(s):	James Stanton, Head of Corporate Governance			
Presented by:	Diane Scott, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	☐	Assurance	☒	Approval
	☒	Discussion	☐	Noting

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

Following changes in the Board Membership in the first half of the year, the Trust Board is presented with the current Terms of Reference and Membership for the Board Assurance and other appointed committees for consideration.

The Terms of Reference for the Board Committees were circulated for comment at each of the Board Assurance Committee meetings in the current cycle. Changes recommended by the Assurance Committees are set out in the paper. Committee members were also given the opportunity to provide additional comments and feedback based on the previous year to the Board, these comments are also provided.

It should be noted that a short review of Trust governance and assurance is due to take place over the coming weeks. It is therefore possible that further amendments may be brought forward for consideration to reflect the findings of the review.

Recommendations for the Board:

The Trust Board is asked to agree the attached Terms of Reference and committee membership.

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 Affairs	Yes		No		

1. Introduction

1. The Terms of Reference for the Board Assurance Committees are presented to the Trust Board each year as an opportunity to consider any necessary updates.

2. The review of terms of reference would usually take place at the May meeting, alongside consideration of other governance assurance matters, as part of the production of the Annual Report. The review was carried out in two parts this year due to the number of changes which were due to take place in senior leadership on the Board. This approach was designed to enable the Board to consider its arrangements with knowledge of its revised membership and their specialisms.

2. Summary of Changes

3. The Terms of Reference for the Board Assurance Committees were circulated for comment in the current meetings cycle. Although the meetings of the People and Culture Committee and Quality Assurance Committee did not take place this cycle, the terms of reference were circulated to members. It should therefore be noted that these committees may wish to revisit their terms of reference in the future.

4. Only minor changes are suggested at this point. These include updated job titles and the recent change agreed by the Trust Board to the quorum of the Logistics and Infrastructure Committee (25 May 2021). Changes are highlighted in red text on the proposed updated Terms of Reference attached Appendix 1:

5. During the discussions by the assurance committees, additional comments were made which are reported to the Board for information and consideration:

    - Updates from Committee Chairs could be given verbally at the meetings, rather than in a written report.
    - Consideration should be given to holding the public part of Board meetings after the private session when appropriate.

6. A short review of Trust governance and assurance is due to take place over the coming weeks. It is therefore possible that further amendments may be brought forward for consideration to reflect the findings of the review.

3. Membership changes

7. The Board membership has seen a number of recent changes. In particular, Bob Alexander and Dr Anne Rainsberry CBE have joined the Trust as Non-Executive Directors (NED) and Line De Decker has been welcomed as an Associate NED.

8. An updated list of the memberships of Board Assurance Committees is attached at Appendix 2 for confirmation. The list also includes the Charitable Funds Committee and Limited Companies.

4. Conclusions/Recommendations

9. The Trust Board is asked to approve the Terms of Reference and memberships as set out in the paper.

Appendix 1

London Ambulance Service
NHS Trust

Audit Committee

Terms of Reference (effective March 2020-March 2021)

1. Purpose

1.1 The Audit Committee (the Committee) has been established in order to focus primarily on the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

2. Constitution

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

3. Authority

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

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

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

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.

5.2 At least one member of the Committee must have recent and relevant financial experience.

6. Chair

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

7. Attendance

7.1 The Chief Finance Officer and the Director of Corporate Affairs should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

7.2 The Non-Executive Chair of the Quality Assurance Committee should be invited to attend all Audit Committee meetings.

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

7.4 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

8. Quorum

8.1 The meeting will be quorate provided that two Committee members are in attendance, including the Chair of the Committee, or their nominated deputy (who must also be a Non-Executive Director). In the absence of the Chair, Committee members may nominate a deputy chair for the purposes of that meeting from their midst.

9. Meeting administration

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

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

10. Notice of meetings

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

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

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

11. Frequency of meetings

11.1 The Committee shall meet a minimum of four time per annum. A calendar of dates will be published with the agenda setting out the dates of the meetings for the remainder of the financial year.

11.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12. Duties

Purpose

12.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

12.2 The Committee shall review the corporate risk register and the Board Assurance Framework and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.

12.3 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

12.4 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

12.5 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

12.6 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

12.7 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Assurance Committees of the Board and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

Internal Audit

12.8 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

12.8.1 approval of the appointment of internal auditors and any question of resignation and dismissal. review and approval of the Internal Audit strategy,

12.8.2 operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

12.8.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

12.8.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

12.8.5 an annual review of the effectiveness of Internal Audit.

External Audit

12.9 The external auditor is appointed by the Trust Board on recommendation from an Auditor Panel established through the Audit Committee.

12.10 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

12.11 The auditor panel's functions are to:

12.11.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules

- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

12.11.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed external auditor;

12.11.3 Advise (if asked) the Trust Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

12.11.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

12.11.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor

12.12 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

12.12.1 consideration of the performance of the External Auditor;

12.12.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

12.12.3 discussion with the External Auditors of their local evaluation of audit risks;

12.12.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

12.12.5 discussion and agreement on the Trust's Annual Governance Statement.

Risk and Assurance Functions

12.13 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

12.13.1 review of the work of the Quality Assurance Committee in the management of clinical risk including assurance gained from the clinical audit function;

12.13.2 review of the work of the Finance and Investment Committee in the management of financial risk;

12.13.3 review of the work of the People and Organisational Development Committee in the management of workforce risk;

12.13.4 review of the work of the Logistics and Infrastructure Committee in the management of risk relating to IM&T, Estates, and Fleet & Logistics;

12.13.5 review of the Executive Leadership Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Risk Compliance and Assurance Group;

12.13.6 review the Board Assurance Framework to ensure that it is focussed on the key strategic risks to the business and clearly identifies controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;

12.13.7 review of the findings of any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);

12.13.8 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

Counter Fraud

12.14 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

12.15 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

12.16 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

12.17 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

12.18 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

Whistleblowing

12.19 The Committee shall ensure that arrangements are in place for investigation of matters raised in confidence by staff relating to matters of financial reporting and control, clinical quality and patient safety, or other matters.

Other

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

13. Review and reporting responsibilities

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

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

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.

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

14. Equality and diversity

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

Approved by the Board at its meeting on 31 March 2020

London Ambulance Service
NHS Trust

Finance and Investment Committee

Terms of Reference (effective April 2020-March 2021)

1. Purpose

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

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

2. Constitution

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

3. Authority

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

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

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

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

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

6. Chair

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

7. Attendance

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

7.2 The Chief Operating Officer, Director of Corporate Affairs and the Deputy Director of Finance should normally attend all Finance and Investment Committee meetings.

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

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance, with Non-Executive Directors being in the majority;

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

9. Meeting administration

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

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

10. Notice of meetings

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

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

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

11. Frequency of meetings

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

12. Duties

Financial Policy, Management and Reporting

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

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

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

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

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

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

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

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

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

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

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

Investment Policy, Management and Reporting

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

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

Procurement

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

Other

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

13. Review and reporting responsibilities

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

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

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

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

14. Equality and diversity

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

Approved by the Board at its meeting on 31 March 2020

London Ambulance Service
NHS Trust

Logistics and Infrastructure Committee

Terms of Reference (effective April 2020-March 2021)

1. Purpose

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

2. Constitution

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

3. Authority

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

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

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

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

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

6. Chair

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

7. Attendance

7.1 The Director of Corporate Affairs should normally attend all Logistics and Infrastructure Committee meetings.

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

8. Quorum

~~8.1~~ The meeting will be quorate provided that the following are in attendance, ~~with Non-Executive Directors being in the majority;~~

8.1.1 Two Non-Executive Members one of Whom must be the Chair or nominated Chair of the Committee; and

8.1.2 At least one of the two Executive Committee members, one of whom must be the Chief Finance Officer or the Chief Operating Officer.

9. Meeting administration

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

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

10. Notice of meetings

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

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

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

11. Frequency of meetings

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

12. Duties

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

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

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

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

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

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

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

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

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

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

13. Review and reporting responsibilities

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

13.2 The Committee will report to the Trust Board after each meeting via an assurance report, which will provide an overview of the discussions at the

meeting, details of any matters in respect of which actions or improvements are needed and decisions taken.

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

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

14. Equality and diversity

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

Approved by the Board at its meeting on 25 May 2021

London Ambulance Service
NHS Trust

People and Culture Committee

Terms of Reference (effective April 2020-March 2021)

1. Purpose

1.1 The People and Culture Committee has been established in order to assure the Board on all aspects of people management and organisational development, including the identification, mitigation and escalation of people-related risks.

2. Constitution

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

3. Authority

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

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

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

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Director of People and Culture and the Chief Paramedic and Quality Paramedic Officer) and shall consist of not less than eight members, all of whom shall have voting rights.

6. Chair

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

7. Attendance

7.1 The Director of Corporate Affairs, Financial Controller, the Head of Workforce Analytics and an Equality and Inclusion Representative should normally attend all People and Culture Committee meetings.

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

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance, with Non-Executive Directors being in the majority;

8.1.1 The Chair or nominated Chair of the Committee; and
8.1.2 At least one of the two Executive Committee members, one of whom must be the Director of People and Culture or Chief Paramedic and Quality Officer.

9. Meeting administration

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

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

10. Notice of meetings

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

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

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

11. Frequency of meetings

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

12. Duties

12.1 To enable the Trust Board to obtain assurance that the Trust achieves the following in a spirit of inclusion and diversity:

Leadership and Performance

12.1.1 Performance – is able to maximise the potential of its people both in delivering against their role and in developing their skills

12.1.2 Leadership Development – is taking appropriate steps to develop its current and future leaders

12.1.3 Multi-disciplinary training – has the systems and processes in place to ensure that its people are well equipped to undertake the tasks that are expected of them and that it can fulfil its workforce planning

12.1.4 Statutory and Mandatory training – ensures that its people have timely access to relevant statutory mandatory training and that they are compliant at all times

Healthy Workplace

12.1.5 Staff support – has appropriate systems and process in place to ensure the health and wellbeing of its people, occupational health offered and supporting them following their involvement in major incidents

12.1.6 Bullying and Harassment – is taking appropriate steps to prevent inappropriate behaviours in the workplace

Engagement

12.1.7 Recognition – has recognition schemes in place which recognise excellent contributions that reflect the Trust's values contributes to the accomplishment of its goals

12.1.8 Employee relations – has an effective strategy for dealing with employee relations and effective partnership arrangements with recognised Trade Unions

12.1.9 Employee voice –has effective methods of staff engagement that promote the concept of 'you said we did' in support of an inclusive approach to working with its people

Talent

12.1.10 Values based recruitment – has the systems and processes in place to ensure that it has the workforce it requires to deliver its goals

12.1.11 Succession planning – is able to replace people in key roles should they no longer be able (short term) or wish (longer term) to fulfil them

12.1.12 Equality, Diversity and Human Rights - has a dynamic workforce that reflects the diversity of its patients

Workforce Analytics

12.1.13 Strategic workforce planning – has appropriate people-related plans and strategies in place to enable delivery of the Trust's strategy and business plans

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

13. Review and reporting responsibilities

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

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

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

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

14. Equality and diversity

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

Approved by the Board at its meeting on 31 March 2020

London Ambulance Service
NHS Trust

Quality Assurance Committee

Terms of Reference (effective April 2020-March 2021)

1. Purpose

1.2 The Quality Assurance Committee has been established in order to provide the Trust Board with assurance on the achievement of the London Ambulance Service NHS Trust's strategic objective in relation to the provision of a high quality, safe, and effective service.

1.3 The Trust's definition of quality encompasses three equally important elements:

- **Care that is safe –** working with patients and their families to reduce avoidable harm and improve outcomes.
- **Care that is clinically effective –** not just in the eyes of clinicians but in the eyes of patients and their families.
- **Care that provides a positive experience –** to patients and their families.

2. Constitution

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

3. Authority

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

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

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

4. Accountability

4.1 The Committee will report directly to the Trust Board.

5. Membership

5.1 The Committee shall be appointed by the Board from amongst the Non-Executive Directors and Executive Committee of the Trust (including the Chief Medical Officer and the Chief Paramedic and Quality Officer) and shall consist of not less than five members (of whom three should be Non-Executive Directors), all of whom shall have voting rights.

6. Chair

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

7. Attendance

7.1 The Director of Corporate Affairs should normally attend all Quality Assurance Committee meetings, with the Chief Executive invited to attend at least annually.

7.2 The Non-Executive Chair of the Audit Committee should be invited to attend all Quality Assurance Committee meetings.

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

7.4 At least twice a year the appropriate Internal Auditor representative should attend Quality Assurance Committee meetings.

8. Quorum

8.1 The meeting will be quorate provided that the following are in attendance, with Non-Executive Directors being in the majority;

8.1.1 The Chair or nominated Chair of the Committee; and
8.1.2 At least two Executive Committee members, one of whom must be the Chief Paramedic and Quality Officer or Chief Medical Officer, or their delegated representative.

9. Meeting administration

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

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

10. Notice of meetings

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

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

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

11. Frequency of meetings

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

12. Duties

12.1 To enable the Trust Board to obtain assurance that:

- People are protected from abuse and avoidable harm *(Safe)*
- People's care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible *(Effective)*
- Staff involve and treat people with compassion, kindness, dignity and respect *(Caring)*
- The leadership, management and governance of the organisation ensures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture *(Well-Led).*

12.2 To receive the following standing items:

- A summary of actions report relating to the appropriate Care Quality Commission (CQC) domain/s to include an update report from the appropriate Executive Led Group/s including exceptions, notifiable events and relevant performance metrics.
- A report from the Quality Oversight Group (QOG) on any key issues and escalations.
- A report on the Trust's Data Quality and information management/governance activities (frequency will be set out in the forward planner accordingly)
- The Trust's corporate risk register – section relating to the appropriate domain in relation to quality and safety. To review the impact of any corporate risks that may impact on the achievement of strategic objectives and therefore should be identified for inclusion onto the Board Assurance Framework.
- The Trust's Board Assurance Framework – section relating to the strategic objectives and associated risks delegated to the Committee or that may impact on the quality and safety of services to patients and their families (at least quarterly).

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

13. Review and reporting responsibilities

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

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

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

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

14. Equality and diversity

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

Trust Board

Members
Heather Lawrence (Chair)
Rommel Pereira (Deputy Chair)
Bob Alexander
Karim Brohi
Sheila Doyle
Amit Khutti
Ann Rainsberry
Mark Spencer
Chief Executive
Chief Finance Officer
Chief Medical Officer
Chief Operating Officer
Chief Paramedic and Quality Officer
Attendees
Jill Anderson (Associate)
Line De Decker (Associate)
Director of Corporate Affairs
Director of People & Culture
Director of Communications and Engagement

Audit

Members
Rommel Pereira (Chair)
Bob Alexander
Sheila Doyle
Attendees
Chief Finance Officer
Director of Corporate Affairs
Chief Executive
Chief Operating Officer
Mark Spencer

People and Culture

Members
Anne Rainsberry (Chair)
Karim Brohi
Mark Spencer
Director of People and Culture
Chief Operating Officer
Chief Paramedic and Quality Officer
Attendees
Chief Executive
Chief Medical Officer
Director of Corporate Affairs
Director of Communications and Engagement

Finance and Investment

Members
Bob Alexander (Chair)
Sheila Doyle
Amit Khutti
Rommel Pereira
Chief Finance Officer
Chief Executive
Attendees
Heather Lawrence
Chief Operating Officer
Director of Corporate Affairs

Quality Assurance Committee

Members
Mark Spencer (Chair)
Karim Brohi
Heather Lawrence
Chief Paramedic and Quality Officer
Anne Rainsberry
Chief Operating Officer
Chief Medical Officer
Attendees
Director of Corporate Affairs
Rommel Pereira

Logistics and Infrastructure

Members
Sheila Doyle (Chair)
Bob Alexander
Amit Khutti
Rommel Pereira
Chief Finance Officer
Chief Operating Officer
Attendees
Director of Corporate Affairs

Charitable Funds

Members
Bob Alexander
Rommel Pereira
Chief Finance Officer
Director of Communications and Engagement
Attendees
Director of Corporate Affairs

Limited Companies

Members
Daniel Elkeles
Rommel Pereira

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Procedural Documents Policy and Corporate Policies			
Agenda item:	11.2			
Report Author:	James Stanton, Head of Corporate Governance			
Presented by:	Diane Scott, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	☐	Assurance	☒	Approval
	☐	Discussion	☐	Noting

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

The Trust Board is asked to review and approve the following Trust Policies:

- TP001 "Policy for the Development and Implementation of Procedural Documents"
- TP003 "Fit and Proper Persons Policy"
- TP004 "Policy on Managing Conflicts of Interest".

The opportunity has been taken as part of the update of the Policy for the Development and Implementation of Procedural Documents to provide additional clarity to the review and approval process.

This has included:

- Producing a list of policies which identifies their approval and review route
- Clarifying the list of Core Policies, which are the responsibility of the Trust Board, and the Organisational Policies, which are to be agreed by the Executive Committee or at Director level eg 'clinical', 'operational', 'corporate', 'people & culture' policies
- Clarification of the policy review intervals and approval of minor updates– to include interim annual reviews and a three year cycle of full reviews
- Encouraging a reduction in the overall number of policies by considering whether groups of policies in a particular area could be consolidated into fewer, more comprehensive policies that make it easier for colleagues to locate the information they need
- Additional support to directorates in ensuring that policy reviews take place quickly, efficiently and effectively.

In addition, annual reviews have been carried out on the Fit and Proper Persons Policy and the Policy on Managing Conflicts of Interest. No major updates are proposed.

Recommendations for the Board:

The Trust Board is asked to agree the following reviewed and updated policies:

- TP001 "Policy for the Development and Implementation of Procedural Documents"

- TP003 “Fit and Proper Persons Policy”
- TP004 “Policy on Managing Conflicts of Interest”

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 Affairs	Yes	x	No		Interim Director of Corporate Affairs

Introduction

1. Policies are a key component of the Trust's control framework. Following feedback from the Care Quality Committee and from directorate policy managers, the Executive Committee (ExCo) has considered proposals for amendments in the Trust's approach to the management of Trust Policies and other procedural documents in order to make the process more effective and to deliver increased assurance in its regular review process.

2. ExCo supported an update to the Trust's policy management process in order to provide assurance that policies will be reviewed and updated on time and with appropriate levels of approval in place.

3. In summary, ExCo supported:

    - The agreement of a proposed list of policies to be designated as:
        - Core Policies – to be agreed by the Trust Board
        - Organisational Policies – to be agreed by ExCo or at Director level eg 'clinical', 'operational', 'corporate', 'people & culture' policies
    - Clarification of the policy review intervals and approval of minor updates– to include interim annual reviews and a three year cycle of full reviews
    - Directors to reduce the overall number of policies by considering whether the list of policies in their areas could be consolidated into a smaller number of more comprehensive policies and greater use of 'procedure' documents
    - A triage process by which directorates would carry out remaining policy reviews.

4. Trust Policy TP001 "Policy for the Development and Implementation of Procedural Documents" has been updated to reflect the above approach.

Policy approvals

5. An updated copy of Trust Policy TP001 "Policy for the Development and Implementation of Procedural Documents", incorporating the supported approach is attached. The Trust Board is asked to approve the revised policy for adoption.

6. Also attached are the proposed Core Policies for Board approval – Fit and Proper Persons Policy and Managing Conflicts of Interest, following endorsement by the Audit Committee on 2 September 2021. No significant changes have been proposed to these documents, which were reviewed as part of the regular review process.

7. Subject to approval, the policies will be shared with all staff via the Communications Team, making full use of the staff and volunteer emails and bulletins, Pulse intranet and the Health Assure system.

8. Also subject to approval, these policies, along with the full list of Core Policies, will be uploaded to the Trust's public website as the first step in making all Trust policies publicly available.

Recommendation

9. The Trust Board is asked to agree the following reviewed and updated policies:

    - TP001 "Policy for the Development and Implementation of Procedural Documents"
    - TP003 "Fit and Proper Persons Policy"
    - TP004 "Policy on Managing Conflicts of Interest"

London Ambulance Service
NHS Trust

Policy for the Development and Implementation of Procedural Documents

Document Control

Document Reference	TP001
Version	2.1
Approved by	Executive Committee / Trust Board
Lead Director/Manager	Director of Corporate Affairs
Author	Director of Corporate Affairs
Distribution list	Trust Board, Executive Committee, Senior Managers, All staff (via intranet)
Issue Date	xx/xx/xx
Review Date	xx/xx/xx

Change History

Date	Change	Approved by/Comments
02/08/20	Full review and Revision of Policy • Addition of Appendix 4 – Policy Approval certificate • Addition of Appendix 5 – Process for publishing • Addition Appendix 6 – Checklist for policy ratification	
09/09/21	Full review and revisions to existing policy • Amended titles for Corporate Affairs • Addition of Core and Organisational Policies and approval routes • Addition Appendix 7 – Checklist for policy review • Addition Appendix 8 – List of policies	Reviewed and approved by ExCo 18 August 2021

Table of Contents

1. Introduction - Policy Objective

1.1. Organisations need formal written documents which communicate standard organisational ways of working. These help clarify strategic and operational requirements and bring consistency to day to day practice. In addition they can improve the quality of work and increase the successful achievement of objectives.

1.2. A policy is a statement of the Trust's principles and intent. The policies in themselves do not specify "how to" and as such any policy should be supported by other working documentation such as procedures. Policies are high-level statements and give Trust rules for consistent practice and to ensure compliance.

1.3. The London Ambulance Service NHS Trust (LAS) is committed to ensuring that its people, patients and partners are fully aware of its objectives and the way those who work for it need to operate to achieve these objectives. This policy aims to define the standard approach to communicating these requirements.

2. Scope and Definitions

2.1. This policy applies to all LAS-wide procedural documents, it does not apply to local/team procedures.

2.2. For the purposes of this policy, the term "procedural document" refers to (and this policy applies to) the following document types:

Strategy: A long term plan for achieving organisational success.

Policy: A statement of an agreed organisational position, the governing principles and aims which staff must follow and cannot be varied except with the approval of the Trust Board, delegated Committee, or Director with delegated authority.

Procedure: A set of actions which is the official or accepted way of doing something, usually in support of a policy. A Standing Operating Procedure (SOP) is a laid-down procedure for doing something. Very often SOPs are written to minimise risks to patients or health and safety risks. They should include information about how to obtain authority for any proposed deviation from the SOP (usually from senior management).

Guidance: A document setting out a preferred method of operation. Unlike with procedures, other methods are not prohibited but a reason for deviation from guidance should be fully justifiable and line management agreement sought in all cases of any doubt.

2.3. In general, strategy and policy define what an organisation wants to do whilst procedure and guidance define how the organisation wants to do it. One document may contain all or a combination of the above. The Corporate Governance team will advise if required.

2.4. Trust Policies fall into two categories for the purposes of approval and review, 'Core Policies' and 'Organisational Policies'. Core Policies are policies which require approval at the Trust Board level. Organisational Policies are those policies where approval has been delegated, to committees below the Trust Board level or directors as set out in the Approval section of this document. This is summarised as follows:

Core Policy: A statement of an agreed organisational position, the governing principles and aims which all staff must follow and cannot be varied except with the approval of the Trust Board (following endorsement by the Executive Committee).

Organisational Policy (e.g. Clinical Policy, Corporate Policy, People & Culture Policy, Medicines Policy, Operational Policy): A statement of an agreed position in relation to an aspect of the organisation's work, the governing principles and aims which all staff must follow and cannot be varied except with the approval of the delegated Committee (including the Executive Committee where specified) or Director with delegated authority.

3. Accountabilities and Responsibilities

Trust Board:

3.1. Responsible for approving all corporate strategies and some key organisational policies.

3.2. The Trust Board is responsible for the effectiveness of this policy and for ensuring that sufficient resources are available to support its implementation.

Board Assurance Committees

3.3. Responsible for seeking and providing assurance by considering and commenting on relevant strategies and policies.

Executive Committee (ExCo)

3.4. Responsible for endorsement of corporate strategies and key Core Policies that require approval by the Board. Responsible for approving Organisational Policies that do not require Board approval and appropriate key procedural and guidance documents.

3.5. The Executive Committee is responsible for monitoring the effectiveness of this policy and for ensuring that the Trust Board is kept informed.

Directors/Senior Managers

3.6. Responsible for developing, proposing and implementing strategies, policies, procedures and guidance relevant to their areas of accountability which are compliant with the Policy for the Development and Implementation of Procedural Documents. Responsible for approving some Organisational Policies that do not require Board or Executive Committee approval and appropriate procedural and guidance documents.

Managers

3.7. Responsible for contributing to the development of strategies, policies, procedures and guidance (including following the consultation and impact analysis processes referred to in this policy), as well as ensuring their implementation, monitoring and reporting of exceptions and adverse experiences as appropriate.

Employees and Other Workers

3.8. Responsible for contributing to the development of strategies, policies, procedures and guidance, as well as following all applicable policies, procedures and guidance and reporting any adverse experiences as appropriate.

4. The Approval and Implementation of Policies and Procedures

Authorisation to develop a policy or procedure:

4.1. The requirement for a policy can be identified by any manager in the Trust. When a need has been identified, the instigator must obtain approval to develop the policy or procedure from the relevant Lead Director for the policy category and agree:

- The Lead Director and Lead Manager (Author) for the policy.
- If and why the policy is needed.
- Target audience of policy.
- Whether anyone else in the Trust is likely to be dealing with the same or similar issue(s) with whom liaison will be necessary, or whether a similar policy already exists which will be superseded by the new policy.
- Ensure that an Equality Impact Assessment is carried out (electronic copies available from the Trust Intranet and Corporate Governance Team).
- Who should to be involved in the policy development e.g. patients, partner organisations, staff, staff side, “experts” and whether any external input is necessary.
- Timescale of when the policy will be developed by and proposed review frequency.
- What form it should take, for example a standalone policy document or a policy backed up by procedure(s).
- Whether the procedure(s) associated with the policy are protocols or guidelines.

Consideration when writing a Policy

4.2. Consideration for users should be given when naming and writing documents. Avoid jargon, unfamiliar abbreviations and unnecessarily technical language. Name documents for maximum user understanding. Documents should contain the key terms in their title where possible and be no longer than 100 characters. The Corporate Governance team can help suggest an appropriate title for policies.

4.3. Long documents that combine procedures with the policy may not be that easy for the intended audience to read. Authors should consider writing separate documents and include references that may be linked.

4.4. Authors should also check existing policies to make sure that out-of-date policies have been made obsolete on the publication system and that there is no confusion with the naming of new policies. The titles of obsolete policies remain on the intranet policy index list, marked as obsolete.

4.5. Old or similar policies that are being replaced should be identified to the approving committees and the Corporate Governance Team who will remove them from general access when the new policy is published.

4.6. The policy approval certificate (see Appendix 4) must detail consultation undertaken and planned dissemination to show who has been consulted and how the target audience will be informed of the changes to the policy or procedure.

4.7. Policies should contain a brief summary of the key points at the beginning to help readers readily understand what is required by the policy.

4.8. Related documents published elsewhere on the intranet should not be included in the policy either in the body of the text or as an appendix. Instead, a hyperlink to the related document should be used. This is to ensure that the policy is always connected to the current version of the related document.

Format and Style

4.9. In addition to the style and format minimum requirements set out in Appendix 2, the following are emphasised for importance.

4.9.1. **Accountability and Responsibility** should clearly define who is responsible for what. Where relevant, the responsibilities of partner organisations and/or other external organisations must be included.

4.9.2. **Definitions** of terminology should be clear within the policy.

4.9.3. The policy should detail **what is required** under the policy. In addition all documents used in the development of the policy, whether referred to in the main body or not, should be included in the reference section (as per template document). Please consider the following for referencing

- Trust supporting procedures and associated policies.
- National Guidance
- DH Standards
- Approved Codes of Practice
- Legislation

Where possible electronic links to the above should be included.

4.9.4. **Other Trust Policies, Procedures, Guidance etc.** that are associated with the document should be clearly identified and the reader pointed in the direction of where to easily obtain copies.

4.9.5. **External Expertise and Accountability** should refer to external expertise, legislation, national policies, etc., adopted in the policy and any accountabilities and responsibilities that external organisations may have.

4.9.6. **Competence (Education and Training)** should

- Refer the reader to the Trusts Training Needs Analysis (TNA)
- Include the process for provision of expert advice with developing the TNA and relevant training plans.
- Detail any other competence required that is not included in the TNA.

4.9.7. **Consultation** All policy documents must show evidence of consultation and have a dissemination plan to demonstrate who has been consulted as

part of development or review and how, once (re)published they will be brought to the attention of personnel in the Trust.

4.9.8. **Review** Policy documents must identify the need to be reviewed on an annual basis. A checklist is attached as Appendix 7 for this purpose. Policy documents should reflect that, where identified as necessary following the completion of the annual checklist process, the policy must be revised, updated, consulted upon and re-submitted for approval in line with the processes set out in this document. The full review process, as set out in Appendix 7, must be carried out at least once every three years, or sooner in line with any statutory or regulatory obligation, for each Organisational Policy. The need for Core Policies to be presented to the Trust Board each year for assurance should be included.

4.9.9. **Approval** Policies must identify the approval route which applies in line with the process identified in this Approval section of this document and attached guidance. Where approval is required by appropriate committees, these should be named in the document. Policy approval paperwork, including a certificate, is to be submitted to Corporate Governance when approving new and revised policies. This certificate is set out in Appendix 4 and is available on the intranet.

4.9.10. **Format:** policies must be written in a way that is suitable for publication on the intranet and should include the minimum requirements identified in Appendix 2. A word document template is available on the Trust Intranet or from the Corporate Governance Team.

4.9.11. **Monitoring and Reporting** should include:

- The process for monitoring and evaluating the effectiveness of the policy, including testing levels of awareness.
- Obtaining evidence of the policy being put into practice (compliance) this will include, how it is to be done, when, frequency and what will be done to rectify areas of noncompliance.

4.9.12. Document control information should be shown on the covering page of each procedural document. This must include:

- Policy Reference and Version
- Date Approved
- Approval Body
- Implementation Date
- Review Date
- Lead Director
- Author
- Distribution

Equality and Confidentiality Impact Assessments

4.9.13. In line with the Public Sector Equality Duty, every procedural document will be screened by the person responsible for its development, to consider whether there is an equality dimension or whether any adjustments are necessary to comply with the duty to promote equality and diversity. This should involve consultation with stakeholders appropriate to the aims of the individual document. The equality screening process and any wider impact assessment should be recorded within the document, using the heading “Equality Impact

Assessment".

4.9.14. The Trust aims to design and implement services, policies and measures that meet the diverse needs of its service, population and workforce; ensuring that where issues for concern are highlighted actions are taken to address them.

4.9.15. Where a policy is new or it is an existing policy that requires significant amendment, an Equality Impact Assessment/Privacy & Dignity Checklist and a checklist for Confidentiality Impact Assessment must be completed.

4.9.16. The Equality Impact Assessment/Privacy & Dignity Checklist enables an evaluation of a policy, service or process to be undertaken and are needed for all policies to comply with the requirements of the Trust's Equality Schemes and legislation.

4.9.17. The Data Protection checklist is required to ensure that all policies are checked using the principles of the data protection legislation to reflect the General Data Protection Regulation and Data Protection Act (2018) and Caldicott Guardian principles of using confidential information. This checklist ensures the Trust complies with the NHS Data Security and Protection Toolkit. Once completed it should be forwarded to the Head of Information Governance.

4.9.18. Copies of each assessment should also be included with the completion of Policy Approval Certificate. The approval paperwork containing the document approval certificate, the Equality Impact Assessment/Privacy & Dignity Checklist and Confidentiality & Data Protection Checklist is available on the Trust intranet or from the Corporate Governance Team.

Consultation:

4.9.19. All policy documents must show evidence of consultation and have a dissemination plan to demonstrate who has been consulted as part of development or review and how, once (re)published they will be brought to the attention of personnel in the Trust.

4.9.20. In developing a policy, consultation must take place with key groups and individuals, in particular:

4.9.20.1. Patients, carers and patient/carer representatives on policies that relate to services/care that directly affect them. For advice on reaching patient and public groups please see the Trust's Patient and Public Involvement Strategy policy. Further advice is available from the Chief Quality Officer.

4.9.20.2. Partner and other external organisations as appropriate.

4.9.20.3. Staff Side on all employment related policies. This should be done in accordance with the Partnership Agreement and by presenting draft documents to the Director of People and Culture.

4.9.20.4. Where there is a relevant Board Assurance or Corporate Committee, certain draft documents should be presented to that committee for review, in line with the Procedural Document Approval Routes set at Appendix 1.

Approval:

4.9.21. Once consultation and impact analyses have been undertaken. All new and revised policy documents should to be reviewed and approved in line with the approval routes set out in Appendix 1 - Procedural Document Approval Routes. The approving bodies will consider the document proposed and approve it or recommend changes as appropriate.

4.9.22. The draft document in the correct format (Appendix 2) should be sent to the Corporate Governance team, who will log as a draft document on the Policy Register. The certificate and assessments should also be submitted.

4.9.23. A policy should normally be scrutinised and signed off at the lower level of the two committees/groups first before passing to the higher-level committees for final agreement. It is good practice to address any comments received at the first committee/group before submitting the policy to the second committee for approval.

4.9.24. If the draft document is staff related, it will be required to be discussed at the Staff Council. It will be sent to them for information purposes only in other instances.

4.9.25. On approval, the lead manager will forward the document and signed completed policy approval paperwork to the Corporate Governance team who will add a reference number to the document and provide it with a published version number.

4.9.26. The Corporate Governance team will only upload the policy onto the Intranet once they have received the completed policy approval certificate. The author should retain a copy of the policy approval certificate for their records.

Policy Register

4.9.27. All procedural documents will be recorded on a Policy Register which is to be maintained and kept up to date by the Corporate Governance team. The Register will be available to employees via the intranet and will also available to all external stakeholders via the website.

4.9.28. Directors/Senior Managers responsible for a procedural document must ensure that the Corporate Governance team is notified when a new document is proposed, or amendments are proposed to an existing document, in order to ensure that appropriate approvals are obtained and the Register remains up-to-date.

Communication of Procedural Documents

4.9.29. A copy of every approved policy and procedure will be posted on the Trust internet and intranet sites.

4.9.30. On induction every member of staff will be advised of the location of the most up to date version of policies on the Trust intranet site. Policies and Procedures may be printed and placed on Trust premises for staff to refer to. These may not be the most recent document therefore staff are advised to always check the intranet for the current version.

4.9.31. Staff will be advised of the introduction of new polices through various media

- Management briefings
- RIB
- Trust Intranet site
- Whilst attending Trust training and education courses.

Local/Team Procedures

4.9.32. Managers are responsible for the development, maintenance and implementation of procedures specific to their area. As a minimum, such procedures should be:

- Developed in consultation with team members
- Brought to the attention of all team members and others who may be affected by the procedure e.g. another team
- Supported by training, if necessary
- Given a clear title (and possibly a unique identifier)
- Dated, including a review date
- Recorded on a list which is kept up to date, including those procedures which have lapsed or been replaced or withdrawn, and posted on the intranet
- Posted on the intranet
- Archived on the intranet.

5. Implementation Plan

5.1. The Trust uses an electronic system to publish, archive and control policies.

5.2. A new policy is assigned a unique identifier number. Each time a policy is republished its version number increases by one and the previous version of the policy is automatically archived. Archived policies are held electronically.

5.3. The policy will be posted on the Trust intranet site and all staff will be made aware of its existence via the Routine Information Bulletin (RIB).

5.2 All new policies or policies with significant amendment must detail as part of the approval certificate who has been consulted as part of the development or review process, the policy's intended audience and how the policy will be brought to its attention. Relying solely on the policy being placed under the relevant section of the intranet is not enough. It is the author's responsibility to ensure that consultation and dissemination takes place.

5.3 When a policy is made obsolete it is archived with a notice displayed on the intranet advising users that the policy has been made obsolete and that it is likely to have been superseded by a different policy or other types of documents.

5.4 Policy approval certificates or where relevant, author e-mail notifications of policy status are stored by the Document Controller.

6. Competence (Education and Training)

6.1. The Director of Corporate Affairs will ensure the provision of advice for managers developing policies. A formal training programme will not be organised.

7. Monitoring Compliance

7.1. The Corporate Governance Team will be the custodians of monitoring compliance with the provisions of this policy.

8. Effectiveness and Reporting

8.1. Approved Trust policies will be published on the intranet and distributed to staff. As set out in this policy, annual reviews (see checklist set out as Appendix 7) should be carried out to ensure their effectiveness and to ensure procedural documents remain fit for purpose.

8.2. A policy can be re-published if there are minor amendments / no changes following its annual review.

9. Policy Review

9.1. All policies must include a scheduled review date and be reviewed on a regular basis. Policies will be reviewed on the basis of an annual/interim review (to take place at least annually) and a full review (to take place at least every three years).

9.2. An annual review should be carried out by the author using Policy Review Checklist (Appendix 7). Where the named author is no longer applicable, the Responsible Director shall designate a new author to carry out the review. This annual review will identify whether a policy requires minor updates or a full update and review. A full review should be carried out at least every three years on all policies (or more frequently as required) and will follow the full policy approval process.

9.3. Document authors are responsible for ensuring that their policies are reviewed on time and for responding to prompts/reminders from the Corporate Governance team.

9.4. The policy review process starts six months prior to the review date and Lead Directors/Managers will be notified by the Corporate Governance team of the list of documents and pending review date for action. It is the responsibility of the Lead Director/Manager to identify an Author and to ensure that policies, procedures and guidance documents are integrated where applicable.

9.5. Review does not occur in isolation and authors should seek advice or information from others in relation to the policy they are asked to review as required. Possible sources of advice include other document authors, managers, Directors, Corporate Governance team or Head of Corporate Governance.

9.6. Reviews should also consider:

Topic/ Objective	How	When
Style and Format	Check made when the document is in draft form as well as prior to publication	As each document is produced and prior to adding to intranet
Definition of Terms used	Checks to ensure clear and simple language used and/or definitions are in place	As each document is presented
Consultation Process	Change sheet checked to ensure correct process followed	As each document is presented

Ratification Process	Change sheet checked to ensure correct process followed	As each document is presented
	Visual check of Policy, Procedure and Strategy database will identify policies outside of process	As each document is presented
	Progress of relevant documents ratification process and notification of documents due for review	As each document is presented
Review arrangements	Change sheet checked to ensure review date is identified	As each document is presented
Associated Documents and references	Change sheet checked to ensure correct process followed for linking and referencing documents	As each document is presented

10. Equality Impact Assessment Statement:

10.1. This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

10.1.1. Eliminate discrimination, harassment and victimisation.

10.1.2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

10.1.3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10.2. The Act sets out nine protected characteristics that apply to the equality duty, which must be considered in the writing of all documents.

11. References

11.1. This policy has drawn on guidance from:

11.1.1. Plain English Campaign Guidelines
http://www.plainenglish.co.uk/

Royal Institute for the Blind Guidelines
http://www.rnib.org.uk/xpedio/groups/public/documents/code/InternetHome. hcsp

11.1.2. NHS Resolution risk management guidance
http://www.nhsla.com

11.1.3. Equality Act 2010
https://www.gov.uk/guidance/equality-act-2010-guidance

Appendix 1 Approval of Procedural Documents

	Responsible	Endorser	Approver	Informed
Strategies	Director	Executive Committee Board Assurance Committee	Trust Board Board Assurance Committee	N/A
Core Policies - Key policies reserved for Board approval	Director	Executive Committee Board Assurance Committee	Trust Board	N/A
Organisational policies reserved to ExCo	Director	At least one other Director	Executive Committee One other relevant Committee	Board Assurance Committee
Organisational policies not reserved to ExCo	Director	At least one other Director	2x Committees	Executive Committee

Appendix 2 - Procedural Document Format

Minimum Requirements for a Procedural Document

(Documents should be written in Microsoft Word and use Word formatting functions). Policies should be written in line with the Plain English Campaign reporting guidelines:

- The Trust template including the Trust Banner (which should remain on the top of the cover sheet) is available on the Trust Intranet site in word format.
- Organise reports into sections.
- Use everyday English whenever possible.
- Avoid Jargon and legalistic words, and explain any technical terms.
- Keep sentence length to an average of 15 to 20 words.
- Use active verbs.
- Always check that report is accurate, clear, concise and readable.
- The grammar check from the 'Word' toolbar should be used to check all documents meet the above requirements by:
- Going into 'tools', spelling,
- Tick the 'check grammar' box.

Formatting should be kept as simple as possible to comply with Royal National Institute for Blind clear print guidelines for those with impaired vision.

- Font size to be 12 point Arial (14 point Arial in requested cases).
- Black text on white background provides best contrast
- Avoid highly stylised typefaces.
- Avoid use of capitals for continuous text.
- Avoid underlining and use of italics.
- Avoid justified text.

As a minimum policies must include: (see also policy template)

- Document Control tables (change record)
- Introduction and policy objectives
- Scope and definitions (explain the reason for the policy, who and what it applies to, definitions are important as the reader may not have a great deal of knowledge in this area)
- Accountabilities and Responsibilities (if somewhere in the document it states a person or committee 'must, should, will' then it should be clearly identified in this section)
- Implementation Plan
- Competence (Education and Training)
- Monitoring Compliance (how will you ensure the policy is complied with? Who will do this? When? And how often? What will happen if compliance is not being achieved?)
- Effectiveness and Reporting (how are you going to make sure the policy is effective? Who is going to do it and when are they going to do it?)
- Policy review (who is going to do it and when, include who will be keeping an eye on current changes in case an earlier review is required and remember to add to their responsibilities)
- Equality Impact Assessment Statement
- References (anyone should be able to find the evidence you have used)

London Ambulance Service
NHS Trust

Document Title

Document Control

Document Reference	
Version	
Approved by	
Lead Director/Manager	
Author	
Distribution list	
Issue Date	
Review Date	

Change History

Date	Change	Approved by/Comments

1. Introduction – Policy Objectives
2. Scope and Definitions
3. Accountabilities and Responsibilities
4. Heading – Policy Content
5. Implementation Plan
6. Competence (Education and Training)
7. Monitoring Compliance
8. Effectiveness and Reporting
9. Policy Review
10. Equality Impact Assessment Statement
11. References

Appendix 3 – Allocation of Unique Identifiers for Procedural Documents

Each procedural document will be given a unique identifier. The first figures will be letters determined by the subject of the document, in accordance with the list below, followed by the next available sequential number for such documents starting with 01, e.g. TP08.

Prefix	Document subject
ST	Strategy
TP	Policy
OP	Procedure
GU	Guidance

- **T**rust **P**olicies and procedures will commence with **TP**
- **St**rategies will commence with ST
- **Gu**idance will commence with GU

Appendix 4 - Policy Approval Certificate

London Ambulance Service NHS Trust

Policy approval certificate

Policy title:	

Policy Number *If existing policy*	
Review Period *Maximum of 12 months or sooner*	

Author(s)	
Authors Job title(s)	
Authoring Department	

Level of Amendments	This policy *does not* require approval through two committees/groups because:		This policy *does* require formal approval through two committees/groups because:	
	☐	no amendments are required	☐	material revisions other than minor amendments are required
	☐	only minor amendments, such as changes in spelling, grammar or contact details are required	☐	it's a new policy

Who has been consulted? *(eg patients, relevant team, group/committee members)*	

To be disseminated to, how and by when *(once fully approved)*	

Schedule of approvals		
Approval Committee/Group	Approval date *(date of meeting policy was approved at)*	Signature of the Chair of the approval committee
1.		Sign
		Print
2.		Sign
		Print

Once fully complete, please forward this certificate and e-mail the final Word version of the policy, to the Corporate Governance Team, committeesecretary@lond-amb.nhs.uk

Sections 1 and 2 should be completed for new and existing policies and for new services and service redesign.

Equality Impact Assessment (EIA) Form for policies and services

Section 1: Equality Impact Assessment

Name and contact no of person completing checklist:
……

Date: ……

Equality analysis screening (Please enter below the names of the project team members who carried out this initial screening with you and their role in the screening (e.g. team colleague or critical friend).

Name	Department	Role
		Critical friend

Aims and outcomes	Description/Details
Give a brief summary of the policy or service including aims, purpose and outcomes	
Who is intended to benefit from this policy/service/function etc. and in what way.	

Questions for you to answer in the EIA process	Yes	No
1. Will or does the policy affect our patients or the public directly or indirectly or our workforce or our employment practice?		
2. Could the policy involve or have an impact upon the Public Sector Equality Duties to: • eliminate unlawful discrimination • promote equality of opportunity • foster good relations between people who share a protected characteristic and those who do not		
3. Could the policy have a different impact on some patients, staff or other people because they have one or more of the protected equality characteristics:	**Yes**	**No**

• **Race** (race, colour and nationality (including citizenship), ethnic or national origins) • **People with disabilities** (including mental, physical, sensory, long term health, learning disabilities) • **Gender** (male, female) • **Age** (young and old) • **Religion or belief** (inc non believers) • **Sexual orientation** (lesbian, gay, bisexual) • **Gender reassignment** (the process of transitioning from one gender to another) • **Pregnancy/ maternity** • **Marital/ Civil Partnership status**		
If **Yes** to any of the above can this be justified on the grounds of promoting equality of opportunity for a "protected characteristic" group or for another reason?		
Can the policy/service/function etc. be used to advance equality and foster good relations, including for example, participation in public life? If so, how?		

Please provide and summarise below any relevant evidence for your declaration above, including any engagement activities – this could include for example the results of specific consultations, complaints or compliments, customer satisfaction or other surveys, service monitoring and take-up, comments from stakeholders and demographic data.

	Yes	**No**
Are there any gaps in the evidence you have which make it difficult for you to determine whether there would be an adverse impact?		
If **yes,** please state below how you intend to acquire this evidence and your timescales for doing so.		

You must complete a full Equality Analysis if you have identified a positive or negative potential impact for any "protected characteristic" group, which is not legal or justifiable or if you have identified any gaps in evidence which make it difficult for you to determine whether there would be adverse impact. Please insert below any issues you have identified/recommendations for the full Equality Analysis.

Please date and sign this form	Signature Date

Privacy and Dignity Checklist for policies and services

Section 2: Privacy and Dignity

What is Privacy?

Privacy refers to freedom from intrusion and relates to all information and practice that is personal or sensitive in nature to an individual

What is Dignity?

Dignity consists of many overlapping aspects, involving respect, privacy, autonomy and self-worth. It is described as a state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect regardless of any difference. While 'dignity' may be difficult to define, what is clear is that people know when they have not been treated with dignity and respect.
(*Social Care Institute for Excellence, Dignity in Care Practice 2010).*

Name and contact no of person completing checklist:
……

Date: ……

	Yes	**No**
1. Is there any privacy and/ or dignity impact for the policy or service?		
If **yes,** please give details below of the impact and the actions being taken to address any adverse impact.		

Please date and sign this form	Signature Date

Confidentiality and Data Protection Checklist

The Confidentiality and Data Protection Checklist must be completed for the review of both new policies and existing policies

Name and contact no of person completing checklist:
…….

Date: ……

	Yes	No
Q1. Does this Policy relate to the collection, use or disclosure of personal data about patients or staff?		
Q2. Is there any potential or evidence that this Policy will or could relate to the collection, use or disclosure personal data about patients or staff?		

If you have answered <u>NO</u> to Q1 and Q2 above, please send the checklist to Information Governance Manager. You do not need to do anything else.

If you have answered <u>YES</u> to Q1 and/or Q2 above, please consider carefully the following questions (based on the Caldicott Principles) prior to returning the Checklist.

	Yes	No
a) Can you justify the purpose(s) of using confidential information? Every proposed use or transfer of person-identifiable information within or from an organisation should be clearly defined and scrutinized, with continuing uses regularly reviewed, by an appropriate guardian.		
b) Is the use person-identifiable information absolutely necessary? Person-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for staff or patients to be identified should be considered at each stage of satisfying the purpose(s).		
c) Is the minimum necessary person-identifiable information used? Where use of the person-identifiable is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.		

	Yes	No
d) Is access to person-identifiable information on a strict need-to-know basis? Only those individuals who need access to personal-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.		
e) Is everyone with access to person-identifiable information aware of their responsibilities? Action should be taken to ensure that those all staff handling person-identifiable information are made fully aware of their responsibilities and obligations to respect confidentiality.		
f) Does the use or disclosure of personal data comply with the law? Every use of person-identifiable information must be lawful. Someone in each organization handling confidential information should be responsible for ensuring that the organization complies with the legal requirements.		

Please date and sign this form and Return copy of completed checklist to: Information Governance Manager,	Signature Date

Appendix 5 – Process for publishing policies

New Policy or Significant amendment

Identification	• New Policy identified • Significant amendment to existing policy identified
Production	• Policy writing and/or revision
Consultation	• Consultation with and feedback received from all relevant stakeholders
Certificate completion	• Sections 1, 2 and 3 of the policy approval certificate are completed by the author
Approval	• Identify two approval committees, consult Appendix 1 • Author submits policy and approval paperwork (policy approval certificate equality impact assessment/privacy and dignity checklist and Confidentiality and data protection checklist) to approval committees
Confirmation of ratification	• Once approved, author supplies electronic Word copy of policy to Corporate Governance Team along with fully signed policy approval certificate • Forward the completed Confidentiality and data protection checklist to the Information Governance Manager
Publication	• Policy is published on the intranet • Original Policy Approval Certificate retained by Corporate Governance team • Dissemination executed by author/department

No Change required or Minor changes

Identification	•No changes required •Minor changes (e.g.new telephone number or job title) to existing policy following consultation
Publication	•Notify Corporate Governance Team by e-mail with word version of policy if minor changes •The policy will be republished. NO committee approval is required

Appendix 6 – Checklist for authors organising the ratification of a new policy or a policy requiring significant change

1. Print a copy of the Policy Approval paperwork from the intranet. As the author/reviewer of the policy, complete sections 1, 2 and 3 of the approval certificate, as well as the Equality Impact Assessment/Privacy & Dignity Checklist and the Confidentiality & Data Protection Checklist.
2. Agree two appropriate Trust committees to approve the new or revised policy.
3. Ratification committee 1: Contact the relevant ratification committee/group secretary to book a date to present your policy. Submit the policy approval paperwork along with the policy.

3a. It is considered best practice to address any comments received from the first ratification committee before submitting the policy to the second committee for final approval.

4. Ratification committee 2: Contact the relevant ratification committee/group secretary to book a date to present your policy. Submit the policy approval paperwork along with the policy.
5. You should provide a copy of the policy approval certificate when you present the policy to each of the two ratification committees/groups to obtain the chairman's signature at the meeting.
6. The chair of each committee will sign the policy approval certificate, when the policy is approved. Retrieve the signed certificate from the committee/group chair at the end of the meeting or from the secretary of the committee/group after the meeting.
7. Once the policy is fully approved and all comments have been addressed, e-mail (post) the completed certificate and word version of the policy to the Corporate Governance team.
8. Submit the agreed 'Confidentiality & Data Protection Checklist' to the Information Governance Manager.
9. Keep a copy of the policy approval paperwork for your own records.

Appendix 7 – Annual Policy Review Checklist

Checklist for the Review of Procedural Documents

Title of document being reviewed:	
Policy Author or Policy Manager:	
Lead Director:	
Date of review:	
Date of next review	

Policies should be reviewed each year to ensure they remain up to date, fit for purpose and contain helpful information and guidance.

Each policy should also undergo a full review in line with the approval process set out in the Trust's Policy on Procedural Documents (TP001) a minimum of once every three years*.

This form has been designed to aid Policy Managers and Directors with their task of carrying out annual reviews of existing policies and identifying whether a more in depth review is need.

The scheduled review process does not override the need to update policies out of this cycle, for example, where there is a change in regulation or law affecting an aspect of service provision.

(unless a different review schedule is required by statute or agreed by the Trust)*

Notes for completion

This form should be completed by the Policy Author or Policy Manager as designated by the Lead Director.

Once complete, the Lead Director should review and sign off the form.

The signed form should then be returned, along with the updated copy of the policy (showing tracked changes where appropriate), to the Corporate Governance team: londamb.Policies@nhs.net

The outcome of the review will be one of four options:

Agreed	The policy or procedural document is agreed as appropriate for a further year by the Director
Agreed with minor updates	The document requires only minor amendments, following which it is agreed as appropriate for a further year by the Director
Temporary extension	Minor updates are agreed to the current policy (eg to update contact details) with a full review to take place within six months
Full review required	The policy is out of date or is overdue a full review

Where there is agreement that the document remains up to date, subject to minor updates (e.g. job titles, contact details, structure charts), and a full review of the policy has been carried out within three years*

(unless a different review schedule is required by statute or agreed by the Trust)*

	Title of document being reviewed:	**Yes**	**No**	**Comments**
1.	**Initial Checks**			
	Is the strategy/policy/procedure/guidance still needed and relevant to the Trust?			
	Is the document correctly labelled as a strategy, policy, procedure or guidance? Is the title clear and unambiguous? *(see definitions in TP001 and suggest relabelling in comments if applicable)*			
	Could this strategy/policy/procedure/ guidance be incorporated within or combined with an existing policy?			
	Is the document in the correct style and format as set out in TP001?			
2.	**Content**			
	Are reasons for development of the document still applicable?			
	Does the document continue to provide staff with the information and direction required?			
	Does the document reflect the current regulatory environment *(please note in comments any changes in law or regulation that need to be picked up)*			
	Does the document reflect the latest evidence base and thinking in its subject area?			
	Are all the contact names, job titles and directorates up to date and current?			
	Are the names of external bodies up to date and current?			
	Do all document references, web and intranet links work if present?			
3.	**Consultation**			
	Have other directorates directly affected by the document been consulted as part of this review? *(please note details in comments)*			

	Title of document being reviewed:	Yes	No	Comments
	If appropriate, has the Staff Council been consulted on the document at this stage?			
	Are Environmental Impact Assessments (EIA) requirements up to date?			
	Does the document identify which Committee/group is its approver?			
4.	**Dissemination and Implementation**			
	The policy will be posted on the Trust internet and intranet site and all staff will be made aware of its existence via the Routine Information Bulletin (RIB). Are plans in place to ensure this information reaches the right people? *Please outline any plans to share in the comments, please confirm, delete or add to the list of steps being taken.*			• *Notification of newly approved/revised policies within one week of approval via a global email* • *Other communication channels will also be used in line with the Trust's Communication processes to inform staff of policy development (for example, by email and notification on the Pulse)* • *Where hard copies need to be circulated to staff, these should be downloaded from the Trust's intranet Policy page by the appropriate line manager.* • *Once issued, individual line managers will be responsible for ensuring that all staff are aware of new policies and policy revisions and that any out of date versions are taken out of local circulation.*
5.	**Monitoring Compliance and Effectiveness**			
	Are there measurable standards to support the monitoring of compliance with and effectiveness of the document?			
	Is there a plan to review or audit compliance with the document?			
	Is the document clear about any training/support that will be necessary to ensure compliance?			
6.	**Review**			
	Has the document been reviewed within the past 3 years? (if no, a full review must be scheduled)			
	Has the next full review date been scheduled?			
	Is it clear who will be responsible for the review of the document?			

Summary of any changes made (please list below)

Summary of Changes	Reason for change	Changes Made by (Name and Job Title)

Outcome of review

Recommendation to director

		Next step	*Tick as appropriate*
Agreed	The policy or procedural document is agreed as appropriate for a further year by the Director	Publication	
Agreed with minor updates	The document requires only minor amendments, following which it is agreed as appropriate for a further year by the Director	Publication	
Temporary extension	Minor updates are agreed to the current policy (eg to update contact details) with a full review to take place within six months	Publication and review scheduled	
Full review required	The policy is out of date or is overdue a full review	Action full review	

Policy Author		Date:	

Director approval

I agree that the attached policy can be published and circulated to staff in accordance with the recommendation above:

Signed by		Date:	
Director name and title			

Additional Comments

Appendix 8 – List of Core, Organisational (ExCo approval) and Organisational (Director level) Policies, Procedures and Guidance

The list of policies and approval levels will be kept by Corporate Governance.

Core Policies – Approved by the Trust Board

- TP001 Policy for the Development and Implementation of Procedural Documents
- TP002 Fit and Proper Person Policy
- TP003 Freedom to speak up Policy
- TP003 Policy Statement of Duties to Patients
- TP004 Complaints and Feedback Policy
- TP004 Managing the Conflict of Interests
- TP005 Risk Management Strategy and Policy
- TP006 Business Continuity Management Policy
- TP007 Anti-Fraud Bribery and Corruption Policy
- HS001 Health and Safety Policy (to be renumbered if agreed as a core policy)

Organisation Policies (approval by ExCo and one supporting committee)

Corporate

- TP009 Access to Health Records Policy
- TP012 Data Protection Policy
- TP022 FOI and Environmental Information Regulations policy
- TP028 Serious Incident (SI) Policy and Procedure*
- TP029 Records Management and Information Lifecycle Policy
- TP048 Information Security Policy
- TP051 Expenses Policy
- TP056 Statutory, Mandatory and Essential Training Policy
- TP060 Policy for Acceptable use of IT and Communication Systems
- TP062 Information Governance policy
- TP077 Security Management Policy
- TP080 Use of Social Media Policy

People & Culture

- HR014 Grievance Policy *(Dispute Resolution Framework)
- HR015 Alcohol, Drugs and Solvent Misuse Policy
- HR032 Management of Change Policy & Procedure
- HR021 Disciplinary Policy & Procedure *(Dispute Resolution Framework)
- HR024 Flexible Working Policy *(Agile Working Framework)
- HR026 Dignity at Work Policy and Procedure
- HR031 Performance Capability Policy and Procedure

**These policies will be superseded and incorporated into wider frameworks as referenced above.*

Organisation Policies (Director level approval)

Corporate

- TP052 Carbon Reduction policy
- TP064 Managing Penalty Charges Notices and Notices of Intended prosecution (PCNs and NIPs) Policy
- TP089 Personally Issued Equipment Policy
- TP095 Legionella Prevention and Control Policy
- TP008 The safe and secure handling of medicines by LAS staff Policy
- TP091 Out of Service (OOS) Policy
- TP014 Ambulance Observers Policy
- TP016 Managing Unreasonable Behaviour (Complaints PALS) Policy
- TP018 Safeguarding children and young people Policy
- TP019 Safeguarding Adults in Need of Care and Support Policy
- TP027 Infection Prevention & Control Policy
- TP034 Duty of Candour and Being Open Policy and Procedure
- TP046 Registration Authority Policy
- TP050 Lease car Policy
- TP053 Supervision of Clinical Staff in Training Policy
- TP057 Waste Management Policy
- TP059 Data Protection Impact Assessment (DPIA) Policy
- TP061 Safe Haven Policy & Procedure (superseded)
- TP065 Driving Standards Policy and Procedure
- TP071 Strategy Process Application of Clinical Audit Policy
- TP078 LAS Forensic Readiness Policy
- TP079 IM&T Remote Working Security Policy
- TP094 Workforce Immunisation Policy
- TP101 Transaction Management Policy
- TP102 Domestic Abuse Policy and Procedure
- TP108 Prevent Policy
- TP111 Management of Medical Devices Policy
- TP112 Sustainable Procurement Policy
- TP117 Incident Reporting and Management Policy
- TP118 Chaperone Policy
- TP122 Safe and Secure Handling of Controlled Drugs Sub-Policy
- TP123 Patient Group Directions Sub-policy
- TP127 LAS Research Policy
- TP131 Antimicrobial Prescribing Policy for Integrated Urgent Care
- TP132 Integrated Urgent Care Prescribing Policy
- TP133 Integrated Urgent Care Policy for Safe and Secure Management of Prescriptions
- TP134 Non-Medical Prescribing Policy
- TP150 LAS Publications Policy

These policies to be assigned numbers on review:

- Administration Maladministration & Malpractice Policy
- Complaints and Appeal Policy
- Premises cleaning policy
- Transfer of Personal Data Policy

Health and Safety (Corporate)

- HS005 Manual Handling Policy

- HS007 Personal Protective Equipment (PPE) Policy
- HS010 The Control of Substances Policy
- HS013 First Aid at Work Policy
- HS016 Latex Policy
- HS017 Lone Worker Policy
- HS018 Stress Management and Wellbeing Policy
- HS022 Management of Sharps Inoculation Incidents Policy

People and Culture

- HR001 Secondary Employment Policy
- HR005 Recruitment and Selection Policy & Procedure
- HR006 Employment History and Reference Checks Policy and Procedure
- HR007 Transgender Employment Policy
- HR012 Office Based Staff Flexitime Policy
- HR016 Ante natal Care Policy.pdf
- HR017 Maternity Leave and Pay Policy
- HR018 Unpaid Parental Leave Policy
- HR020 Adoption Leave Policy
- HR022 Managing Attendance Policy
- HR023 Fertility Treatment Policy
- HR027 Policy on Professional Clinical Registration
- HR028 Clock Change UK Daylight Saving Time
- HR029 Relationships between employees Policy
- HR033 Employment Break Policy
- HR034 Special Leave Policy
- HR036 Redeployment of Pregnant Operational Paramedics
- HR039 Management of Safeguarding Allegations Against Staff Policy
- HR040 Shared Parental Leave Policy & Procedure
- HR042 Guidelines on the Working Time Regulations
- HR043 Smoke-Free Policy
- HR045 Payment of Travelling Time Policy
- HR044 Operational Rest Break Policy

Operations

- OP026 Vehicle Equipment Use and Inventory Checks Policy
- OP014 managing conveyance of patients policy
- OP031 Consent to Examination or treatment Policy
- OP037 Identifying & Acting upon National Clinical Guidance Policy
- OP039 Resuscitation Policy
- OP046 First Responder Policy
- OP047 Close Relationships Policy
- OP059 Stroke Care Policy
- OP048 Ambient Listening Policy
- OP077 Airway Management Policy and Procedure
- OP001 Uniform work wear and office wear Policy
- OP070 Physical Competencies Assessment Rooms for HART Policy

Procedures and Guidance

The named “Responsible Directors” are responsible for the approval of these documents

Procedures

Corporate

- TP011 Fuel Card Procedure
- TP015 Responding to Enquiries Procedure
- TP017 The Management of Health Records Procedure
- TP024 Managing Patient Confidentiality
- TP030 Retention and Disposal Procedure
- TP035 Risk Management Procedure
- TP036 Public Engagement Events Procedure
- TP047 Electronic Information Handling Procedure
- TP058 Internal Outbreak Procedure
- TP063 Checking Driving Licences Procedure
- TP065 Risk Reporting Assessment Procedure
- TP067 Road Traffic Collision Reporting Investigation Adjudication Procedure
- TP068 Legal roadworthiness etc Checks Procedure
- TP069 Vehicle Hire Procedure
- TP096 Individual Learning Account (ILA) Procedure
- TP104 Visitors Procedure
- TP119 Safeguarding Supervision Procedure

Health and Safety (Corporate)

- HS006 Workplace Inspection Procedure
- HS008 Provision and Use of Work Equipment Procedure
- HS009 Display Screen Equipment
- HS012 Violence Avoidance and Reduction Procedure
- HS012B Post Violence Support Procedure
- HS014b Service Wide Evacuation Policy and Procedure
- HS023 Central Alerting System (CAS) Procedure

People and Culture

- HR011 Corporate and Local Induction Guidance
- HR026 Dignity at Work Procedure
- TP030 Records Management Retention and Disposal Procedure

Operations

- OP003 Incident Pager and SMS Procedure
- OP009 Responding to Railway Incidents Procedure
- OP010 Maintenance of Location Alert Register Procedure
- OP022 Operational Radio Procedure
- OP023 Dispatch of Resources by EOC Procedure
- OP025 Scheduled Maintenance and Exchange of Ambulance Equipment Procedure
- OP025 Scheduled Maintenance Equipment

- OP029 Use of Electronic Personal Dosimeters Procedure
- OP033 Resource Centre and Operational Ambulance Staffing Procedure
- OP036 Paediatric Care Procedure
- OP040 Deviation from Clinical Guidelines
- OP049 Airwave Hand Portable Policy and Process
- OP052 On-Day Dynamic Resourcing Procedure
- OP053 Audible and Visual Warning Devices Procedure
- OP054 Insulin Dependent Diabetics and Emergency Driving Procedure
- OP060 Control Services - Call Taking Procedures
- OP061 EOC Management of Complex Incidents Procedure
- OP068 The Use of CAD with limited functionality Procedure
- OP072 The Use of Restraint on Patients Procedure
- OP073 The use of contracted taxis to convey patients Procedure
- OP075 Vehicle Cleaning Procedure
- OP076 Station Cleaning Procedure
- OP079 TED Bag Usage Procedure

Guidance

- GU10 Antimicrobial Guidelines LAS
- HR014 Grievance Policy
- Disciplinary and Grievance during Covid-19 Guidance

London Ambulance Service NHS Trust

Fit and Proper Person Policy

Document Control

Document Reference	TP002
Version	1.1
Approved by	Trust Board
Lead Director/Manager	Director of Corporate Affairs
Author	Director of Corporate Affairs
Distribution list	Trust Board, Executive Committee, Senior Managers, All staff (via intranet)
Issue Date	01/12/19
Review Date	27/08/2021

Change History

Date	Change	Approved by/Comments
27/08/2021	References to Director of Corporate Governance/Trust Secretary updated to Director of Corporate Affairs	James Stanton, Head of Corporate Governance
27/08/2021	Acronyms updated with full titles	James Stanton, Head of Corporate Governance
27/08/2021	References – links updated	James Stanton, Head of Corporate Governance
27/08/2021	Appendices added	James Stanton, Head of Corporate Governance

1. Introduction - Policy Objective

1.1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the "**2014 Regulations**") place a duty on all NHS providers not to appoint, or have in place, an individual as a Director (Executive or Non-Executive), or "performing the functions of, or functions equivalent or similar to the functions of a Director" unless they satisfy the requirements as set out in the Regulations and repeated below.

1.2. The London Ambulance Service NHS Trust (LAS) is required to ensure that directors are 'fit and proper' for the role and make every reasonable effort to assure itself by all available means. This policy sets out the Trust's systems and processes are in place to ensure that all new directors and existing directors are, and continue to be, fit, and that no appointments meet any of the unfitness criteria set out in the 2014 Regulations.

1.3. This policy provides details of the specific requirements placed upon the Trust to ensure director appointments meet the Fit and Proper Person Requirement (FPPR). The FPPR is integrated into the Care Quality Commission (CQC) registration requirements and the regulatory and inspection approach. Legislation also articulates the expectation that where an individual no longer meets these requirements, the Trust must take appropriate and proportionate action to ensure that the office or position in question is held by an individual who meets such requirements and, if appropriate, inform the appropriate regulator. The CQC recognises that a Trust may not have access to all relevant information about a person, or that false or misleading information may be supplied to them. However, it expects Trusts to demonstrate due diligence in carrying out checks and that they have made every reasonable effort to assure themselves about an individual by all means available to them.

2. Scope and Definitions

2.1. The following **roles** fall within the scope of the relevant provisions of the Regulated Activity Regulations:

- Trust Chair
- All Non-Executive and Associate Non-Executive Directors
- All Executive Directors/Board members
- All Executive Committee members
- Director of Corporate Affairs
- Any other board member (regardless of voting rights) not listed above
- Any other person who performs the functions of, or functions equivalent or similar to, those of a director.

2.2. An individual falls under the requirements of the Regulated Activity Regulations regardless of whether they undertake the above role via a temporary, secondment or interim basis. The individual does not have to be an employee of the Trust to fall within the scope of this policy.

2.3. These requirements must be met at the point of commencing the role and on an

ongoing basis

2.4. Individuals who fall into the categories above must be able to demonstrate that they:

2.4.1. Are of good character, including by reference to the matters set out in paragraph 4.6 below;
2.4.2. Have the required qualifications, the competence, skills and experience required for the relevant office for which they are employed (or engaged);
2.4.3. Are able, by reason of their physical and mental health, after any required reasonable adjustments, capable of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
2.4.4. Can supply relevant documentation, as set out in schedule 3 to the 2014 Regulations, to support the FPP requirement (and has supplied such information to the Trust, in accordance with paragraph 3.3 below);
2.4.5. Have not been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity);
2.4.6. Are not 'unfit' by reason of matters set out in paragraph 2.5 below.

2.5. In accordance with schedule 4 part 1 of the 2014 Regulations, a person is deemed "**unfit**" if:

2.5.1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2.5.2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
2.5.3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
2.5.4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
2.5.5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
2.5.6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment

2.6. The CQC's definition of 'good character' is not the objective test of having no criminal convictions but rather a judgement to be made as to whether a person's character is such that they can be relied upon to do the right thing under all circumstances.

2.7. The Trust will use its discretion in reaching a decision regarding character. However, in accordance with Schedule 4 Part 2 of the 2014 Regulations, the Trust will take into consideration, in determining whether an individual is of "**good character**", whether he or she:

2.7.1. Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an

2.7.2. offence;

2.7.3. Has been erased, removed, or struck off a register of professionals maintained by a regulator of health care or social work professionals.

3. Accountabilities and Responsibilities

Trust Chair

3.1. The Trust Chair takes overall responsibility and accountability for ensuring all those required to confirm that they meet the requirements of the Regulated Activity Regulations do so at appointment and as an ongoing requirement.

Those within the scope of the FPPR

3.2. Those who fall within the scope of the FPPR are responsible for holding and maintaining their personal suitability for the role they are undertaking. They are required to respond to any requests of evidence of their ongoing suitability and to disclose any issues which may call into question their suitability for the role they are undertaking.

3.3. All relevant post holders are obliged to complete a declaration on appointment (Appendix 2) in accordance with paragraph 4.3 below, and, where already appointed, an annual FPPR declaration (Appendix 1) in accordance with paragraph 4.7 below. This declaration will be retained by the Director of Corporate Affairs. Where concerns are raised about a Director's fitness (whether such matters are self-declared, or of which the Trust becomes aware via other means), the Trust shall investigate the issue in accordance with paragraphs 4.12-15 below, and shall (where the individual is determined not to be fit, in consequence of that investigation):

3.3.1. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets the requirements of the 2014 Regulations, and

3.3.2. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the relevant regulator.

Director of Corporate Affairs

3.4. In conjunction with the People and Culture directorate, the Director of Corporate Affairs is responsible for ensuring all appointment checks (as outlined in Appendix 3) are undertaken for Executive Directors and Executive Committee members and that the results are recorded and evidenced within the individual's

file

3.5. The Director of Corporate Affairs will liaise with the appointments team of NHS England / Improvement on appointment of the Chair and Non-Executive Directors to the Trust to ensure that the FPPR is met with respect to these individuals.

3.6. In conjunction with the People and Culture directorate, the Director of Corporate Affairs is responsible for undertaking an annual refresh of suitability (as outlined in Appendix 3) for all of those who fall within the scope of the FPPR.

4. Fit and Proper Person Requirement compliance

New appointments

4.1. The Trust shall complete the checklist set out in Appendix 3 for new appointments as relevant and will include the following:

- Proof of identity;
- DBS check to the level required by the role;
- Occupational Health Clearance as relevant to the role;
- Evidence of the right to work in the UK;
- A check of employment history and two references one of which must be the most recent employer. A minimum of three years continuous employment including details of any gaps in service need to be validated. (Discretion on the period of validation for Non-Executive Directors can be applied by the Chair and the Director of Corporate Affairs and documented on the personal file.); and
- Qualifications/registration applicable to role.

4.2. In addition, the following registers will be checked:

- Disqualified directors
- Bankruptcy and insolvency
- Removed Charity Trustees
- A web search of the individual.

4.3. All new appointments into the relevant posts need to complete a FPPR Declaration form (Appendix 3). This form and summary guidance will be included with the application pack and form part of the application process for the position.

4.4. The Trust will have regard to information on when convictions, bankruptcies or similar matters are considered ‘spent’. However, there is no time limit for considering serious misconduct or responsibility for failure in a previous role. In consideration of any instances of serious misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC.

4.5. The Chair of the appointments panel for Board members and Executive Committee members will be responsible for ensuring compliance supported by the Director of Corporate Affairs and People and Culture directorate. In addition to being responsible for ensuring that a declaration of “rationale for

appointment" is completed, the Chair of the appointments panel will ensure that a detailed checklist is completed and retained on the director's personal file for the purposes of audit by CQC (Appendix 3).

4.6. Where the Trust deems that the individual who is to be appointed is of good character notwithstanding the presence of a matter outlined in Schedule 4, Part 2 of the Regulations (Good Character), the reasons will be recorded in the minutes of the Nomination and Remuneration Committee and the information about the decision will be made available. The appointment process will include an evaluation against the Trust's values, and any relevant external guidance. External advice will be sought as necessary.

Process for considering on-going fitness

4.7. The Trust shall regularly review the fitness of directors to ensure that they remain fit for the role they are in. Every March there will be a requirement for all individuals in roles that fall within the scope of the FPPR to complete a further form of declaration confirming that they continue to be a fit and proper person. Confirmation of compliance will be published in the Trust's Annual Report.

4.8. The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

4.9. The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust's values and behaviour standard including the leadership behaviour expected. The Chief Executive will be responsible for appraising the Executive Directors and Executive Committee members (unless they report to the Chief Operating Officer, will therefore have this responsibility). The Chair will be responsible for appraising the Non-Executive Directors. The Chief Executive will be appraised by the Chair. The Chair will be appraised through the agreed appraisal process that includes feedback from Non-Executive Directors and Executive Directors to the Senior Independent Director.

4.10. Individuals are required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form Existing post holders (Appendix 1). For Board directors, the Fit and Proper Persons Requirement Disclosure Form – existing post holders will be considered by the Chair and the Director of Corporate Affairs. The annual consideration will include other matters raised in the year. An annual statement will be filed onto the personal file.

4.11. The Chair will be notified of any issues of non–compliance and is responsible for making an informed decision regarding the course of action to be followed. Current post holders that cannot satisfy the declaration questions will not necessarily be barred from continuation of employment/office as it will depend

on the relevance of the information provided in respect of the nature of the position, and the particular circumstances. The Trust will address this in the most appropriate, relevant and proportionate way on a case by case basis.

Action to consider for concerns about an individual's continued FPPR compliance

4.12. Where matters are raised (whether in the course of new appointments, or annual declarations made, or other matters that come to the Trust's attention in other ways) that cause concerns relating to an individual being fit and proper to carry out their role the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis. In consideration of any potential misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC. Where it is necessary to investigate or take action the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'.

4.13. The Trust reserves the right to suspend an Executive and Non-Executive Director, or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

4.14. Should there be sufficient evidence to support a conclusion that the individual is not or is no longer fit and proper, then the Trust shall take such action that is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements. As such, the Trust may terminate the appointment of the Executive / Non-Executive Director with immediate effect, in line with the Trust's Resolution Framework.

4.15. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc.) no longer meets the FPPR the Trust must also inform the relevant regulator.

5. Competence (Education and Training)

5.1. The Director of Corporate Affairs will ensure the provision of advice in relation to the declarations to be made. A formal training programme will not be organised.

6. Monitoring Compliance

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Process in relation to the checks required pre-engagement.	Director of Corporate Affairs	New director file review	Annual	Trust Board
Process in relation to annual review	Director of Corporate Affairs	File review of Executive and Non-Executive Directors.	Annual	Trust Board

7. Effectiveness and Reporting

7.1. The Trust Board will receive a report to confirm the outcome of the annual FPPR checking process as part of the outcome of the Trust's Annual Corporate Governance Review. The Nomination and Remuneration Committee will also receive reports regarding new appointments of any Board members. The Chair is the responsible officer for ensuring compliance for new starters. A summary of compliance will appear in the Trust's Annual Report, as set out above.

8. Policy Review

8.1. This policy should be reviewed annually, as part of the Trust's Annual Corporate Governance Review.

9. Equality Impact Assessment Statement:

9.1. This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

9.1.1. Eliminate discrimination, harassment and victimisation.

9.1.2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

9.1.3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9.2. The Act sets out nine protected characteristics that apply to the equality duty, which must be considered in the writing of all documents.

10. References

10.1. This policy has drawn on guidance from:

10.1.1. Care Quality Commission FPPR guidance
http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors

10.1.2. Plain English Campaign Guidelines
http://www.plainenglish.co.uk/

10.1.3. Royal Institute for the Blind Guidelines
http://www.rnib.org.uk hcsp

10.1.4. NHS Resolution risk management guidance
https://resolution.nhs.uk/

10.1.5. Equality Act 2010
https://www.gov.uk/guidance/equality-act-2010-guidance

London Ambulance Service NHS Trust

FIT AND PROPER PERSON REQIREMENT PERSONAL DISCLOSURE FORM – applicants

(This form will form part of the application process for all posts that are considered to meet the Fit and Proper Person Requirement (FPPR))

First Names	
Surname	
If you are known by any other name please state	

Position	

Please respond to the following questions. Please continue on a separate sheet if there is insufficient space detailing the number of the relevant question/s. A hard copy of the signed form will be required.

1. Are you currently or have you been the subject of action by the police?

N.B Action includes, but is not restricted to: investigation, summons, arrest, bound over, caution, reprimand, warning, driving offences, charge conviction or imprisonment which are not deemed 'protected' under the amendment to the Exceptions order 1975*, issued by a Court or Court-Martial in the United Kingdom or in any other country?

NO / YES

If **Y E S** , please include below details of the order binding you over and/or the nature of the offence, the penalty, sentence of order of the Court, and the date and place of the Court Hearing.

You are not required to tell us about parking offences or spent driving offences

*You can read guidance and the criteria for the filtering of these convictions and cautions from the Disclosure and Barring Service website at:
https://www.gov.uk/government/organisations/disclosure-and-barring-service

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

NO / YES

If **Y E S** , please include below details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body.

You are reminded that you have a continued responsibility to inform us immediately if you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country.

You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current NHS Counter Fraud and Security Management Service (CFSMS) investigation following allegations made against you?

NO / YES

If **Y E S** , please include below details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the NHS CFSMS.

4. Have you been investigated by the Police, NHS CFSMS or any other Investigatory Body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO / YES

If **Y E S** , please include below details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body.

Investigatory Bodies include: Local Authorities, Customs and Excise, Immigration, Passport

Agency, Inland Revenue, Department of Trade and Industry, Department of Work and Pensions, Security Agencies, Financial Service Authority. This list is not exhaustive and you must declare any investigation conducted by an Investigatory Body.

5. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?

NO / YES

If **Y E S** , please include below details of the employment, office or position held, the date that you were dismissed and the nature of allegations of misconduct made against you.

6. Have you ever been disqualified from the practice of a profession, or required to practice subject to specified limitations following fitness to practice proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO / YES

If **Y E S** , please include below details of the nature of the disqualification, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned.

7. Are you currently or have you ever been the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO / YES

If **Y E S** , please include below details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned.

8. Are you subject to any other prohibition, limitation, or restriction?

NO / YES

If **Y E S** , please include below details.

9. Have you been responsible for, been privy to, or contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?

NO / YES

If **Y E S** , please include below details.

10. Are there any other matters that may be relevant to your position which might cause your reliability or suitability to be called into question?

NO / YES

If **Y E S** , please include below details.

Declaration

Important: The Data Protection Act 2018 requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. The Data Protection Act 2018 defines 'sensitive personal data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence.

The information that you provide in this Declaration Form will be processed in accordance with the Data Protection Act 2018. It will be used for the purpose of determining your suitability for the senior position you are applying for. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work. It may also need to be disclosed to the Care Quality Commission or, where applicable, your Professional Regulator

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by the Trust for the purpose of checking that I satisfy the requirements of the FPPR for the position applied for.

I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in an investigation in accordance with relevant Trust processes and could lead to the termination of an appointment.

I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a 'fit and proper person' or any grounds under which I would ineligible to continue in post come to my attention.

Name:

Signed:

Position:

Date:

Disclosure and Barring Service (DBS) checks

STAGE 1

In order to complete your DBS and join the update service you are required to undertake the key tasks below:

1. Please use the following link to access our electronic DBS system and complete the DBS form.

   https://disclosure.capitarvs.co.uk/cheqs/rbLogin.do

   Please select Option 1 of the main site and enter the following log in details:

   Organization Reference – LONDONAMBULANCE

   Password – DBS2016

2. You will need to bring your original ID documents (Passport, Driving Licence etc) and proof of address (Bank Statement, Council Tax Statement or Utility Bill) to the Trust.
3. You will then need to use your DBS application form reference number to join the DBS update service, either at the point of application, or during the application process – you can join the update service with your e-reference whilst your check is being processed or with your DBS certificate number within 19 calendar days from the date it was issued. You should be issued with your e-reference number once your ID has been checked.
4. If you join with your application form reference, the application form must be received by the DBS within 28 days of you joining. When your DBS certificate is issued they will automatically add it to your account. Your subscription to the service will then be live.

Or

5. You can join when you receive your DBS certificate, with your certificate number. If you wait to get your DBS certificate you must join within 19 calendar days of your DBS certificate issue date.

STAGE 2

6. Once you have completed your DBS application and received your DBS Reference/Certificate Number:
7. As you should be aware your DBS application has now been processed successfully.
8. If you have not joined the DBS update service as part of your DBS application, you should now join the DBS update service using your unique DBS reference number using the following link

   https://secure.crbonline.gov.uk/crsc/apply?execution=e2s1

9. You must join the update service within 19 calendar days of your DBS certificate issue date.
10. Please confirm to the following email address: londamb.DBS@nhs.uk once you have completed the update application process either initially when completing your DBS application or subsequently as detailed above.
11. If you experience any problems in putting the Update Service details please wait for your Certificate Number and then input the Update Service details (You must join the update service within 19 calendar days of your DBS certificate issue date).

FIT AND PROPER PERSON REQIREMENT PERSONAL DISCLOSURE FORM – existing post holders

(Annual review and ad hoc declarations)

1. Fitness to carry out the role of Director (or Director-equivalent post) in the London Ambulance Service NHS Trust (the Trust) is determined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulated Activities Regulations').

2. This document forms part of your contract of employment and by signing the declaration below, you are confirming that you do not fall within the definition of an 'unfit person' or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

3. It is a condition of your employment that you provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post.

4. The Chair and Non-Executive Directors are also required to meet the fit and proper persons test for Directors.

5. The Trust shall not appoint, or permit to continue as a Director, any person who is an unfit person.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation. The Care Quality Commission (CQC) document 'Regulations 5: Fit and Proper Persons: directors – Guidance for providers and CQC inspectors, January 2018' as amended from time to time provides further guidance on the requirement.

7. The requirements of Regulation 5 of the Regulated Activities Regulations are that:

   a) Are of good character, including by reference to the matters set out in paragraph 8 below;

   b) Have the required qualifications, the competence, skills and experience required for the relevant office for which they are employed (or engaged);

   c) Are able, by reason of their physical and mental health, after any required reasonable adjustments, capable of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

   d) Can supply relevant documentation, as set out in schedule 3 to the 2014 Regulations, to support the FPP requirement (and has supplied such information to the Trust);

   e) Have not been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity);

   f) Are not 'unfit' by reason of matters set out in paragraph 8 below.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

   a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

   b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

   c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

   d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

   e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

   f) The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

9. The Trust will use its discretion in reaching a decision regarding character. However, in accordance with Schedule 4 Part 2 of the 2014 Regulations, the Trust will take into consideration, in determining whether an individual is of "good character", whether he or she:

   a) Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence;

   b) Has been erased, removed, or struck off a register of professionals maintained by a regulator of health care or social work professionals.

I acknowledge the extracts from the Regulated Activities Regulations above.

I confirm that I comply with the requirements as set out in Section 7 above, having regard also to matters in section 9 above.

I confirm that I do not fit within the definition of an 'unfit person' as listed in Section 8 above.

I confirm that there are no other similar grounds under which I would be ineligible to be appointed to/continue in post.

I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a 'fit and proper person' or any grounds under which I would ineligible to continue in post come to my attention.

Name:

Signed:

Position:

Date:

London Ambulance Service NHS Trust

FIT AND PROPER PERSON REQIREMENT CHECKLIST/DUE DILIGENCE – To be completed on appointment and annually thereafter

First Names	
Surname	
If you are known by any other name please state	

Position	

Pre-Employment Checks	
Proof of Identity received:	**Yes/No** Details: •
Right to Work:	**Yes/No** Details: •
Sponsorship/Work permit/Visa received:	**Yes/No** Details: •
Full employment history	**Yes/No** Details: •
References	**Yes/No** Details: •
DBS:	Enhanced/Standard/ N/A* **circle as appropriate*
Professional Registration/Qualification	**Yes/No** Details:

	•
Occupational Health Declaration form received:	**Yes/No** Details: •
Employment rationale received:	**Yes/No** Details: •

New Starter Arrangements	
New Starter/Payroll Form received:	Yes/No Date passed to payroll:
Induction date:	

Fit and Proper Person Requirement Checks		
FPPR Declaration form completed:	**Yes/No** Details: •	
Register of Interest completed**:**	**Yes/No** Details: •	
Due diligence completed:	*Bankruptcy/insolvency* https://www.insolvencydirect.bis.gov.uk/eiir/	**Yes/No**
	Disqualified Directors Register https://beta.companieshouse.gov.uk/	**Yes/No**
	Removed Charity Trustees http://apps.charitycommission.gov.uk	**Yes/No**
	Internet based web search/Social profiles	**Yes/No**

London Ambulance Service NHS Trust

Policy for Managing the Conflict of Interests

Document Control

Document Reference	TP004
Version	1.1
Approved by	Trust Board
Lead Director/Manager	Director of Corporate Affairs
Author	Director of Corporate Affairs
Distribution list	Trust Board, Executive Committee, Senior Managers, All staff (via intranet)
Issue Date	
Review Date	27/08/21

Change History

Date	Change	Approved by/Comments
15/06/2020	Link to Declaration of Interest form updated	
27/08/2021	Updated Director title to 'Director of Corporate Affairs'	
27/08/2021	4.3 Updated team name to Corporate Governance (throughout) and amended wording to reflect declarations received via online submission.	
27/08/2021	4.8 Publication details updated to reflect publication to website	
27/08/2021	4.9 Added contact details for Corporate Governance team	
27/08/2021	4.11 ABPI link updated	
27/08/2021	4.68 footnote links updated	
27/08/2021	4.79- 4.80 Updated reference to FTSU/Whistleblowing Policy	
27/08/2021	11. Weblinks updated	

1. Introduction - Policy Objective

1.1. The London Ambulance Service NHS Trust (LAS) and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

1.2. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

1.3. Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

1.4. This policy should be reviewed in conjunction with the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Trust Board.

1.5. This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations
- Supports good judgement about how to approach and manage interests.

2. Scope and Definitions

2.1. A **'conflict of interest'** is:

2.2. "A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- **Actual** - there is a material conflict between one or more interests
- **Potential** – there is the possibility of a material conflict between one or more interests in the future

2.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

2.4. Interests fall into the following categories:

- **Financial interests:**

  Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making.

* This may be a financial gain, or avoidance of a loss.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association† with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

3. Accountabilities and Responsibilities

3.1. At LAS we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as **'staff'** and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

3.2. Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as **'decision making staff'**. Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct of delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

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† A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

4. Identification, declaration and review of interests

Identification & declaration of interests (including gifts and hospitality)

4.1. All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

4.2. A declaration of interest(s) form is available at: https://las.trustwide.live/forms/declaration-of-interest/

4.3. The Corporate Governance team will record and collate declarations received from staff.

4.4. After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

Proactive review of interests

4.5. We will prompt decision making staff quarterly to review declarations they have made and, as appropriate, update them or make a nil return.

Records and publication

4.6. The organisation will maintain registers for the declaration of interests, and for registering gifts and hospitality.

4.7. All declared interests that are material will be promptly transferred to the register by the Corporate Governance team.

Publication

4.8. We will:

- Publish the interests declared by decision making staff quarterly.
- Refresh this information annually.
- Make this information available on the Pulse and the London Ambulance Service NHS Trust website.

4.9. If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Corporate Governance team (londamb.CommitteeSecretary@nhs.net) to explain why. In

exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

Wider transparency initiatives

4.10. LAS fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

4.11. Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

4.12. Further information about the scheme can be found on the ABPI website: https://www.abpi.org.uk/our-ethics/disclosure-uk/

Management of interests – general

4.13. If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

4.14. Each case will be different and context-specific, and London Ambulance Service NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

4.15. Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

Management of interests – common situations

4.16. This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

Gifts

4.17. Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

4.18. Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared.

4.19. Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the London Ambulance Service NHS Trust not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

4.20. What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy

* The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Hospitality

4.21. Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.

4.22. Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.

4.23. Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

4.24. Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

4.25. Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

4.26. What should be declared:

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

* The £75 value has been selected with reference to existing industry guidance issued by the ABPI http://www.pmcpa.org.uk/thecode/Pages/default.aspx

Outside Employment

4.27. Staff should declare any existing outside employment (including self-employment) on appointment and any new outside employment when it arises.

4.28. Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.29. Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

4.30. The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

4.31. What should be declared:

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Shareholdings and other ownership issues

4.32. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

4.33. Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.34. There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

4.35. What should be declared

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Patents

4.36. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

4.37. Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

4.38. Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

4.39. What should be declared:

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

Loyalty interests

4.40. Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

4.41. What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Donations

4.42. Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

4.43. Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

4.44. Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

4.45. Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.

4.46. Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

4.47. What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

Sponsored events

4.48. Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.

4.49. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

4.50. No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.

4.51. At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

4.52. The involvement of a sponsor in an event should always be clearly identified.

4.53. Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.

4.54. Staff arranging sponsored events must declare this to the organisation.

4.55. What should be declared:

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

Sponsored research

4.56. Funding sources for research purposes must be transparent.

4.57. Any proposed research must go through the relevant health research authority or other approvals process.

4.58. There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

4.59. The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

4.60. Staff should declare involvement with sponsored research to the organisation.

4.61. What should be declared:

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
    - their name and their role with the organisation.
    - Nature of their involvement in the sponsored research.
    - relevant dates.
    - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored posts

4.62. External sponsorship of a post requires prior approval from the organisation.

4.63. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.

4.64. Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.

4.65. Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

4.66. Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

4.67. What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

Clinical private practice

4.68. Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

4.69. Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.†
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

* Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.nhsemployers.org/publications/terms-and-conditions-consultants-2003-contract

† These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.nhsemployers.org/publications/terms-and-conditions-consultants-2003-contract)

4.70. What should be declared:

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Management of interests – advice in specific contexts

Strategic decision making groups

4.71. In common with other NHS bodies London Ambulance Service NHS Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

4.72. The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Trust Board
- The Executive Committee.

4.73. These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

4.74. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

4.75. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

Procurement

4.76. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

4.77. Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

Dealing with breaches

4.78. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

Identifying and reporting breaches

4.79. Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns in accordance with the Trust’s Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy.

4.80. To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. Further information about how concerns should be raised are detailed in the Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy.

4.81. The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

4.82. Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

Taking action in response to breaches

4.83. Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. People & Culture), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

4.84. Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority, the Police, statutory health bodies (such as NHS England / Improvement or the Carer Quality Commission), and/or health professional regulatory bodies.

4.85. Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

4.86. Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

Learning and transparency concerning breaches

4.87. Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee.

4.88. To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Pulse and Trust's website as appropriate, or made available for inspection by the public upon request.

5. Implementation Plan

5.1. The policy will be posted on the Trust internet and intranet site and all staff will be made aware of its existence via the Routine Information Bulletin (RIB).

6. Competence (Education and Training)

6.1. The Director of Corporate Affairs will ensure the provision of advice for all members of staff with queries about conflicts of interest. A formal training programme will not be organised.

7. Monitoring Compliance

7.1 The Director of Corporate Affairs will hold the 'Register of Interests' of directors and senior staff. The Director of People and Culture will ensure that there is a register of declarations by staff of secondary employment.

8. Effectiveness and Reporting

8.1 The Register of Interests will be subjected to an annual review, as part of the counter fraud work plan. The outcome of that review will be reported to the Audit Committee.

9. Policy Review

9.1. This policy will be reviewed annually unless an earlier review is required. This will be led by the Corporate Governance team.

10. Equality Impact Assessment Statement:

10.1. This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

10.1.1. Eliminate discrimination, harassment and victimisation.

10.1.2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

10.1.3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10.2. The Act sets out nine protected characteristics that apply to the equality duty, which must be considered in the writing of all documents.

11. References

11.1. This policy has drawn on guidance from:

- Freedom of Information Act 2000
- ABPI: The Code of Practice for the Pharmaceutical Industry (2021) ABHI Code of Business Practice
- Code of Conduct for NHS Boards - NHSBSA (NHS Appointments Commission)
- Managing Conflicts of Interest in the NHS – Guidance for staff and organisations (2017) https://www.england.nhs.uk/wp- content/uploads/2017/02/guidance- managing-conflicts-of-interest-nhs.pdf
- Plain English Campaign Guidelines http://www.plainenglish.co.uk/
- Royal Institute for the Blind Guidelines http://www.rnib.org.uk/
- NHS Resolution risk management guidance https://resolution.nhs.uk/
- Equality Act 2010 https://www.gov.uk/guidance/equality-act-2010-guidance

Appendix 1 Policy Summary

As a member of staff you should…	As an organisation we will…

• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
 	
• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent
 	
• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
 	
• **NOT** misuse your position to further your own interests or those close to you
 	
• **NOT** be influenced, or give the impression that you have been influenced by outside interests
 	
• **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money
	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
	
	• Identify a team or individual with responsibility for:
	
	  ○ Keeping this policy under review to ensure they are in line with the guidance.
	  ○ Providing advice, training and support for staff on how interests should be managed.
	  ○ Maintaining register(s) of interests.
	  ○ Auditing this policy and its associated processes and procedures at least once every three years.
	
	• **NOT** avoid managing conflicts of interest.
	
	• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Board Assurance Framework and Corporate Risk Register			
Agenda item:	12			
Report Author:	Frances Field, Risk and Audit Manager			
Presented by:	Diane Scott, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	☒	Assurance	☒	Approval
	☒	Discussion	☐	Noting

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

This paper provides the Board with an updated Board Assurance Framework (BAF) and Corporate Risk Register (CRR). Current BAF risk levels are summarised below. No movements in the level of risks have been proposed for consideration by the Directors or Board Assurance Committees this cycle.

	Target	Current	Proposed movement
BAF 61 - COVID 19	8	16	-
BAF 58 - IT failure	4	16	-
BAF 45 - Cyber Security	10	15	-
BAF 56 - Recruitment/Retention	8	16	-
BAF 63 - Future Funding	5	15	-
BAF 65 - Immunisation	8	12	-
Total risk score	43	90	
Residual to target gap		47	

Details of the strategic BAF risks are set out overleaf and further background is included in the attached BAF Report. Updates to current BAF risks are marked in red text.

Two new risks have been included on the on Corporate (Trust Wide) risk register following review by the Trust's Risk Compliance and Assurance Group. These include a risk that the Trust would not be able to manage either two simultaneous Significant or Major Incidents due to the LAS HQ Special Operations Centre being unavailable. Updates on this and the other Corporate risks are set out overleaf and a copy of the Corporate Risk Register is provided for information.

As part of the new Chief Executive's review of initial management arrangements, it has been agreed that responsibility for the management of the Board Assurance Framework and Corporate Risk Register will be brought together under the Director of Corporate Affairs. Following feedback from the Board Assurance Committees, the opportunity will be taken to review the format and content of the BAF to ensure that it appropriate captures the level and type of strategic risk within the Trust.

Recommendations for the Trust Board:
The Board is asked to note this report and approve the Board Assurance Framework

Routing of Paper – Impacts of recommendation considered and reviewed by:					
Directorate	**Agreed**				**Relevant reviewer [name]**
Quality	Yes	X	No		
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		
Communications & Engagement	Yes		No		
Strategy	Yes	X	No		
People & Culture	Yes	X	No		
Corporate Affairs	Yes	X	No		Diane Scott, Interim Director of Corporate Affairs

Board Assurance Framework

Current Risks:

- **BAF risk 61 -** COVID-19 Impact: Risk reviewed on 1 September 2021, by the Chief Operating Officer with no change to the residual risk score which remains at 16 (4 x 4):
  - Finance sub-category risk for COVID-19: Risk reviewed on 9 September by the Financial Controller with no change to the residual risk score which remains at 15 (5 x 3).
  - Operational sub-category risk for COVID-19: The risk was reviewed on 1 September 2021, with no change to the residual rating which remains at 16 (4 x 4).
  - Clinical safety sub-category risk for COVID-19: No change to residual risk score of12 (4 x 3).
  - Quality sub-category risk for COVID-19: No change to residual risk score of 12 (4 x 3).
  - People and Culture sub-category strategic COVID-19: No change to residual risk score of 12 (4 x 3).

- **BAF risk 58 –** There is a risk of catastrophic failure of IT systems caused by software, hardware or communications failure may result in business continuity/ manual processes being invoked. Expected to be an ongoing residual risk due to the critical nature of IT systems in deploying resources to patients. This risk has been reviewed and updated by the Chief Information Officer with no change to residual risk score which remains at 16 (4 x 4).

- **BAF risk 45 -** A cyber-attack could materially disrupt the Trust's ability to operate for a prolonged period. This risk has been reviewed and updated by the Chief Information Officer with no change to residual risk score which remains at 15 (5 x 3).

- **BAF risk 63**: Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a mimumum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards. The risk was reviewed by the Chief Finance Officer on 8 September 2021 with no change to the residual risk score which remains at 15 (5 x 3).

- **BAF risk 56** -The Trust's ability to recruit and retain registered clinicians to our core front line operations (a sustainable workforce) will be affected by the changing landscape of the NHS which opens opportunities for paramedics to be employed in other healthcare setting and which will impact our ability to meet operational targets. Residual risk score remains at 12 (4 x 3).

- **BAF Risk 65** - There is a risk that the health and wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease. Residual risk score remains at 12 (4 x 3).

To note: updates to current BAF risks are marked in red text in the attached BAF report

Progress on capturing Transformation Risk:

Work has continued on the development of the Trust's risk approach to transformation. Initial proposals have been reviewed and are being amended to reflect the feedback given by both Executive and Non-Executive Directors. Following consideration by the Logistics and Infrastructure Committee and its suggestion that a single risk approach be used similar to BAF 61 (Covid), it is proposed that a Transformation risk be captured utilising sub categories,

as with the Covid risk, reflecting each of the transformational programme streams and the cross cutting issue of funding issue. This proposal is being further developed and expected to be formalised by the Executive Committee in September.

There is a risk that the Trust will not be able to deliver its transformation programme (including Hub 1) within the expected timeframe and funding envelope, impacting its ability to mitigate its critical infrastructure risks. This risk is currently being articulated and will be presented to the Trust Board for approval.

New Risk rated 15 or above on Corporate (Trust Wide) risk register

- RISK ID 1258 **-** There is a risk that the LAS would not be able to manage either 2 simultaneous Significant or Major Incidents. This is caused by the un-availability of the LAS HQ Special Operations Centre. It is unavailable due to work having started to remove all the facilities and equipment within it. To develop a new fit for purpose SOC at HQ.
  Update: The group agreed to accept the risk at 15 with a review after the controls have been updated. The Group agreed for the risk to be added to the Corporate (Trust wide) Risk Register.

New risks rated below 15 on Corporate (Trust Wide) risk register

- RISK ID 1255 - There is a risk around the assurance provided by corporate policies as a significant number remain overdue for review, this could lead to staff not having access to the latest information and guidance on Trust policy and practice, which may affect our CQC compliance which may lead reputational damage to the Trust if not properly managed.
  Update: The Group agreed for the risk to be added to the Corporate (Trust wide) Risk Register at a risk score of 9.

Current Risk on Corporate (Trust Wide) risk register

- 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.
  Update: There was no new update following a discussion with the director and deputy director of 111/999 services, the manual-in solution was still considered to be unviable. The group asked if there was a request to tolerate the risk or if there were any further mitigation that can be put in place. The risk remains at 16 and an alternative solution is to be confirmed.

- RISK ID 1145 – There is a risk that medical devices issues may not be managed appropriately due to the Trust not employing or contracting the services of a medical device specialists.
  Update: Following the last update, an independent specialist (EEAST) has completed a gap analysis of the Medical Devices Management requirements, of which a report has gone to the Trust Board. The next step is to prepare a Medical Devices Improvement Plan, and the Trust is working collaboratively with Guys & St Thomas's with a view to reaching a long-term solution. The group agreed that the risk remains at the current level until the review with GSTT has been completed and any further controls have been identified.

- 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.

Update: There are on-going updates to the neighbouring schemes both to the cameras and plant pots, once they have been reviewed they will either be removed or replaced by cameras. ANPR restrictions are being installed where possible which will minimise disruption for LAS vehicles. The group agreed to tolerate for a further 6 months.

Tolerated Risks

- Risk ID 775 - There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers.

- 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.

Board Assurance Framework: August 2021

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.

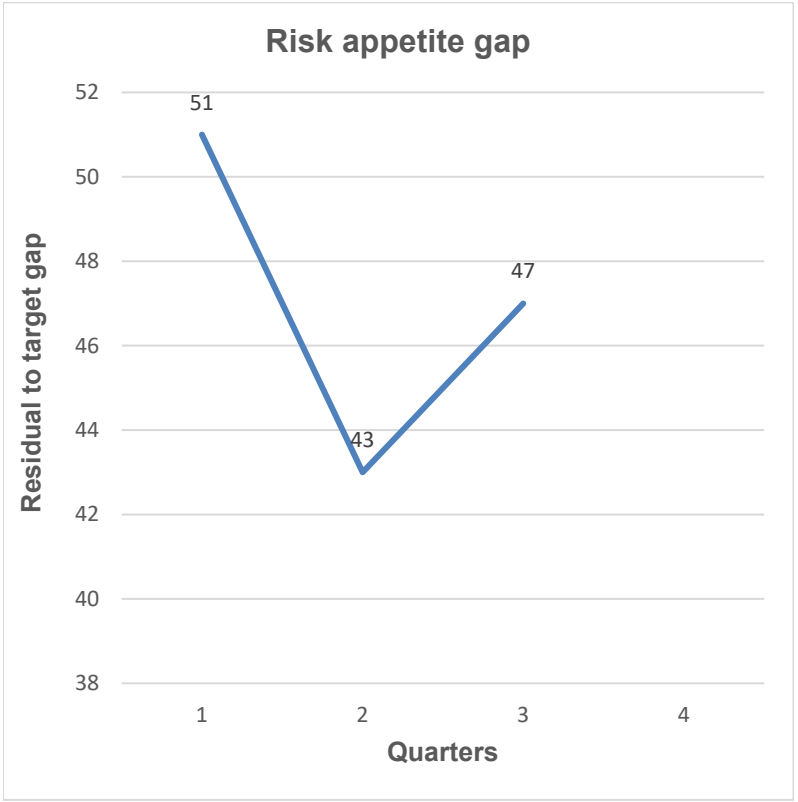
The Board is asked to note the changes highlighted in red and in particular the risks exceeding the Board tolerance scores as shown in the table below.

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	⟺
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	16	Low (6-10)	Yes	⟺
Due to the national uncertainty over future funding arrangements, from 21/22, there is a risk that the Trust will only secure a minimum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards.	20	15	Moderate (12-16)	No	⟺
There is a risk that the Health and Wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease	16	12	Low (6-10)	Yes	⟺

BAF Risk reporting Trend – 2021/2022

	Target	Jan '21	Apr '21	July '21
BAF 61 COVID 19	8	20	12	16
BAF 58 IT failure	4	16	16	16
BAF 45 - Cyber Security	10	15	15	15
BAF 56 Recruitment/Retention	8	16	16	16
BAF 63 - Future Funding	5	15	15	15
BAF 65 - Immunisation	8	12	12	12
Total risk score	43	94	86	90
Residual to target gap		51	43	47



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**	4 x 5 **20** 26.05.20	**Controls** 1. Sustainability plans have been reviewed to cover operational response, and supplemented by the development of a priority 8-point plan that is overseen by the Strategic Response Group. 2. Pandemic business continuity plans being reviewed as part of the annual EPRR assurance process. 3. Throughout the Trust's response to the pandemic, a Senior Leadership meeting has been in place to support the organisational response. This has enabled information to be shared widely, a collective approach to delivering a resilient operational response to the situation, and robust decision making. As levels of elevated demand are forecast to continue throughout the summer and the Trust's move to REAP 4, an Incident Director was appointed to in mid-June 2021 to oversee and coordinate the ongoing organisation's response to surge demand, through the Strategic Response Group and Service Delivery Group which meets daily. 4. Post COVID considerations led by the CEO to agree the optimal operating model including resources and estates requirements, identify and	~~4 x 4 16~~ 26.05.20 ~~4 x 3 12~~ 11.11.20 ~~4 x 5 20~~ 08.02.21 ~~4 x 3 12~~ 30.03.21 4 x 4 16 01.07.21 ⇧	1. COVID-19 decision making review underway. 2. To review and assess the Trust's Strategy and strategic risks following COVID 3. The organisation has been asked to set out its position including funding to deliver health care at system level.	Complete Ongoing Ongoing	**6-10**	

		26.05.20	retain efficiencies and operating opportunities across all areas of operations. 5. In the process of agreeing the 2021/22 winter plan to ensure the Trust is resilient ahead of future surges in demand and in advance of seasonal winter pressures. This includes both internally and with the system to align forecasts with NHS England and other system partners 5. 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 6. 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 7. 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. Whilst most of these activities have been on hold due to the pandemic and Government restrictions, we are now progressing with our plans to recruit 269 international paramedics, 100 via our internal recruitment team, and the remaining 169 candidates via an external international recruitment provider. 8. Substantive 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 9. Patient Safety and Risk Hub established to collate incidents and risks, and other quality data as well as produce the daily safety and risk hub report. 10. PSIP monitoring and reporting all patient safety incidents – COVID19 and non-COVID19 related – monthly end to end review of patient pathway incidents (IUC and Emergency pathways 11. Worked with CQC and NHSI and agreed SI process whilst recognising the scale of investigations required to meet LfD regulatory requirements 12. 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. 13. 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. 14. Secured capital of £26.7M to support the capital programme for transformation requirements in 21/22. CRL and cash to cover the gap of £7m is required and work is ongoing with NWL ICS to identify available capital or revenue and supporting cash to facilitate transformation. 15. 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. 16. A case is currently being made to NHSE National and Regional teams and NWL					

			ICS for recurrent expenditure requirement including post Covid resilience. 17. The Trust has developed an efficiency programme across all areas of the business, building in benefits realisation principles from PWC audit of D999 programme to deliver savings to meet the 2% CIP requirement expected of all organisations plus cost pressures that may arise in the 2nd half of 21/22. However the H2 efficiency requirement is likely to be a minimum of 3% and maximum of 5%, **Assurances** 1. Reports are provided to the Board Assurance Committees on COVID-19 related activities. 2. Reports provided to Executive Committee who sign off strategic risks and actions. 3. Status reports provided to the Trust Board via weekly NED calls and monthly Trust Board meetings.					

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 settings and which will impact our ability to meet operational targets.	**~~4 x 4~~** **16** **23.05.19**	Controls 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. 2. Whilst most of these activities have been on hold due to the pandemic and Government restrictions, we are now progressing with our plans to recruit 269 international paramedics, 100 via our internal recruitment team, and the remaining 169 candidates via an external international recruitment provider. 3. In 2020/21 we recruited 180 graduate and qualified paramedics. In 2021/2022 we are planning to recruit 160 and we are currently working pro-actively with our non-partner universities to increase this number. 4. Ambulance services have developed (signed off at ExCo), an 18 month recruitment plan for paramedics and non-registrants which takes into account the expected requirement over the year, as well as the PCN requirement from April 2021. 5. Engagement in national HEE workforce planning group to influence debate on challenges of English Ambulance Trusts with funded paramedic places. 6. The Trust will hold primary authority for the supply of Paramedics to the 220	**~~4 x 3~~** **~~12~~** **23.05.19** **4 x 4** **16** **29.09.20** ⟺	1. Procure and appoint an external international recruitment provider – the supplier recommendation has now been approved following a 3-week delay. Expected to deliver international recruits from October '21. 2. Procure and appoint an external TEAC provider 3. Complete 121 retention with all international paramedics (July 2021) 4. Establish a skills mix that will meet the demand profile of the Trust with a realistic reliance on paramedic numbers 5. Develop and agree design for an Operating Model for Ambulance Services (on-going)	July 2021 Complete July 2021 Q3 2021/ 2022	**6-10**	

			London Primary Care Networks. This number had originally been built in to the recruitment plans for 2021/22.but has been revised from 192fte to 70 fte as the PCN take-up is expected to be much lower than originally forecast. Pilots with Merton PCN and Redbridge PCN commenced in October 2020 and will provide us with the opportunity to test arrangements for PCNs and apply any lessons learned in advance of the full launch in April 2021. The paramedics currently working within the PCNs are benefiting from new experiences and gaining new skills to bring back to the Trust. 7. To improve our internal pipeline of registered clinicians, we are partnering with Medipro to provide additional training capacity for our TEAC programme. 8. The Workforce Development & Planning Programme is meeting fortnightly to review performance against workforce plans. 9. Under the Ambulance Operations Programme there is a retention work stream which is focusing on the design and implementation of initiatives to reduce the number of planned leavers. This includes working with the LAS International Support team to put in place 121 retention interviews with our international paramedic staff, addressing the feedback from the iPara survey and supporting this group with applications for visa extensions and indefinite leave to remain and promoting opportunities for staff who are considering retirement.					

			10. The Trust has an experienced recruitment team who have demonstrated their ability to flex to meet the recruitment targets required of the organisation 11. The Trust has developed a paramedic apprenticeship programme to attract and retain non clinical employees. 12. The Trust is developing accessible career pathways for non-registered clinical roles. Introduced new Band 4 role (Assistant Ambulance Practitioner). Two cohorts totalling 130 have joined in 2020/21, one will be operational in February 2021 and the second cohort in July 21. In 2021/2022 we are recruiting over 400fte AAPs and TEAC roles. 13. The LAS Academy is coming to an end and we will move to the partnership with Cumbria for an apprenticeship programme. 14. Covid Paramedic bank to LAS Bank - procedure now in place to help support front-line resourcing. 15. We have developed Ambulance Ops, 111 and 999 workforce sustainability Plans. **Assurances** 1. The International recruitment campaign is ongoing via skype interviews for 2021/22 subject to available training places. 2. ExCo led Strategic Workforce Planning Group (SWPG) (now the Workforce Development & Planning Programme) put in place to develop and agree a three year strategic workforce plan which takes into account internal and external priorities is currently under review.				

			3. The Workforce Development & Planning Programme is meeting on a fortnightly monthly basis supported by work streams for IUC and Ambulance Operations. 4. Skills Mix Matrix is the subject of ongoing executive meetings. The Workforce Development & Planning Programme will own this on behalf of ExCo. 5. Monthly tracking of leavers against forecast, joiners, visa expiry data.					

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	**4 x 4** **16** 28.7.20	**Controls** 1. Completed a review of CAD infrastructure, vulnerabilities and weakness, Report provided to COLT and LIC and recommendations accepted 2. Report on telephony system in EOCs completed and submitted to COLT and LIC and recommendations accepted 3. Contract set up with Northrop Grumman to carry out daily checks on the CAD database put in place 4. Regular monitoring of CAD performance in place and ongoing 5. New generator provided at HQ prior to lockdown 6. ITK links established with all English Trusts and the Trust now receiving updates from all. 7. Contractor appointed to oversee UPS implementation – plan developed. 8. CAD system replicated across both sites – site switchover in the last 12 months 9. Significant internal knowledge of systems 10. Due to the ongoing lack of resilience of the UPS system at Bow and the limitations of the building, a temporary solution in the form of a containerised bespoke hired solution will be sourced. This will be located in the car park for the remaining duration of call centre operations at Bow. It is anticipated that this solution will be in place by August 2021. **Assurances**	**4 x 4** **16** 28.7.20 ⟺	1. CAD Replacement Strategy 1 -. Replacement of existing HW including move to external DC's - Completed successfully on 15/09/2020. - Decommissioning in progress and scheduled for completion end of November. 2. CAD Replacement Strategy 2 – Replacement of the CAD System (Hard ware/Soft Ware) – targeted May 2022 (D999). 3. Define and agree remediation plan for UPS: - New HQ UPS install completed and operational18/10/20. - Bow – containerised bespoke solution to be sourced 'business case pending' to be TBC post ARC - HQ new Generator – work in progress. 4. Complete project review and lessons learnt for UPS programme. Complete replacement of UPS enables opportunity for replan. 5. Business cases to be developed / approved to determine the voice solution relating to Avaya architecture fall back arrangements and resilience for current and proposed Avaya	Complete 30/05/22 Complete Post ARC Sep 21 Complete Complete	**6-10**	

			1. Regular reporting to committees, sub committees and groups. 2. IT Delivery Board established with Terms of Reference 3. Draft roadmap developed and is being socialised with operations 4. Commissioned independent reports. 5. Routine planned maintenance. 6. Outline business cases. 7. Project boards established for replacement of critical systems 8. Capital allocation of funds for corrective actions. 9. D999 Programme Board established and overseeing key projects 10. Issues with systems discussed at all levels of the Trust		systems. going forward (Avaya CM7 6. Review CISCO telephony platform and create a plan for transitioning from the current system. 7. CAD Essentials Board has been superseded by the IMT Delivery Board 8. CAD dashboard to be implemented and reviewed at IMT Delivery Board 9. Cyber to be moved to ICT and a clear roadmap developed to resolve outstanding issues including patch management 10. Completion of build of new hardware platform for existing CommandPoint to be completed at Crown Hosting Centres 11. IT Priorities reassessed and focused on key areas 12. IT Structure to be reviewed and areas of capacity and capability identified and corrected - Projects to replace or mitigate for all faults on telephony, CAD, radio and mobile data put in place. Tactical/Strategic Telephony and LAS Infrastructure Business Cases under review and CAD Replacement Strategies in progress to address 13. Network configuration to be reviewed and upgraded to include resilience. 14. Primary network site of Bow to be relocated to external data	Complete Complete Complete Complete Complete Complete 30/10/21 25/02/22		

					warehouses at Corsham. 15. Relocate all hardware platforms out of Bow data centres and into Crown Hosted Data Centres 16. Relocation of all Trust services from systems in Bow to new hardware platforms in Crown Hosted Data Centres	30/05/22 30/05/22		

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.	5 x 4 **20** 14.12.17	**Controls** 1. Technical cyber protection, detection and remediation solutions are deployed but require review. 2. The continuation of a professional cyber security team as a managed service to deal with incidents and cyber response e.g. Royal Surrey ransomware notification. Information Security Management support in Corporate Affairs. 3. Auditable set of documents covering people, processes, procedures and technical controls; reviewed by NHSD and third parties at least twice a year 4. Broad set of real-time security reporting and alerting with ability to take immediate action 5. NHS specific intelligence feed from NHS Digital implemented in technical controls and cyber responses **Assurances** 1. Compliance-based cyber security KRIs/KPIs (reported to IM&T SMT and monthly CEO performance review) 2. Performance reporting to L&IC through IM&T 3. Internal Audit and independent audit against DSPT 4. Additional NHSD assurance support through CORS programme 5. CareCert notifications performance measured and reported as part of the IM&T's KPIs,reported to IM&T SMT & ExCo monthly	5 x 3 **15** 15.1.18 ⟺	1. Deliver technical control/assurance projects: a. Network segregation and access control (Cisco ISE and TrustSec) b. Hardening of internet-facing systems (configuration and improved access control) c. N365 – Underpinned by the IG Compliance monitoring and data loss prevention - Investigating existing M365 access to Information Protection technology d. SolarWinds Logging solution and Security Information & Event Management (SIEM) 2. Leverage NHSD funded opportunities: a. Cyber Risk Framework workshops to enable enterprise integrated cyber risk management b. CORS Support – Supplier cyber management process, training needs analysis, baseline security architecture patterns, cyber cultural vision statement c. Cyber training opportunities e.g. CISSP and CIPR NCSC recognised qualifications. 3. Recruitment of substantive IG and Information Security resource at 2nd line of defence.	CIO Dec 21 Nov 21 October 21 Complete CIO Complete Complete Complete	**6-10**	

STRATEGIC GOAL 4: Provide the best possible value for the tax paying public, who pay for what we do								
Executive Lead Chief Finance Officer		**Assuring Committee** Finance and Investment Committee						
No. and Risk description		**Initial risk score**	**Key controls and assurances**	**Residual risk score**	**Action plan**	**Timescale**	**Risk tolerance**	**Board update**
63	Due to the national uncertainty over future funding arrangements, from 21/22 including uncertainty of future commisstioning arrangements, there is a risk that the Trust will only secure a mimumum level of funding more in line with pre-Covid contract funding, that is insufficient to deliver sustainably against agreed national quality and performance standards for the second half of 2021/22. This risk relates to all commissioned services including 999 and IUC /111 services covering NEL / SEL and NWL	**5 x 4** **20** 11.11.20	**Controls** 1. Case made to regulator and ICS system leaders for investment in ambulance operations modernisation programme to realise Carter identified efficiency opportunity over 3-5 years. The Trust needs to get further commitment from commissioners that they will support the transformation programme, including the ambulance operations modernisation business case. 2. Comprehensive resource model developed which links workforce, frontline fleet capacity, finance, and demand to forecast ability to deliver national response performance standards. 3. Income for H1 of 2021/22 agreed with ICS with agreement of receipt of non NHS income and additional surge costs excluded. 4. Efficiency Delivery Programme established with oversight over all CIP programmes, with best practice approach to benefits realisation captured from external review of Digital investment programme and improved governance put in place to ensure effective identification, implementation and tracking of CIPs. 5. CFO linking with national tariff setting, National Ambulance Implementation and Improvement Board and commissioner CFO group to ensure transparency and ongoing awareness of cost to deliver	**5 x 3** **15** 11. 11.20 ⟺	1. Identify components of the strategic efficiency plan to PID level. 2. Monthly reporting of downside or worst case scenarios included in the Finance Report. 3. Implement financial control transformation plan. 4. Implement service line reporting. 5. Work with pan-London ICS CFOs lead to achieve buy in to modernisation Programme. 6. Work with pan-London ICS CFO's and London region to secure required CDEL and supporting cash. Currently secured additional £4.8M CRL for 21/22 7. Agree H2 income plan by the end of End of September 21. 8. Prioritisation of capital is complete and revenue service development for H2 remains outstanding and will be completed in September. 9. Complete lean process review of IUC/111 services to support commissioning discussions. 10. Secure funding from NWL ICS for Hub 1	Complete Complete 30 Sep 21 30 Sep 21 Ongoing 30 Sep 21 30 Sep 21 30 Sep 21 30 Sep 21 31 Dec 21	12-16	

			expectations set through NHSE & Regional directives. **Assurances** 1. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn. 2. Bi-monthly Integrated Performance Reports to the Trust Board. 3. Bi-weekly meetings to agree short and medium term forecasts and resourcing required to deliver performance. 4. Asset disposal plan aimed at closing £14.5M of the Trust's capital cash requirement. 5. Benefits realisation including efficiency delivery is on the internal audit review plan to report by Q1. 6. End to end process review for IUC services to be completed by the end of September 2021 to optimise efficiency and support commissioner discussions. **Gap in Control** 1. Capital Plan of £34.7M developed for 21/22 with a capital remaining CDEL and cash gap of £4.8M closed through movement in accruals and assuming loan financing of £7M for Hub 1 repayable on disposal of Romford. 2. H2 income plan to be agreed by end of September 2021 for both 999 and IUC/111 services. 3. Prioritisation of capital is complete and revenue service development for H2 is completed pending agreement and availability of resources in H2.					

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 and Culture**	**Assuring Committee**	**People and Culture Committee / Quality Committee**					
No. and Risk description		**Initial risk score**	**Key controls and assurances**	**Residual risk score**	**Action plan**	**Timescale**	**Risk tolerance**	**Board update**
65	There is a risk that the Health and Wellbeing of our staff and volunteers may be compromised due to lack of contemporaneous immunisation records indicating a lack of assurance around immunity, which could result in individuals being required to isolate following exposure to an infectious disease **Source** Recent review of OH records indicate transfer of vaccination record information between previous providers does not provide assurance of immunity. Lack of evidence of immunity may result in recommendation for restricted attendance or isolation following exposure.	**4 x 4** **16** 3.11.20	Immunisation catch up programme commenced. Records are now captured in ESR Analysis of immunisation records to identify any gaps Contract tracing processes in place to identify and protect staff at risk of lack of immunisation /immunity Initiation of work through the ESR Account Manager and local/regional user groups to create a reporting framework in ESR. A task and finish group commenced work to review the systems and processes pre & in early employment to improve the opportunities for immunisations prior to commencement in roles where the risks are the highest. **Gaps in controls** Some staff have no results from historic immunity testing. There have been periodic Occupational Health provider changes, where the transfer of records from one third party provider to the next was incomplete, missing or corrupted. No systems in place for periodic immunity reviews.	**4 x 3** **12** 3. 11.20 ⟺	Data analysis using OHIO/ESR to understand the full scope of the issue. Design and deliver clear concise factual communications to staff about: • The issues • The risks • The solutions Delivery of the Phase 1 immunisation catch up programme will be completed in December 2020 Verbal Update from CMO to board recommending next steps for immunisations programme, with paper presented to ExCo on 17.3.21. Appointment of OH specialist as LAS advisor Design and implement immunisation assurance reports from OHIO. Predetermined by data accuracy activity currently underway Task and finish group- Review & redesign the approach to immunisations, timings of checks and processes starting at the pre	Complete Complete Complete Complete Complete 31/12/21 Ongoing	**6-10**	

			There is a cohort of staff for whom we can't demonstrate that we have offered vaccines due to lack of records. There is lack of staff uptake of immunisations and personal record keeping There are no systems in place for risk assessments of "non or low responders" to vaccines. ESR does not currently report in a format which provides assurance on immunisation status. An OH specialist advisor has been interviewed and offered the post. There was an initial start date of June 2021 but indications are we will be able to have support from May initial 3 days per week and then increasing to fulltime from June. The focus will be on the immunisation programme and providing the CMO and Director of P+C / Head of Wellbeing with the necessary expert advice around the OH retender and specialist OH advice and support. This appointment, which will initially be fixed term to ensure there is organisational benefit, was a recommendation from the FAOW investigation supported by the Audit committee but has been challenging to secure due to COVID and OH providers supporting the national vaccine programme.		employment. Currently being worked into retender spec. timeline will be in line with contract renewal. Review the clinical evidence for periodic immunity reviews. Complete – there is little clinical evidence to support - for OH vaccines. Hep B immunity peaks at approximately 4-12 weeks following vaccination and then declines Measles and Rubella – immunity is achieved following vaccination course Varicella – immunity assumed following exposure in childhood/ immunity achieved through vaccination course if necessary Pertussis – immunity evidence not required EPP non responders ONLY require periodic review of Hep B disease status (not immunity) to avoid infecting patients This evidence may be different for Covid vaccines Complete delivery of Phase 2 of the immunisation catch up programme. Review and revise the Workforce Immunisation Policy in line with the evidence for or against periodic immunity reviews. Launch new processes enabling staff to take personal responsibility to attend appointments , keep up to date and maintain oversight of personal	Complete Ongoing Complete – no action required currently Ongoing		

					immunisation records. Trust has a H&S responsibility to maintain records to: Demonstrate duty of care to protect employee against BBV (Hep B) Demonstrate d.o.c. to protect the public against disease (MMR). Recommend Trust retains responsibility to maintain records. Encourage personal record keeping but not to rely on this as the sole source Scope and tender process underway for a proactive and flexible OH service which strives for continuous quality improvement and uses the " Making Every Contact Count" principles to assess health and lifestyle choices, including immunisation status awareness and checks through every staff interaction. This has commenced and is noted for completion by 30 June 2021. Decision paper to July EXCO for agreement of which option to pursue: • BAU/Nothing • Open Tender • Partnership • In house Ensure the OH contract award includes the requirement for a live bi-directional OH interface with ESR. PAM group will pursue this (in contract extension lifetime – June 2022) – this is being agreed within the Trust	Jan 2022 Jan 2022		

					Complete a validation audit with the appointed OH contract holder to validate records transferred to them with those in ESR prior to switching on the bi-directional interface for vaccination data. No other OH data will be shared. Future action post OH contract award/partnership set up Continue to engage with NHSE/I as they develop digital “immunisation passports”. Provide information and lobby for this to interface with OH records &/or ESR.	Jan 2022 Ongoing timeline for delivery not yet defined by NHSE/I		

Appendix 1

Risk Appetite Statement

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 Public	LAS has a MODERATE risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.	12-16
Innovation (clinical & financial)	Partners Our People	LAS has a HIGH risk appetite for innovation that does not compromise quality of care.	20-25
Financial/VFM	Partners Public	LAS has a MODERATE risk appetite for financial/VFM risks which may ensure the achievement of the organisation's strategy whilst ensuring that the risk of financial loss is minimised and statutory requirements are complied with.	12-16
Compliance/ Regulatory	Partners Our People	LAS has a LOW risk appetite for Compliance/Regulatory risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	6-10

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	16	8

Risk reviewed on 1 September 2021 by Chief Operating Officer –residual risk score remains at 16 (4 x 4).

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 respond to the 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; including in times where the Trust is undergoing development and transformation.
- Responsive staffing across different LAS services and impact on staffing availability from transformation work as well as BAU.
- 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:

- Throughout the Trust's response to the pandemic, a Senior Leadership meeting has been in place to support the organisational response. This has enabled information to be shared widely, a collective approach to delivering a resilient operational response to the situation, and robust decision making. As levels of elevated demand are forecast to continue throughout the summer and the Trust's move to REAP 4, an Incident Director was appointed to in mid-June 2021 to oversee and coordinate the ongoing organisation's response to surge demand, through the Strategic Response Group and Service Delivery Group which meets daily.
- Regular meetings taking place to ensure a timely response in case the Covid pressures increase and pose a risk to performance delivery. In that case a plan is in place to stand up a daily response meeting looking at specific pressure points to allow a daily exec oversight of trust position and decision making such as: Alignment and joint working with the system, operational and performance oversight, resource availability and staff absence and Fleet and PPE status.
- We are operationally supporting a wide programme of vaccinations to staff which is progressing well to date.
- Medium term forecast and planning is undertaken by the trust to cover the response to demand expected during the government proposed roadmap, and regular meetings established with the NHSE analytics team to align and test forecasting assumptions.
- In the process of agreeing the 2021/22 winter plan to ensure the Trust is resilient ahead of future surges in demand and in advance of seasonal winter pressures. This includes both internally and with the system to align forecasts with NHS England and other system partners.

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	16	8

- Sustainability plans were reviewed in June to cover operational response, and this has since been supplemented by the development of a priority 8-point plan that is overseen by the Strategic Response Group.
- 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 plans are in place to reinstate or put an equivalent function in place if required.~~
- 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.
- 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.
- Targeted focus and initiatives to mitigate the increasing Category 2 demand, through additional clinical validation and review of dispatch guidance, and pilots to determine opportunities to increase capacity through reduced job cycle time
- Separated out the Covid-19 calls from 999 and 111 to allow a specialised response.
- A New Fuel policy and procedure to support business continuity has been rolled out.
- 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. Further RPE testing of staff is currently underway to fit and make available additional disposable FFP3 masks to frontline crews
- 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.
- Joint After Actions Reviews undertaken with NHSE/I (London) and lessons identified used to inform more resilient future plans
- 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. Maintain regular contact with suppliers to ensure their position has not changed and that the suppliers remain in a position to supply us.

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	16	8

- 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. This is continually being re-assessed based on the current REAP level which the Trust is operating.
- Review of the impact on staff capacity and availability as a result of transformation projects and development of services by the Trust.
- MOU's are in the process of being signed off with LFB and MPS to support with front line staffing as required to meet increasing demand, and arrangements have been made with external private blue light providers (VEHO) and partner universities to bring on board paramedic students on the Trust bank.

COVID-19 Sub-category Strategic Risk Assessments

Responsible Director: John Martin		**Quality**	
Risk assessment using NHS risk matrix	**Initial Rating**	**Current Rating**	**Target Rating**
	20	**12**	**2x3= 6**

Residual risk score remains at 12 (4 x 3).

Key activities:

- Review all assurance quality and risk processes to ensure they remain at minimum value level. This does bring a risk in terms of improving our regulatory quality rating.
- All compliance and standards audits continue. Quality reviews have recommenced.
- COVID19 Review for patient harm has following wave 2 has been completed and learning will be taken forward.
- Demand has decreased significantly to normal level and number of incidents have also returned to normal levels.
- Deteriorating patient process trialled in 2020 re-introduced to provide information to prioritise patients waiting at ED departments. Five case studies submitted to QGARD for national review of harm.
- QOG and associated sub committees have re-commenced.
- CQRG has re-commenced for external review of quality.
- Planning taking place for post lock down changes.

Controls to identify and mitigate risk:

- Patient Safety and Risk Hub established to collate incidents and risks, and other quality data as well as produce the 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
- Regular Senior Leadership Development to escalate any issues
- PSIP monitoring and reporting all patient safety 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
- All quality assurance systems assessed to maintain oversight whilst reducing pressure on operational staff – i.e. audits , serious incidents (BAU processes)
- Working with national leads for safeguarding, coroners to maintain oversight whilst reducing operational pressures.
- Re-assessment of resource with new teams joining the directorate and impact of EpCR e.g. EBS to ensure utilise skills and re-deploy staff as needed to deliver the agenda
- Business plans included additional resources required e.g. QI for future management of resources and delivery of agenda.

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	**15**	**5**

Risk reviewed on 9 September 2021 with updates made to controls, no change to residual risk score of15 (5 x 3).

Strategic Risk Description:

There is a risk that the Trust is unable to deliver its key performance metrics due to insufficient Covid funds being secured for the second half of 21/22.

Underlying Cause

The financial arrangements for H1 of 21/22 have now been notified by NHSE. Arrangements for H2 remain uncertain and should be notified by September 2021.

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 approved financial plan including CIP has been issued to Directorates based on agreed budgets with budget holders and is being monitored with focus on Covid spend to determine ongoing run rate and bear down on any unnecessary spend.

2. Is unable to identify and sustain cost efficiencies from opportunities post Covid-19
   Actions taken:
   - The Trust has developed an efficiency programme across all areas of the business, building in benefits realisation principles from PWC audit of D999 programme to deliver savings to meet the 2% CIP requirement expected of all organisations plus cost pressures that may arise in the 2nd half of 21/22. However the H2 efficiency requirement is likely to be a minimum of 3% and maximum of 5%.

3. 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 £26.7M to support the capital programme for transformation requirements in 21/22. CRL and cash to cover the gap of £7m is required and the source of financing will be agreed with NWL pending capital receipts.

4. 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.

Responsible Director: Lorraine Bewes	**Financial**

- 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

1. 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.
2. A case is currently being made to NHSE National and Regional teams and NWL ICS for recurrent expenditure requirement including post Covid resilience.
3. Review of monthly Covid spend by Directorate
4. Development of downside mitigation plan
5. Development of a BAU and transformation efficiencies plan

Assurance of controls

1. Monthly finance reports to the ExCo and the Finance and Investment Committee including forecast outturn.
2. Bi-monthly Integrated Performance Reports to the Trust Board

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	**12**	**8**

Residual risk score remains at 12 (4 x 3).

As the Trust emerges from the consequences of the second COVID wave the priority is the continued response to our patients and the rapid assimilation of learning from wave 2 into actions that may mitigate the consequences of a 3rd wave.
The new Clinical Safety Plan has been launched and has had its first review stage with excellent feedback. This will allow a more dynamic targeted approach undertaking specific actions to mitigate specific challenges
Staffing levels in the ECAS/CHUB and IUC are being reviewed with the experience gained from wave 1 and 2
We are continuing to work with partners to embed pathways which were beneficial for patients during COVID waves in recognition of the fact that acute hospital providers will continue to see bed pressures as they manage the consequences of COVID
We have worked collaboratively with London providers to introduce remote oximetry

Strategic Risk Description:

Risk of reduced patient outcomes or experience from the COVID pandemic surge and response.

Due to significant increases in demand due to Winter pressures and 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. Although we knew that a second spike during Winter would be difficult, and we were preparing for it, we could not have predicted the new variant, the increased rate of transmission and the volume of sick patients. Managing this 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 appropriate senior clinicians from across the organisation and supported by doctors from NHSE and the ICS under the NHSE COVID staff sharing agreement in place for London.
- Increased senior clinical support in EOC to provide clinical support to the different specialist functions including clinical guidance for front line crews on cardiac arrest care and decision making, intelligent conveyance, hospital diverts.
- Utilisation of advanced paramedic urgent care clinicians in the ICS area where the highest demand is to manage patients closer to home.
- Use of the Clinical Safety Escalation Plan (CSEP), with additional COVID measures, to safely manage the 999 calls in EOC and maximise guiding patients to the right place for care to meet their clinical need. The level and actions of the CSEP are reviewed by the Gold Commander four times per day and decisions logged.
- 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 navigators at 111 to oversee the CAS queue and ensure prioritisation of the sickest patients
- Increase in cover on the 24-hour senior clinical on call to include an additional shift from 10 – 19 to support the senior clinical on call as part of the Trust Strategic Command.
- 24 hour on call Strategic Medical Advisor and Senior Clinical Leadership.

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	**12**	**8**

- 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 and access from both hear and treat and see and treat.
- Working with each ICS to support the development of pathways to enable timely off-loading of ambulance handovers to enable the next 999 patient to be attended.
- All LAS clinical pathway changes taken through LAS Clinical Advisory Group and then changes monitored through Patient Safety and Clinical Effectiveness Group.
- LAS engagement in review of regional and national pathway and processes through NASMED and the NHSE Clinical Advisory Groups, both at regional and director level of all clinical decision making.

- Re-contact 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 (i.e. requires pre-alert to ED or had died)
- Structured judgment review for patients who have experienced to delay in call answering or waited 2 x 90th centile for a frontline response.
- Serious incident panel met weekly throughout to review any incidents raised via internal systems, quality alerts or via the patient experiences team.
- Direct support to crews who have been in contact with a confirmed COVID-19 patient through the welfare team, with input from the Wellbeing Hub.
- 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.
- 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.
- 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/
- As the Trust prepares for wave 3 we have escalated to REAP 4 and introduced the modified skill mix in partnership with LFB and MPS. This is maximising our responding resources.
- Clinical hub staffing is being increased in line with our learning from wave 2. This supports the use of the clinical escalation plan and makes additional clinical support available for clinicians operating within a modified skill mix.
- Additional senior clinical support has been planned from the clinical directorate if required. This is in line with the process we followed in wave 2.

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.

COVID-19 Strategic Risk Assessments

Responsible Director : Damian McGuinness		**People and Culture**	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	**12**	8

Residual risk score remains at 12 (4 x 3).

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.
   - The Trust is developing accessible career pathways for non-registered clinical roles. Introduced new Band 4 role (Assistant Ambulance Practitioner) to fill the gaps identified by the Ambulance Ops Sustainability Plan. Two cohorts totalling 130 have joined in 2020/21, one will be operational in February 2021 and the second cohort in July 2021. In 2021/2022 we are recruiting over 400fte AAPs and TEAC roles.
   - 111 and EOC have been increasing their staffing levels to meet the anticipation of increased demand. We have a programme of on-going call handling recruitment in place to March 2022.
   - Partnership arrangements with LFB are under discussion to provide business as usual and surge support as needed.
   - Partnership arrangements have been put in place with the Met Police to support us at peak times.
   - Engaged with and employed 3rd year Paramedic Students to undertake bank shifts.

2. **Limited welfare and wellbeing support to meet staff's physical, emotional and mental wellbeing requirements.**

   Key activities and actions to mitigate risks:

   - Substantive 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.

COVID-19 Strategic Risk Assessments

Responsible Director : Damian McGuinness		**People and Culture**	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	**12**	8

- 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.
- There is a national programme of lateral flow testing which has been in place since December 2020, designed to help prevent the spread of COVID-19. Tests will help to identify staff and volunteers who should be isolating.
- There is a national COVID-19 vaccination programme which has been in place since December 2020 to protect staff and patients. To date 81% of staff have had their first vaccination and 66% are fully vaccinated.
- Completed individual risk assessments Trust wide.
- The Wellbeing Team are following up on a weekly basis with those staff who have not yet engaged with the vaccination programme and we are also providing support and advice to those staff who have indicated that they are undecided.

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 individual/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".
- 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. Whilst most of these activities have been on hold due to the pandemic and Government restrictions, we are now progressing with our plans to recruit 269 international paramedics, 100 via our internal recruitment team, and the remaining 169 candidates via an external international recruitment provider.
- 12 to 18 month Workforce plan created incorporating additional skills types and volunteers that will enable surge capability as required.
- Under the Ambulance Operations Programme there is a retention work stream which is focusing on the design and implementation of initiatives to reduce the number of planned leavers. This includes working with the LAS International Support team to put in place 121 retention interviews with our international paramedic staff, addressing the feedback from the

Responsible Director : Damian McGuinness		People and Culture	
Risk assessment using NHS risk matrix *	**Initial Rating**	**Current Rating**	**Target Rating**
	16	**12**	8

iPara survey and supporting this group with applications for visa extensions and indefinite leave to remain.

- In 2020/21 we recruited 180 graduate and qualified paramedics. In 2021/2022 we are planning to recruit 160 and we are currently working pro-actively with our non-partner universities to increase this number.

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 and risk assessments completed
- Additional IT resources provided – laptops, heads sets, MS Teams 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 staff side / management consultation arrangements in place
- People & Culture Committee short form process established and utilised as required.
- Membership of COVID, Senior Daily Leadership Meeting (SDLM) 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 has been implemented to provide swift resolution of staff issues supported by external mediation resource.
- National reporting for WRES, WDES and staff survey has recommenced.

ID	Sector / Department	Description	Risk level (current)	Controls in place	Risk Owner	Last review date	Assurance	Risk level (Target)	Expected date for risk closure	Progress Notes:
775	Estates	TOLERATED RISK There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers to prevent neutral from being lost during a network power outage. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services independently at Bow and HQ.	20	Business resilience fall back accommodation in is place for all operations currently working out of Bow and this has been tested with fall back at Waterloo and other locations across the LAS estate. The business recovery plan was enacted and LAS was able to continue to deliver services across London.	Goodman, Andrew	15/04/2021	1. Ops, Strategic Assets and Property and IMT project team have been reinstated 2. A risks and options paper was developed by the team on the 22/3. And this included the set of tests that would be undertaken on the equipment	5	31/03/2022	28/06/21 Risk reviewed in RCAG on Tolerated Paper, Toleration noted and continues. 22/06/21 - GB SF TL - Isolation transformers have been installed at HQ and St Andrews house Bow, we are working on providing a temporary solution - going to ARC for approval.
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 if not properly managed.	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. All patients whose calls have been missed and not noted to have recontacted the service will be called back	Niner, Jacqui	11/02/2021	Incidents are raised on Datix to document when phones are left unmanned but logged in. All patients whose calls have been missed and not noted to have recontacted the service will be called back	4	30/09/2021	26/07/21 - Risk Reviewed at RCAG - MW confirmed this risk had been discussed at LIC and he would contact Barry Thurston via correspondence to identify any potential way forward.
1145	Health, Safety and Security	There is a risk that medical devices issues may not be managed appropriately due to the Trust not employing or contracting the services of a medical device specialist which may lead to equipment not being safe or fit for purpose which could impact on patient and staff safety.	20	Health and safety manager monitoring medical device alerts and process flow developed Policy in place (overdue for review)	Syma Dawson	11.05/2021	H&S Manager monitors medical device alerts via a spreadsheet	6	31/03/2023	26/07/21 - Risk Reviewed at RCAG - Update provided from EJ : "An independent specialist (EEAS) has completed a gap analysis of the Medical Devices Management requirements, of which a report has gone to the Board. The next step is to prepare a Medical Devices Improvement Plan, and the Trust is working collaboratively with Guys & St Thomas's to take this forward, with a view to reach a long-term solution." The group agreed that the risk remains at the current level until the review with GSTT has been completed and any further controls have been identified.
1066	Supply & Distribution	TOLERATED RISK There is a risk of the disruption to the business continuity for medicines supply within the LAS due to the lack of a contingency site which may lead to the inability to pack and distribute medicines if not properly managed and could lead to prosecution if non compliant with Medicines Act 1968.	16	Chief Pharmacist has raised via various managerial routes. The review work has been shared internally. Approval received for new medicines packing unit.	Maheswaran, Sumithra	Goodman, Andrew	18/05/2021	6	31/03/2022	30/07/21 Business Continuity Risk Review SR-B, CS - Currently writing a BC Plan including a fall back option within and outside of the organisation.
1081	Fleet and Logistics	TOLERATED RISK 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. Chief Pharmacist has carried out a detailed review of the medicines packing function in line with Good Distribution Practice criteria.	Goodman, Andrew	19/04/2021	Chief Pharmacist has carried out an initial assessment.	2	31/03/2023	26/07/21 Risk reviewed at RCAG as part of the Tolerated risks.
1133	South East Sector	TOLERATED RISK 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 and also the introduction of Low traffic Neighbourhood Schemes LTNs. 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 Return CRU to certain areas of London Emergency Services Group established and meeting monthly with LAS, LFB, MPS, sub director of streets and TfL head of traffic flow. 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 LAS consistently objecting to calming measure that put physical barrier in place (planters or lockable bollards)	Khadir Meer	11/02/2021	Review of performance and impact on job cycle times Monitor incidents via Datix	5	29/03/2024	26/07/21 - Risk Reviewed at RCAG - MW confirmed that there are ongoing meetings with the local authorities where FOI requests and the impact of the restriction to access are discussed. ANPR restrictions are being installed where possible which will minimise disruption for LAS vehicles.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Quality Report			
Agenda item:	For Information			
Report Author:	Helen Woolford, Quality Improvement and Learning			
Presented by:	John Martin, Chief Paramedic and Quality Officer			
History:	N/A			
Purpose:	☒	Assurance	☐	Approval
	☒	Discussion	☒	Noting

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

The Trust's Quality Report, containing July 2021 data, provides an overview of the quality performance through relevant quality KPIs and information across the organisation.

The report is summarised on the quality assurance summary page which highlights both positives as well as area where further action or improvement is required.

Recommendation for the Committee:

The Trust Board is asked to note the information provided within this reports.

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

Directorate	Agreed				Relevant reviewer
Quality	Yes	x	No		Chief Paramedic and Quality Officer
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 Affairs	Yes		No		

NHS
London Ambulance Service
NHS Trust

London Ambulance Service – Quality Report

Report for discussion at the Trust Board

Analysis based on July 2021 data, unless otherwise stated

Contents Page

Quality Report Summary

London Ambulance Service NHS Trust

Quality Domain	Metric	Jul-21	Highlights from this report by quality domain	Metric	Jul-21	Potential concerns and actions being taken
Safe	Rate of Low/No Harm Incidents per 1000 Contacts - 999	3.0	**Incidents:** The Trust continues to see consistent incident reporting which indicates a good reporting culture as well as a culture of openness. The number of incidents graded moderate harm and above has increased due to the high levels of demand being experienced. Delays identified will undergo a Structured Judgement Review (SJR) to look at the impact this had on care and treatment. **Infection Prevention & Control:** Hand Hygiene compliance for July 2021 is 96%. Compliance exceeds the expected Trust target of 90% for the group station that submitted data. Of note, 14 out of 18 group stations submitted OWR data for July 2021. Overall submissions totaled 51 during July, this decrease is expected as the quarterly targets have been met. Vehicle prep deep clean compliance remains positive at the Trust's expected target of 95%. Premises cleaning for 15 Group Stations/Services who submitted data for analysis provides a Trust compliance of 96%. This score continues to exceed the Trust performance target of 90%. Stations that failed to achieve 90% are escalated to the facilities manager to establish why and ensure remedial actions are put in place.	Handover delays	160	**Handover Delays:** There were 160 Handover/Transfer issues reported in July 2021. This breakdown to 98 incidents regarding handover delays in ED Over 60 Mins and 62 incidents delays of over 30 minutes. This can be attributed to the high demands the wider health service is experiencing as a result of the current pressure. **Medical Equipment** continues to be one of the highest reported category of patient safety incidents. The majority of these are failure of devices rather than missing devices which had previously been seen over the course of the year. **Actions being taken**: The supply and distribution leadership team is almost complete with the last appointment starting on the 16th August 2021 being the new Medical Equipment Specialist who will be responsible for overseeing where all the devices are and for ensuring they are brought in for scheduled maintenance/servicing and ensuring all ambulances have the equipment they need. **Safeguarding level 2 & 3 training:** The number of trained staff is below the Trust target of 90% with a particular concern with the number of staff trained in IUC services. **Action being taken:** The Safeguarding team have ensured that there are sufficient places on training courses throughout 2021/22 and are working with IUC to ensure staff are released to attend training. There will be the ongoing challenge to ensure staff attend training due to activity and demand on the Trust including changes in REAP levels. **Trajectory:** To achieve 90% compliance for both training by March 2022. **Statutory & mandatory training:** As at 31st July the compliance rate was 82% which is tracking below the Trust wide 85% target. The compliance rate has decreased by 1% when compared with the June figure. **Action being taken**: Regular reports are sent to managers and individuals to remind them of when training is due.
	Rate of Low/No Harm Incidents per 1000 Contacts - IUC	0.9		Medical Equipment Incidents Report	137	
	OWR Hand Hygiene Compliance	96%		Percentage of Level 2 Safeguarding Training	81.2%	
	VP Deep Clean A&E Vehicles	95%		Percentage of Level 3 Safeguarding Training	55.8%	
	Premises Cleaning Audit	96%		Statutory & Mandatory Training Compliance	82%	
Effective	ROSC to Hospital (AQI) - Reported 4 Months in Arrears ROSC At Hospital	35%	The LAS was the best performing Trust in three out of four Cardiac arrest AQI metrics: ROSC to hospital (overall; 34.7%), 30 day survival (overall; 12.7%) and 30 day survival (Utstein; 41.9%) LAS placed 3rd for ROSC to hospital in the Utstein group at 52.2%, well above the national average of 46.9%. This is a significant improvement on February 2021 where LAS ranked 10th for overall survival and 9th for Utstein survival. The LAS ranked 1st for the mean call to hospital for suspected stroke patients (01:08) in March 2021, well above the national average of 01:22. This position is maintained from February 2021 when the LAS ranked 1st in England (with a mean call to hospital time of 01:09). The LAS achieved an average call to balloon time of 02:00, 16 minutes shorter than the national average. This result ranked the LAS 1st nationally for the second month running.	MCA level 2 training	-	**MCA Level 2 Training:** MCA level 2 is currently not offered. **Action being taken:** Plans to include this in 2021-22 CSR programme are being developed. **PDR:** Compliance has fallen to 68% down from 75% reported in June. **Action being taken**: People and culture are working closely with Corporate teams (who have lower compliance levels than frontline teams) to improve their compliance levels. This includes weekly PDR reports to highlight team members who have an expired PDR date and those who are due to expire in the coming three month period **CPI Completion rates:** Due to operational pressures associated with REAP 4, Clinical Team Managers have been required to fulfil frontline duties resulting in a substantial drop in CPI completion across the LAS. **Action being taken:** To counter this, where paramedics on non-patient facing duties are available they are being allocated CPI audits for Group Stations with the lowest completion rates. **OWR compliance:** This is currently at 59% which is up from 58% reported in June. This remains below the Trust target of 85% and further action is required. **Language Line**: The number of lost calls has been increasing over the last year. This is due to increased activity/demand on the service. Action being taken: The Trust entered into a new contract with Language Line on the 1st June 2021 and includes specific KPIs relating to longest time to answer / language not available metrics. A number of actions are to be progressed but are being impacted on by the current demand being experienced.
	ROSC to Hospital (AQI) Utstein - Reported 4 Months in Arrears ROSC At Hospital	52%		Personal Development Review (PDR) Compliance	68%	
	Stroke - Call to Arrival at Hospital mean (hh:mm)	01:08		CPI - Completion Rate (% of CPI audits undertaken)	84%	
	Call to Angiography - Mean (hh:mm)	2:00		Operational Workplace Review (OWR) compliance:	59%	
				Language line % of Lost Calls	1.59%	

Quality Report Summary

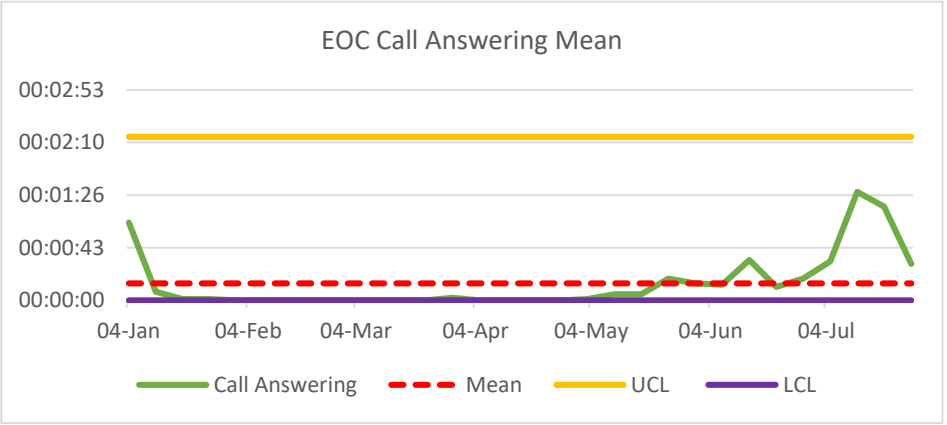
London Ambulance Service NHS Trust

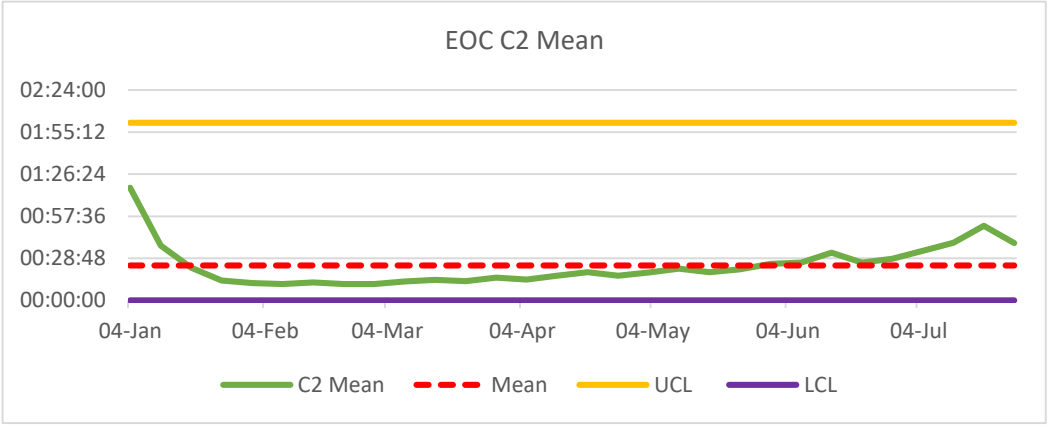
Quality Domain	Metric	Jul-21	Highlights from this report by quality domain	Metric	Jul-21	Potential concerns and action
Caring	Number of CMC care plans viewed by LAS	5868	**End of Life care:** The number of CMC views remains positive. The Macmillan End of Life Care programme team won the NHS Parliamentary Award for Excellence in Urgent and Emergency Care. This award was for the work of the Macmillan programme, which came to an end in March 2021, and celebrates achievements in improving the quality of care provision for EoLC patients through training, education, pathways and increasing the use of CMC.			
Responsive	Rate of Complaints	0.14	**Complaints:** Complaint numbers continue to be above the annual average of 88 with 134 received in July. The percentage of complaints versus the call rates against calls attended has also increased. These are being appropriately managed in a timely manner by the Patient Experience Team. **Number of Public Engagement Events:** The public engagement team held 11 events in May which reaching an approximate audience of 2,617 on the following topics Drugs and Alcohol, Choose well, knife crime and education events on the Ambulance Service.			**Complaints:** In light of the increased demands on Ambulance Trusts, the complaints team are seeking support from NASPEG (National Ambulance Service Patient Experiences Group) for Ambulance Trusts to adhere to a further 'pause' to the complaints process and to inform the Ombudsman and NHSE/I of the outcome.
	Number of Public Engagement Events	11				
Well led	Percentage of All Risks Reviewed Within the Last 3 Months	100%	**Risk management :** The Trust's compliance in July was 100% for risks reviewed within the last 3 and 100% of all risks approved within 1 month (the target for both is 90%). The risk team continue to liaise with all teams to ensure regular risks review meetings take place and risks are reviewed on a regular basis whilst acknowledging the additional pressures of REAP 4. **Trajectory:** Due to demand on the Trust the trajectory to achieve the 90% KPI target was adjusted to July 2021 and achieved.	Number of PfDs	1	**Preventing Future Deaths:** There has been 1 PFDs since the last report (June 2021) regarding a communication failure to provide accurate and relevant clinical information to the HEMS team and to ensure the earliest possible activation of HEMS clinicians through the triaged emergency call. **Policies:** There remains no policies overdue for a review with 70 under review and 37 in date. This has remained the same since the last quality report produced in June 2021. The ExCo approved the adoption of an annual (or interim) and full three year review cycle for each policy. **Action being taken:** Having received approval of a revised process the initial review of outstanding policies will utilise a checklist questionnaire which will prompt the rationalisation of polices through combining, grouping and re-categorising as procedures where appropriate. **Trajectory:** Operational pressures continue to impact the 90% compliance trajectory as the process is directly impacted by REAP levels and approval committees. The revised approvals approach will reduce operational impact and the team continue to work towards 90% compliance.
				% of all policies in date	34%	

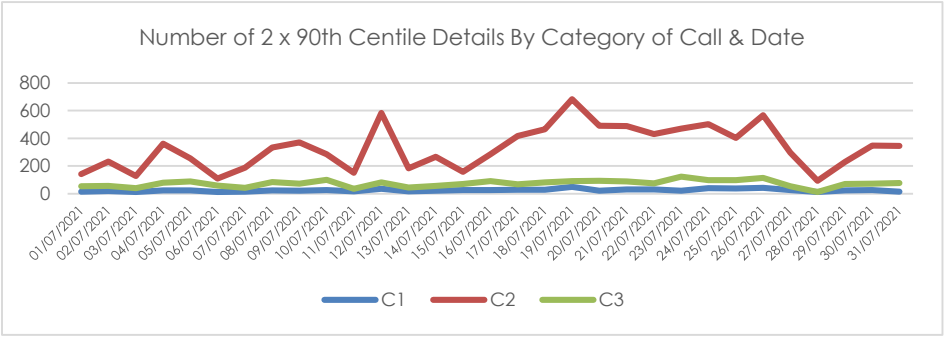
999 Operational Context

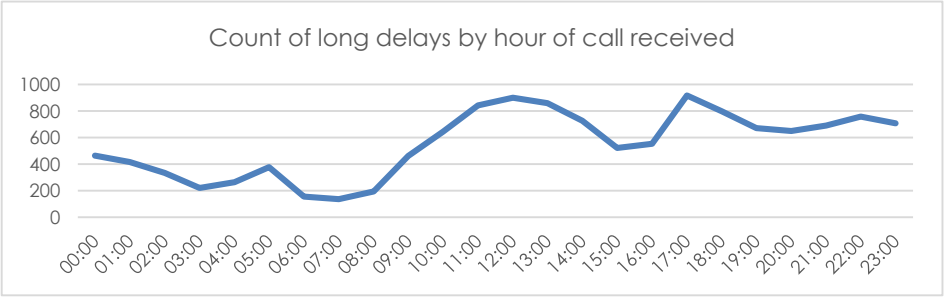
The service is meeting some operational delivery KPIs, with call answering and mean response times for Cat 1 within national set timeframes. There have been some challenges in the delivery of Category 2, 3 and 4 and actions are being taken to recover the performance.

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









In July 2021 there were 13,272 long delays, 9% of these resulted in a blue call.

	C1	C2	C3	Grand Total
Total	759	10258	2255	13272
Blue Call	152	922	72	1146

This is 95% increase from June 2021. From the table below we can see from Apr'21 – Jul'21, each month the number of long delays have nearly doubled from the previous month.

Apr-21	May-21	Jun-21	Jul-21
1764	3160	6789	13272

The top three determinants where a long delay incurred was:

- DX012 - Emergency Ambulance Response (Category 3) (8% n = 1124)– 47 required a blue call
- DX0112 – 111 referral chest pain (5% n = 682) – 35 required a blue call
- 36C5A – Protocol 36 Pandemic Card High Risk Conditions (5% n = 598) – 14 required a blue call

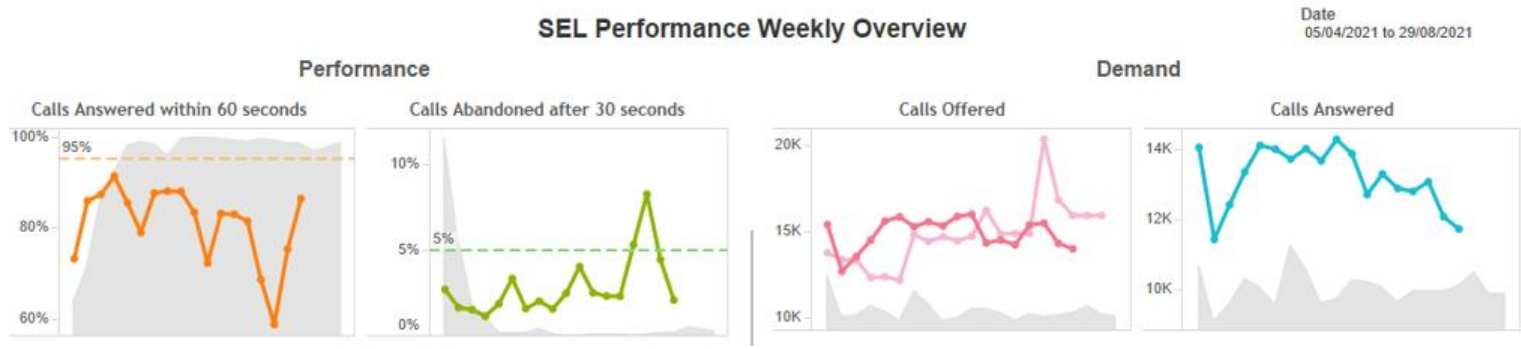
51% (n=6815) experienced a long delay were not conveyed and 49% were conveyed. It was also found that 13% (n=1760) of all long delays occurred between the hours of 11:00 and 14:00.

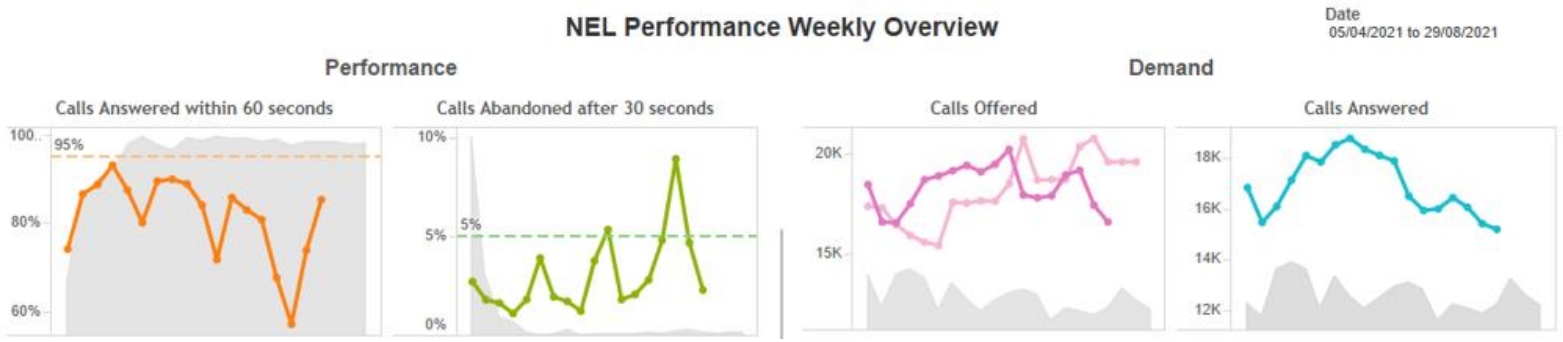
Action being taken include:
Forecasting and planning focus remains a part of the Strategic Response Group (SRG)
Daily operational performance review and actions via the Strategic Delivery Group (SDG)
Daily clinical safety reviews and daily patient safety reviews to oversee quality and clinical safety

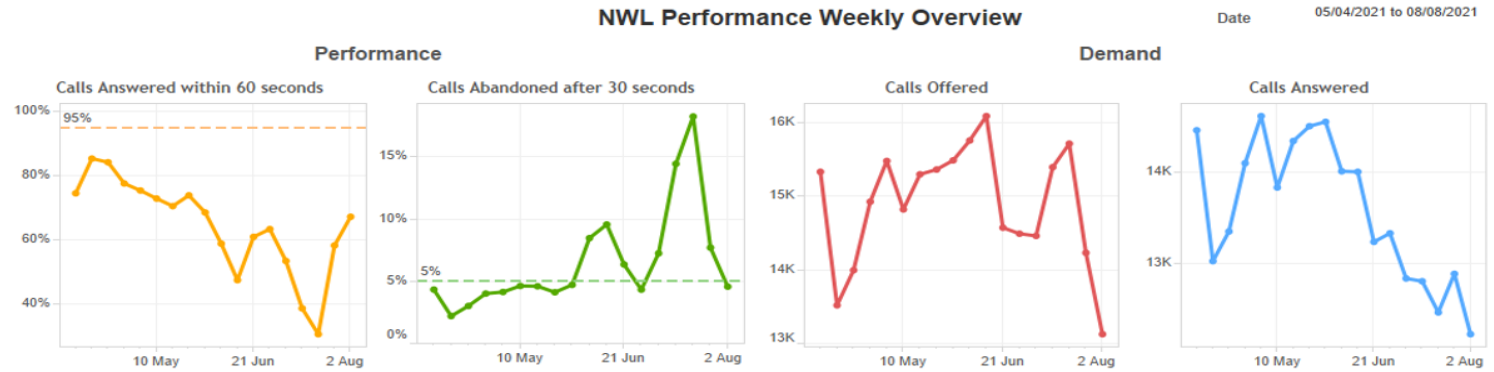
IUC Operational Context

The performance of 111 call handling against strategic objectives is being monitored closely to ensure performance is being managed within set performance targets/thresholds for IUC in SEL/NEL/NWL.

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







IUC Operational Context

The performance of 111 call handling against strategic objectives is being monitored closely to ensure performance is being managed within set performance targets/thresholds for IUC in SEL/NEL/NWL.

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

Indicator (KPI Name)	Status	WC 05/07/2021	WC 12/07/2021	WC 19/07/2021	WC 26/07/2021	Sparkline
SEL IUC Priority 1 - % LAS 35 minutes safety threshold	🔴	77.2%	66.5%	74.2%	73.8%	
SEL IUC Priority 2 - %las 75 minutes safety threshold	🔴	74.9%	70.3%	41.9%	71.5%	
SEL IUC Priority 3 - %LAS 150 minutes safety threshold	🔴	59.7%	65.8%	44.8%	66.6%	
SEL IUC Priority 4 - %las 260 minutes safety threshold	🔴	67.8%	69.1%	60.1%	79.0%	
SEL IUC Priority 6 - %LAS 420 minutes safety threshold	🟡	76.1%	80.6%	80.4%	90.4%	
SEL IUC Priority 7 - %LAS 540 minutes safety threshold	🟢	94.4%	97.6%	88.4%	97.6%	

Indicator (KPI Name)	Status	WC 05/07/2021	WC 12/07/2021	WC 19/07/2021	WC 26/07/2021	Sparkline
NEL IUC Priority 1 - % LAS 35 minutes safety threshold	🔴	70.0%	58.9%	64.5%	68.1%	
NEL IUC Priority 2- %LAS 75 minutes safety threshold	🔴	56.4%	43.7%	30.7%	54.3%	
NEL IUC Priority 3 - %LAS 150 minutes safety threshold	🔴	65.5%	58.1%	50.9%	70.9%	
NEL IUC Priority 4- %LAS 260 minutes safety threshold	🔴	72.9%	74.1%	68.8%	82.0%	
NEL IUC Priority 5 -%LAS 360minutes safety threshold	🔴	80.4%	76.9%	75.5%	81.5%	
NEL IUC Priority 6 - %LAS 420 minutes safety threshold	🔴	86.5%	77.2%	67.2%	80.0%	

- 🟢 KPI on or ahead of target
- 🟡 KPI off target but within agreed threshold
- 🔴 KPI off target and outside agreed threshold
- ⚪ KPI not reported / measurement not started

1. Safe

We must ensure we protect our patients and staff from abuse and avoidable harm. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

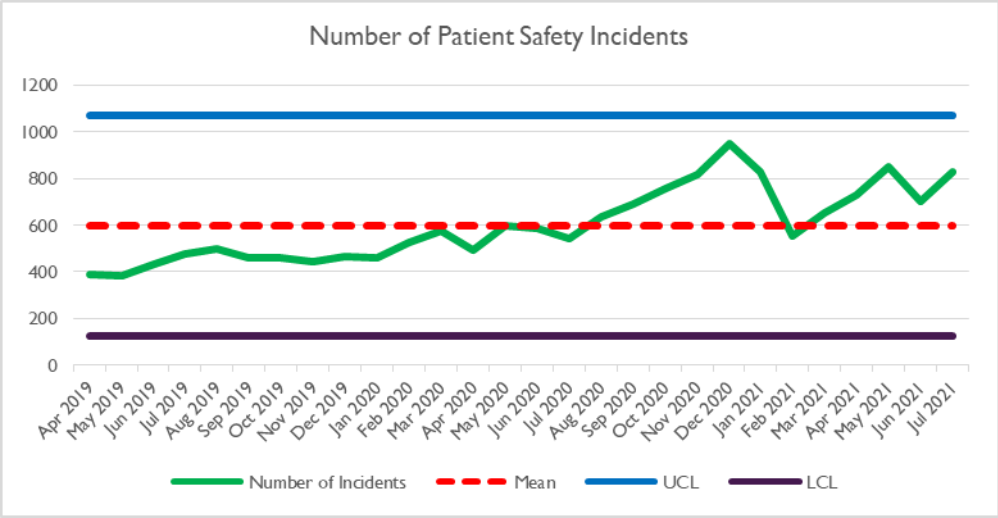
- Patient Safety
- Infection Control
- Medicine Management
- Safeguarding
- Health and Safety
- Clinical & Non Clinical Claims and Legal Inquests
- Outcome of Quality Visits (Environmental & Equipment)
- Statutory and Mandatory Training

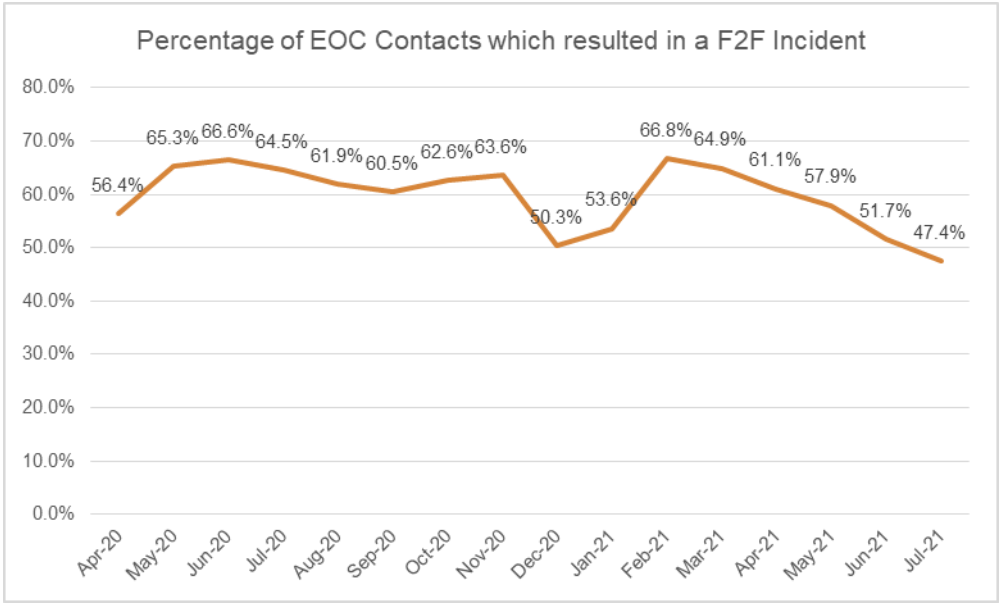
Outstanding Characteristic: *People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.*

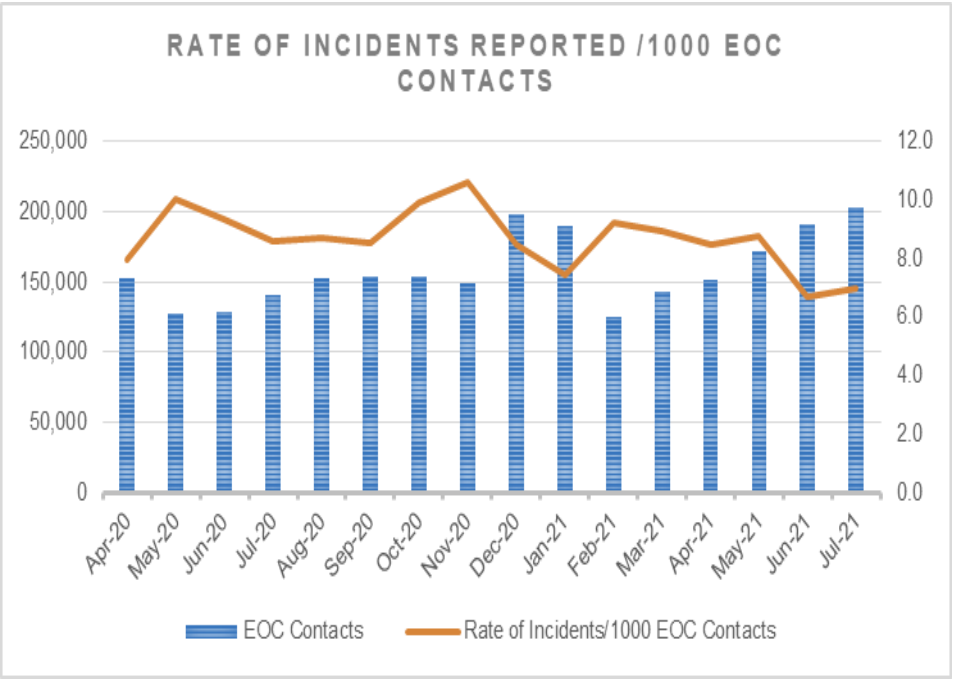
Safe Scorecard- Patient Safety Incident Reporting Context

The number of patient safety incidents reported across the 999 service remains steady when compared against the number of EOC contacts and face to face incidents.

Owner: Helen Woolford | Exec Lead: Dr. John Martin







The number of patient safety incidents reported per month has varied between April 2019 – July 2021. From March 2020 there has been an increase which correlates to the 1st national lockdown within the UK and the peak of the 1st COVID19 pandemic wave. The number of reported patient safety incidents then increases again correlating to the second COVID19 wave on the service in the winter of 2020.

The number of patient safety incidents per month between February 2021 – present has been increasing, with 831 PSIs reported in July 2021, the 3rd highest month between April 2019 – July 2021, this can be attributed to the current REAP 4 level the trust has been at since 17th June 2021.

The rate of incidents reported per 1000 EOC contacts has slightly decreased the last few months, this is because the number of EOC contacts has increased, hence the rate of incidents is lower, with July 2021 showing as 203,434 contacts which is the highest between April 2020 – July 2021. Likewise, the graph on the left, shows a decrease EOC contacts resulted in a face to face incident as a result of the increase in EOC contacts.

Safe – 999 Patient Safety Incident Management

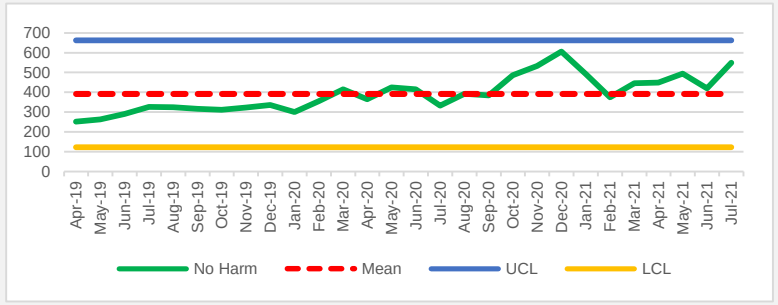
London Ambulance Service NHS Trust

The severity of harm of patient safety incidents indicates a good reporting culture of no and low harm incidents. Moderate harm and above incidents are reviewed for an enhanced investigation in line with the Patient Safety Incident Response Framework.

Owner: Helen Woolford | Exec Lead: Dr. John Martin

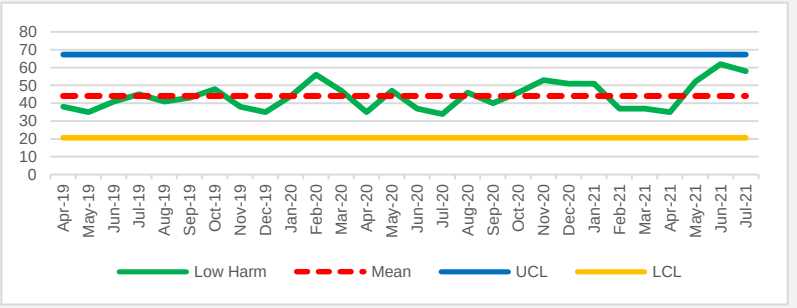
No Harm/Near Miss

Jul'21: **550**



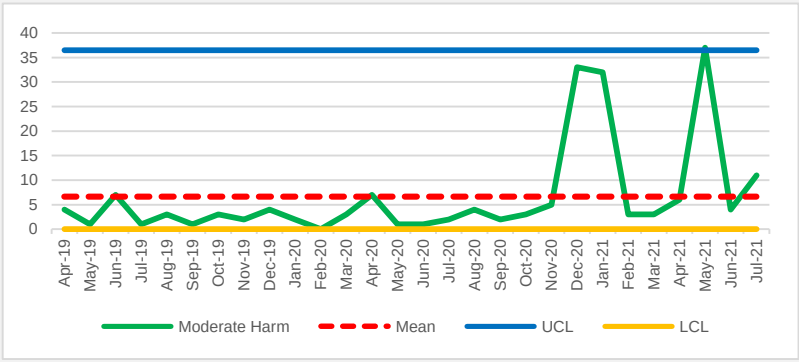
Low Harm

Jul'21: **58**



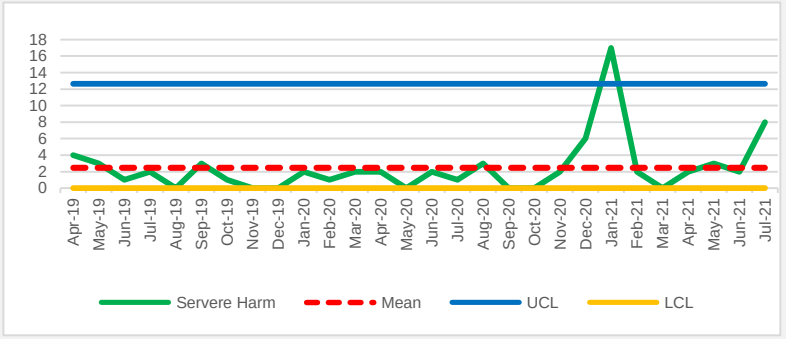
Moderate Harm

Jul'21: **11**



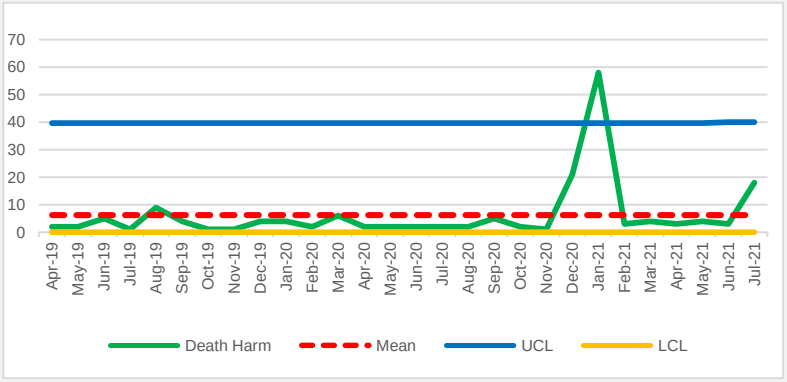
Severe

Jul'21: **8**



Death

Jul'21: **18**



Analysis of SPC graphs:

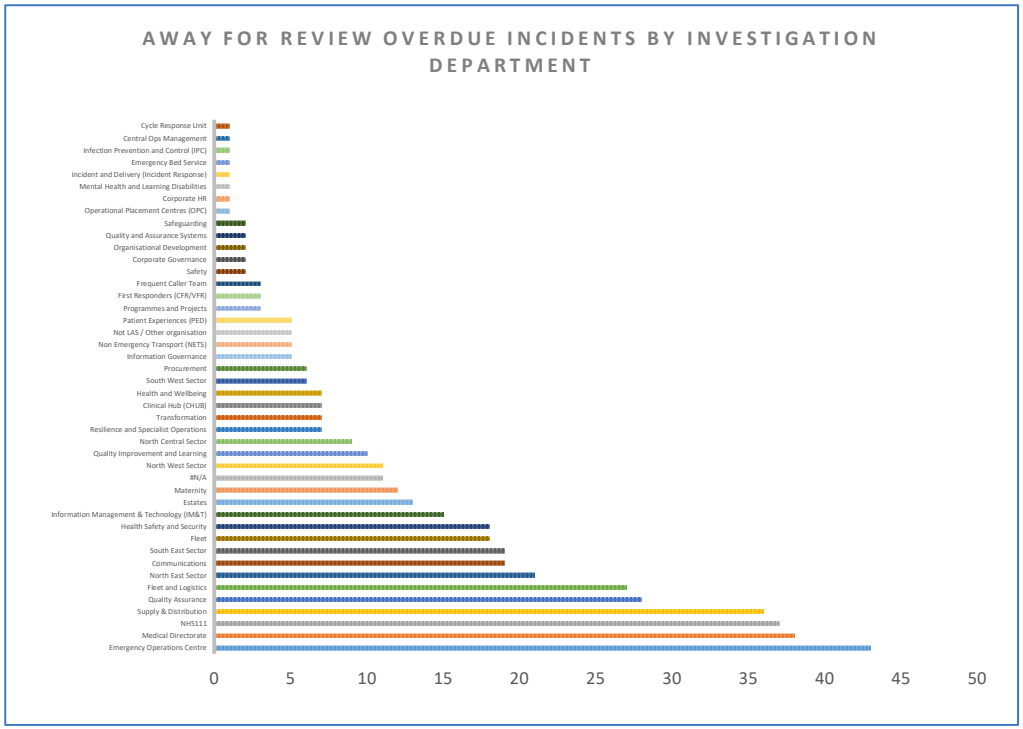
The number of reported no and low harm incidents continues to be monitored to manage themes/trends emerging. This is reviewed and acted upon monthly via the Trust's Safety Investigations Assurance and Learning Group (SIALG). There has been an increase in no harm incidents over the last few months which, in part, can be attributed to the increase in demand being experienced by the Trust.

The number of moderate, severe and death patient safety incidents reported increased in July 2021. This is due to an increase in the number of delayed response incidents highlighted via the team's daily review of delays experienced both in call answering and dispatch of resource. In addition, 8 of the 18 death incidents, 2 of the 11 moderate harm incidents and 1 of the 8 severe harm incidents were found via the re-contact audit which is auditing the months of December 2020 and January 2021;the height of the winter COVID19 wave experienced by the Trust.

Safe – 999 Overdue Incidents

The number of overdue incidents on the Trust's risk management system, Datix, continues to be monitored centrally with action being taken within sectors/directorates to ensure investigations are completed and action are moved to closure.

Owner: Helen Woolford | Exec Lead: Dr. John Martin

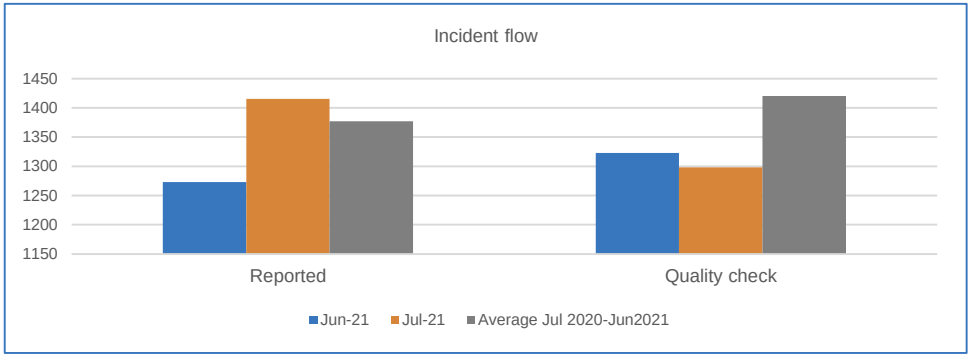


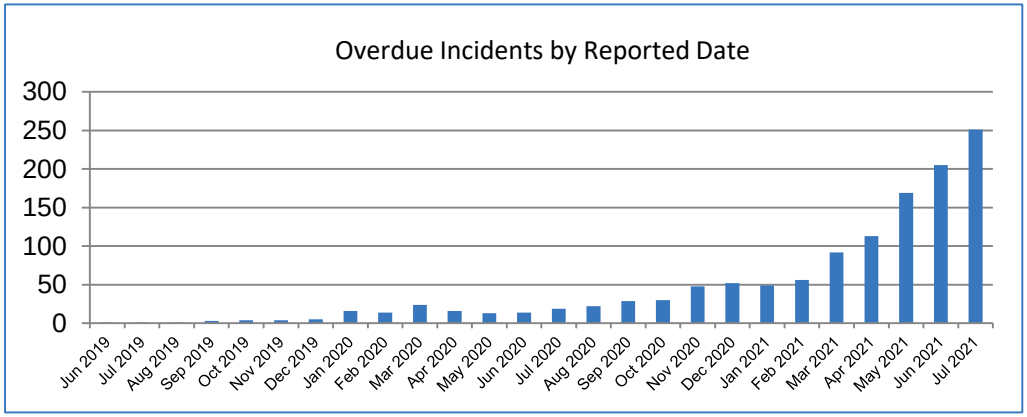
There are 1022 incidents (as of 13/08/2021) which have been opened on the system longer than 35 working days (this excludes SIs, PSIIs and COVID19 reviews). This is a 10% increase from June 2021 where there were 928 overdue incidents. This breaks down to:

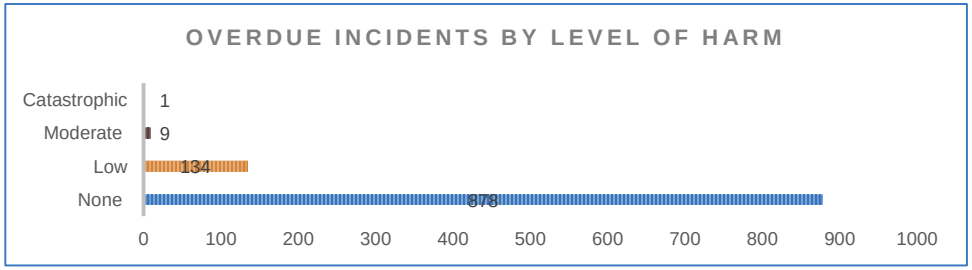
- 554 patient incidents
- 242 staff incidents (the 9 overdue moderate harm incidents are staff related)
- 12 visitor incidents
- 214 Trust related incidents

On average (Jul 2020 to Jun 2021) 1377 incidents are reported monthly on the system and 1420 incidents are investigated and moved to Quality check for final closure. During July 2021 the number of incidents reported was slightly higher than average, and the number of incidents moved to Quality check significantly lower than average. This can be attributed to the increased pressures being experienced and being at REAP 4.

All incidents continue to be monitored daily by the Incident and Risk Hub. The Quality Governance and Assurance Managers (QGAMS) also work with the sectors/depts. to ensure incidents are investigated in a timely manner. Of the overdue incidents, the highest number, 142 incidents (14%) sits within EOC. In regards to harm levels, 86% of overdue incidents have been labelled as No Harm and 13% as Low Harm.



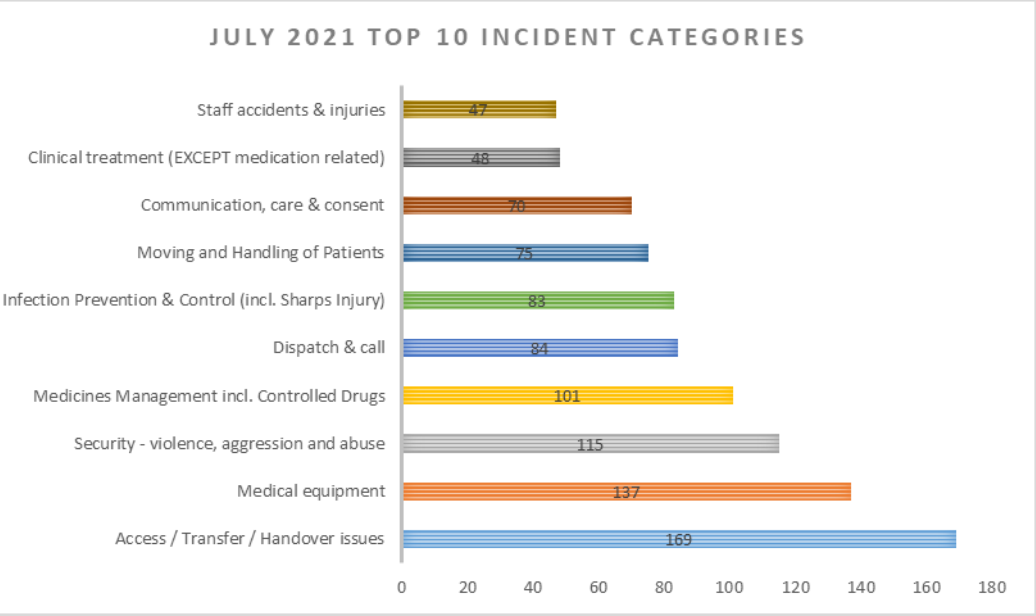




Safe – 999 Incident Category Analysis

Incident trends and themes are monitored by the Trust's Safety Assurance and Learning Group to ensure improvement and actions are being taken to address recurrent incidents.

Owner: Helen Woolford | Exec Lead: Dr. John Martin



The top 3 incident categories in July 2021 were Access/Transfer/Handover, Medical Equipment and Security – Violence, Aggression and Abuse.

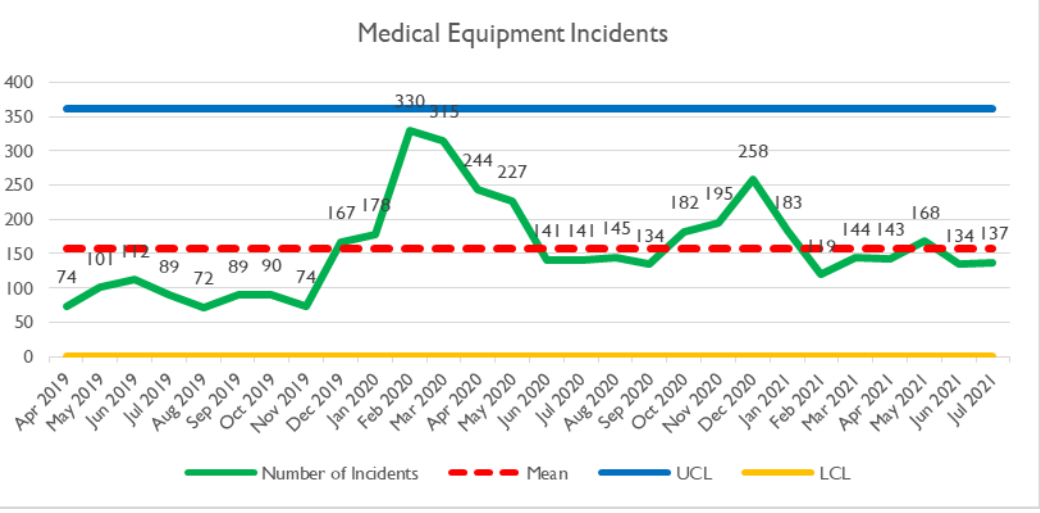
There were 169 Access/Transfer/Handover Transfer issues in July 2021. Delayed Handover in ED (Over 60 Mins) (98 incidents) and Delayed Handover in ED (Over 30 Mins) (62 incidents). This can be attributed to the high demands the service is currently seeing.

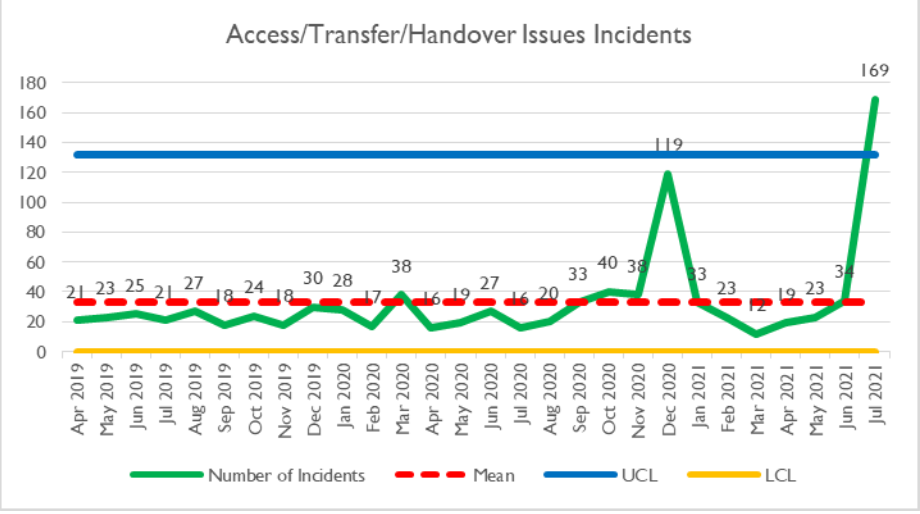
Themes relating to medical equipment indicate that there has been a change from missing equipment to failure of equipment in recent months.

The supply and distribution leadership team is almost complete with the last appointment starting on the 16th August 2021 being the new Medical Equipment Specialist who will be responsible for overseeing where all the devices are and for ensuring they are brought in for scheduled maintenance/servicing and ensuring all ambulances have the equipment they need.

Over the last month there has been one reported failure of a BM Kit, which was immediately replaced with new stock, no other issue has been reported. Following up on previous issues the new BVMs are in stock and being feed into circulation via the Make Ready Hubs, over 300 Tympanic thermometers have been place in circulation and there is currently a pro-active focus on ensuring adequate Oxygen saturation Probes are available.

The Central Asset Management System has been successfully trialled, and with support from Mitre, will start a phased go live from the 9th August for consumables with equipment following. This will see the systematic tagging of all medical equipment with passive RFID tags to manage the tracking, inventory, storage and maintenance of all medical devices





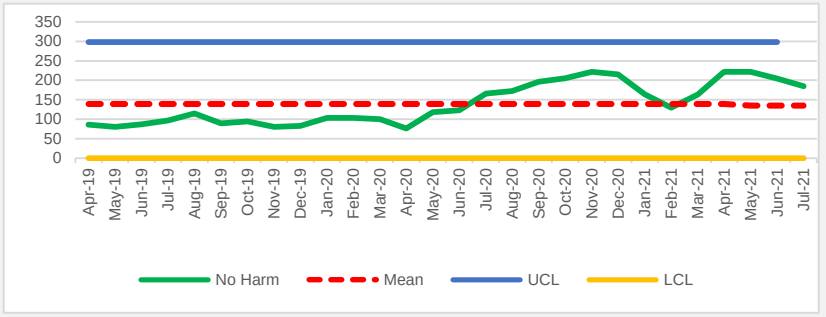
Safe – IUC Incident Management

The severity of harm of patient safety incidents indicates a good reporting culture of no and low harm incidents. Moderate harm and above incidents are reviewed for an enhanced investigation in line with the Patient Safety Incident Response Framework.

Owner: Helen Woolford | Exec Lead: Dr. John Martin

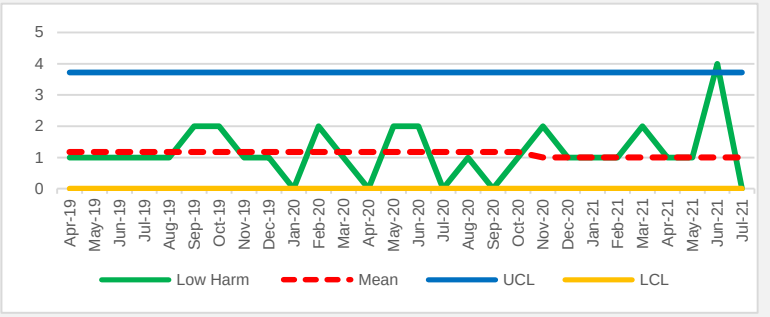
No Harm/Near Miss

Jul'21: **185**



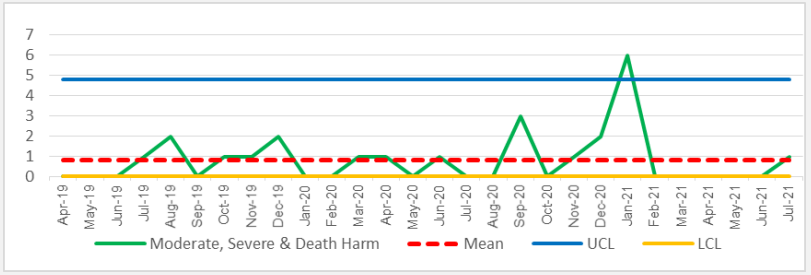
Low Harm

Jul'21: **0**



Moderate, Sever & Death Harm

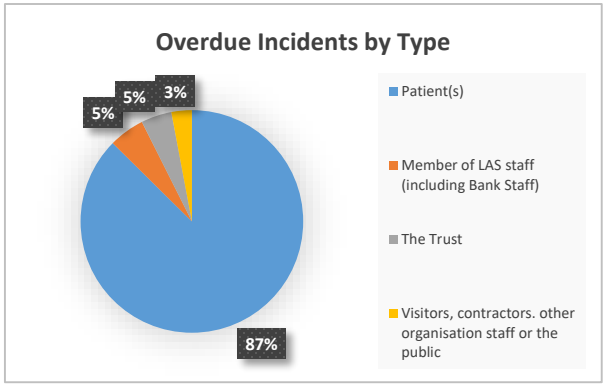
Jul'21: **1**

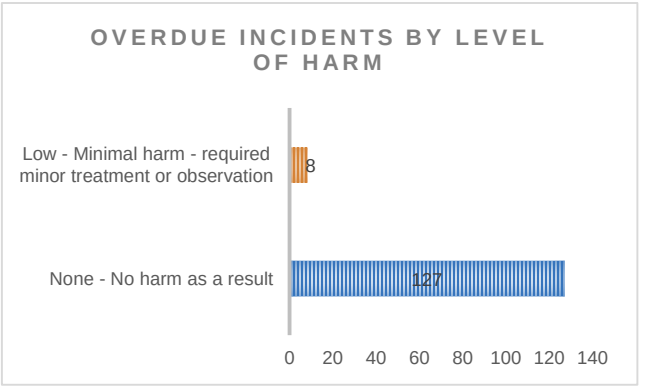


Analysis of SPC graphs:

The number of reported incidents continues to be positive in reporting numbers. This is a sign of a good reporting culture. There has been an increase in the number of no harm incidents reported in the last year.
The reason for the increase in no harm incidents is because IUC have increased incident reporting for language line issue, a new category has been added on Datix for such issues, supervisors and team managers are working hard to ensure they report all incidents of issues to help provide improved learning and promote a good reporting culture within LAS.

Incident Management





There are 135 incidents (as of 13/08/2021) which have been opened on the system longer than 35 working days (this excludes SIs & COVID 19 reviews).

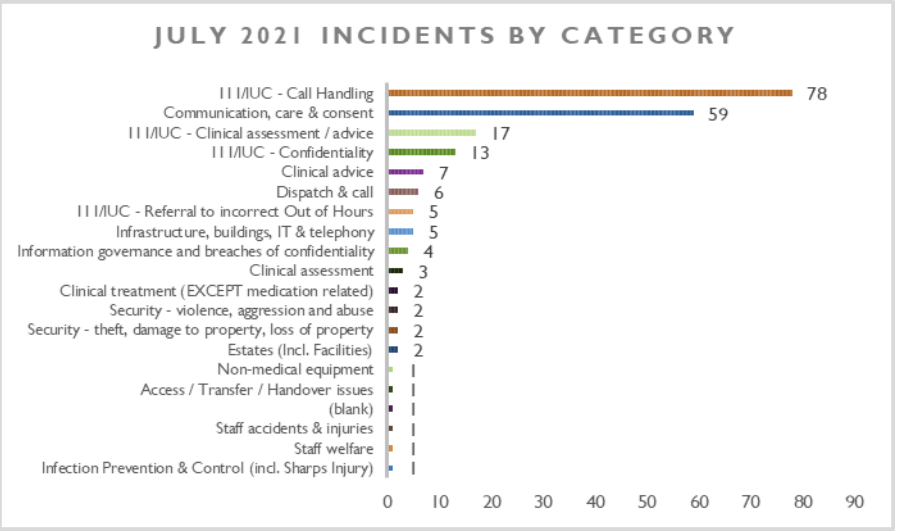
This breaks down to 118 patient incidents, 7 staff incidents 4 visitor incidents and 6 Trust related incidents.

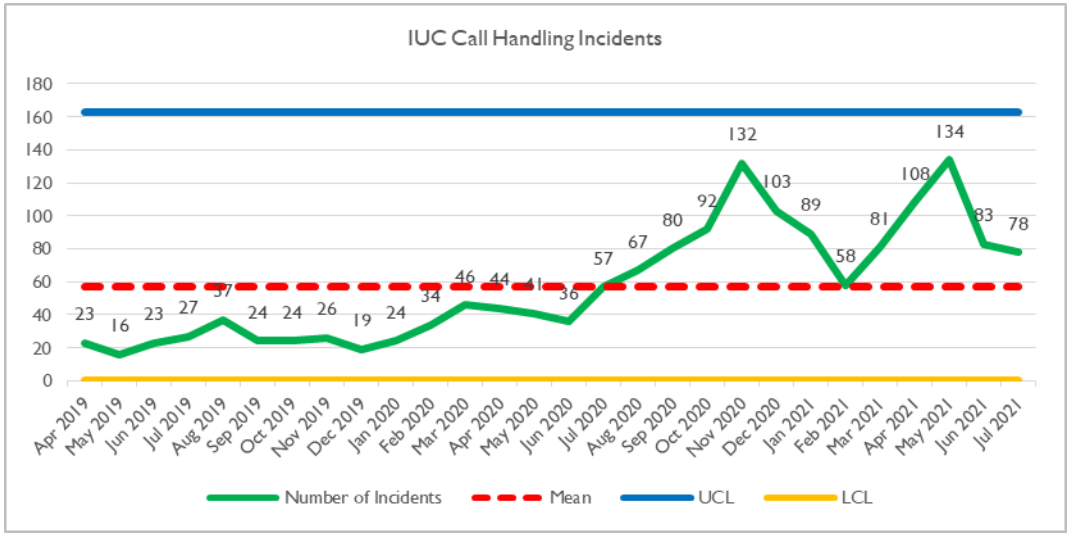
55% of incidents are in the Local Review stage and 45% in the Away for Review stage. 94% of incidents have been classified as No Harm.

Safe – IUC Incident Management

Incident trends and themes are monitored by the Trust's Safety Assurance and Learning Group to ensure improvement and actions are being taken to address recurrent incidents.

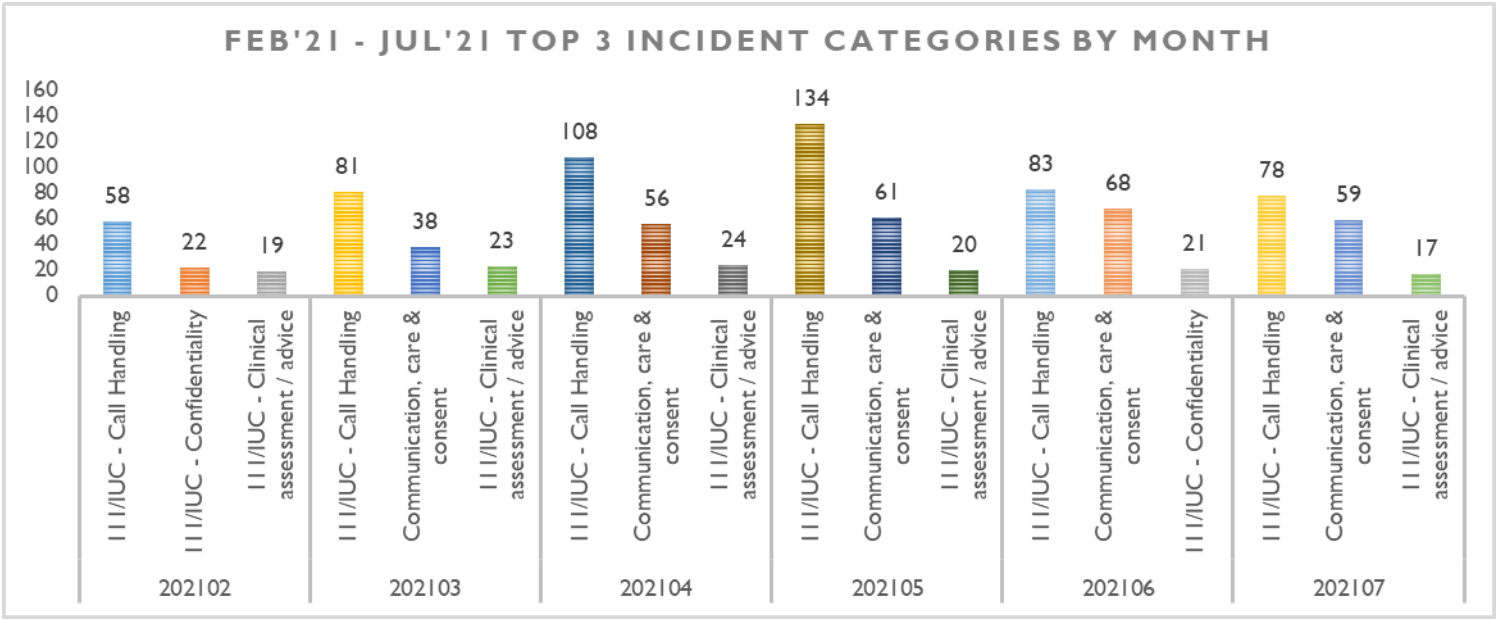
Owner: Helen Woolford | Exec Lead: Dr. John Martin





The top 3 Incident categories in July 2021 were Call Handling, Communication Care and Consent and Clinical Assessment and Advice.

The number of Communication, Care and Consent has been increasing, this is because incidents whereby an ambulance is sent without patient awareness (including lab contacts to request ambulances for patients based on blood results and times where the line has dropped out with clinical concern, etc.) will no longer be reported as an authorised breach of confidentiality. These will be reported on Datix under "Communication care and consent" --> "Communication failure with patient". It has been deemed that there are no patient confidentiality breaches as the information has not been sent to a third party and/or the ambulance has been sent in the patient's best interest. This includes when an ambulance is being sent for a patient via another ambulance service (e.g. NWAS).



Safe – Patient Safety Incident Response Framework (PSIRF)

London Ambulance Service NHS Trust

Owner: Helen Woolford | Exec Lead: Dr. John Martin

The Trust continues to test and develop the Framework to ensure it is correctly embedded within supporting processes and governance structures. All learning is fed back to NHS E/I to support the national development of the overall framework ahead of national roll out in 2022.

During July 2021, a total of **26** (including NHS 111) reported incidents were assessed under the Patient Safety Incident Response Framework (PSIRF) and the Trusts Patient Safety Incident Response Plan (PSIRP).

Of these 26, 18 were identified as requiring an enhanced level of investigation. The breakdown of the 28 are as follows:

National Priority – Patient Safety Incident Investigations (PSII)

1 incident met the Nationally - defined priority requiring an internal investigation where a death was clinically assessed as more likely than not being due to problems in care. This case had been first reviewed by the Trust's Learning from Death process.

Local Priority – Patient Safety Incident Investigations (PSII)

1 incident met the Trusts Patient Safety Incident Response Plan (PSRIP) under the Local Priority of *Face to Face Clinical Assessment* and is being investigated as a PSII.

1 incident met the Trusts PSIRP under the Local Priority of *Emergent Patient Safety Incident* and is being investigated as a PSII.

Patient Safety Review (Non PSII) including Thematic Review

1 incident met the Trusts PSIRP under the Local Priority of *clinical assessment of spinal injuries* and is being investigated as a PSR.

1 incident met the Trusts PSIRP under the Local Priority of *Face to Face Clinical Assessment* and is being investigated as a PSR.

1 incident met the Trusts PSIRP under the Local Priority of *Call Handling* and is being investigated as a PSR.

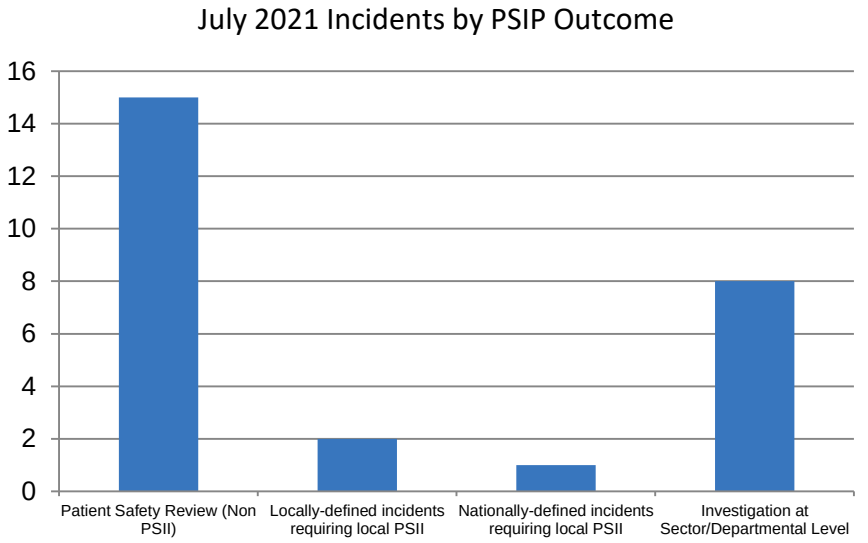
12 incidents did not meet the Trusts PSIRP and are are being investigated as a PSR via a structured Judgement Review. The incidents involve a delayed response with the possibility of harm caused as a result. The other two incidents are being investigated as PSRs.

Local Review

The remaining 8 incidents were referred to Sector/Department management teams to continue with a local investigation.

The following mitigating actions have taken place:

- Re distribution of the guidance relating to the dispatch of FRUs to 10D2 and 10D4 determinants.
- Themes from patient safety incident have been shared with managers via the Monthly Managers Incident and Learning meeting which is hosted by the Quality Improvement and Learning Team.



Implementation of PSIRF:

The Trust went live with the PSIRF on the 1st April 2021 and the focus is now on developing a set PSRIF process and governance structure that will be tried and tested.

The implementation has seen strengthen governance and assurance processes regarding investigation of incidents from the point of being reported, ensuring that those meeting the PSII criteria are escalated in a timely manner to the PSIP for confirmation. In terms of assurance, this has been further strengthen for those incidents re-categorised with clear rationales and clinical reviews recorded on the incident records.

Next Steps of the implementation:

- Continue to implement Framework and communicate across the service
- Engaged with the Trust's Patient and Public Council (PPC) to support the development of the desired patient standards as part of the PSIRF.
- Continue to attend monthly PSIRF webinars with early adopters to fed back and also learn from others.
- Looking at the QI element of the framework and beginning to take this forward.

Safe – Safety Investigation Actions

The number of safety investigation actions on the Trust's risk management system continue to be monitored centrally to ensure they are closed within their set timeframe.

Owner: Helen Woolford | Exec Lead: Dr. John Martin

There continues to be a focus on SI actions, at the end of July there were **191** open actions, of these **30** 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 sends 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 (SIALG) where escalations to departments are communicated, if required.

The ability of some actions owners to make progress on their actions has been impacted by the Trust Reap 4 level and action owners performing alternative roles.

There are 2 incidents which are oldest and highest in priority:

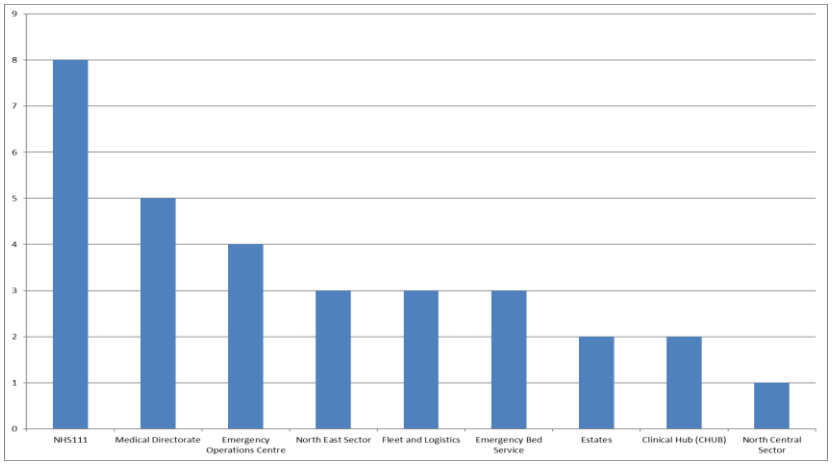
The Trust to review the discharge guidance for paramedics located in Appendix 3 of the Managing the Conveyance of Patients Policy and Procedure.

Update
The review has taken place and is awaiting assurance to be updated.

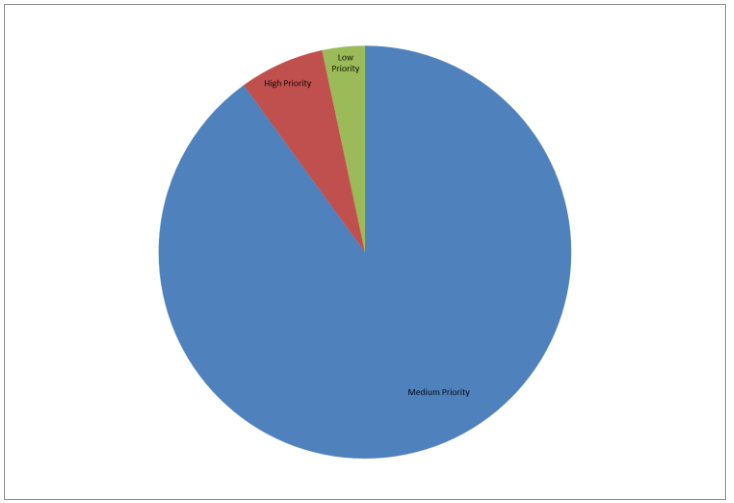
The Trust to Implement a process whereby appropriate internal stakeholders discuss clinical staffing in Integrated Urgent Care and identify areas of concern. Any remedial action required in extreme situations should be discussed and agreed to prevent the Clinical Assessment Service queue from reaching such escalation levels

Update
Recently appointed Deputy Director of 111/999 & Clinical Assessment Service as part of the IUC restructure will give greater assurance regarding capacity to review staffing levels. In the interim this is discussed on a weekly basis at the IUC clinical meeting with all relevant stakeholders engaged

Overdue actions by Sector / Department



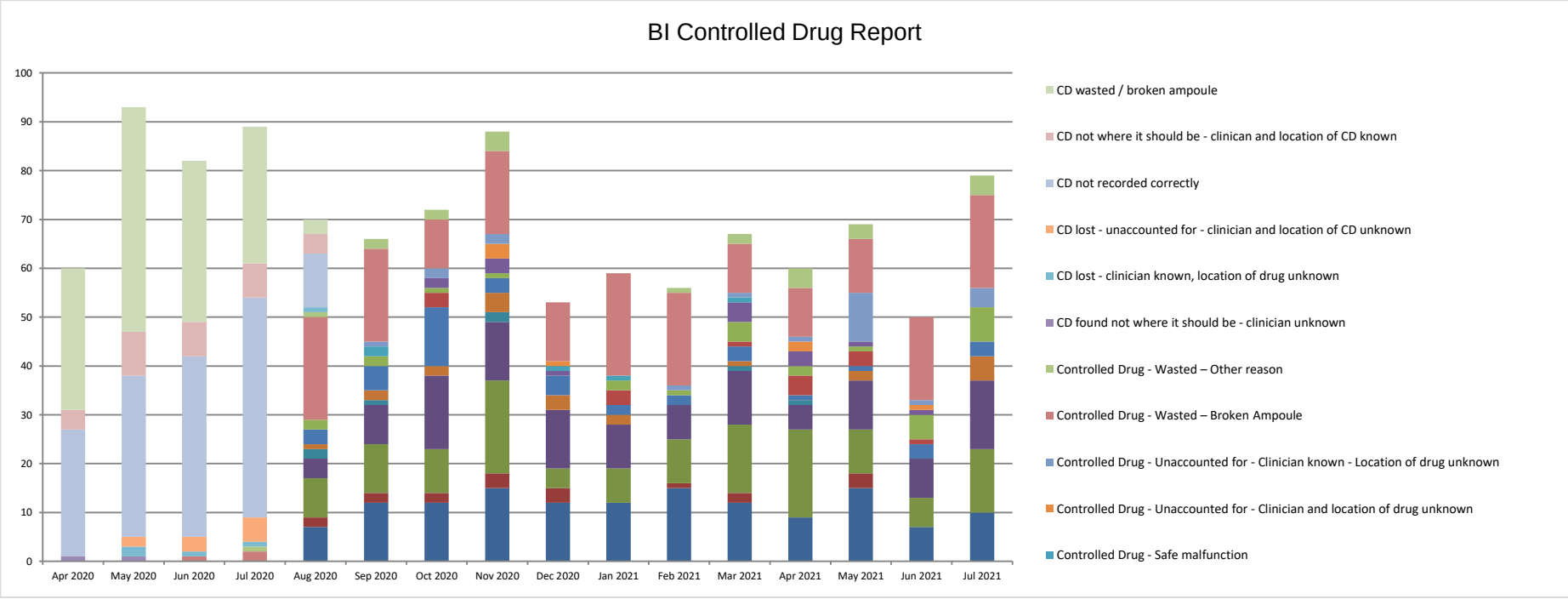
Overdue actions by priority of action



1. Safe - Medicine Management

London Ambulance Service NHS Trust

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



- No unaccounted for losses of schedule 2 controlled drugs
- Total of 82 other controlled drug (CD) incidents including
    - Documentation errors (n=44)
    - Morphine retained off-duty (n=8)
    - Morphine reaction (n=1)
    - Breakages, wastage or damage (n=29)
- Non-controlled drugs incidents
    - Kitprep discrepancy (n=10)
    - Breakages (n=5)
    - Drugs unsecured (n=2), supply issue (n=1) drugs not available (n=2) or temperature breach (n=1)
    - Drugs usage form discrepancy (n=1) or expired medication (n=1)
    - Allergic reaction to medicine (n=1) or administration error by non-LAS staff (n=3)
    - Inappropriate administration of diazepam (n=2), hydrocortisone (n=1), ipratropium (n=1), naloxone (n=1), Entonox (n=1), paracetamol (n=4) and TXA (n=1)

Assurance

- Incidents where morphine retained off duty identified in a timely fashion ensuring drugs returned and secured promptly.
- No further losses of Abloy key devices ensuring CD safe access and security not compromised

Actions

- Addition of further diazepam supplies to ensure further doses can be given at scene where required
- Costings for system modifications to enable paramedic prescribing complete
- Preparation of medicines packing unit continues

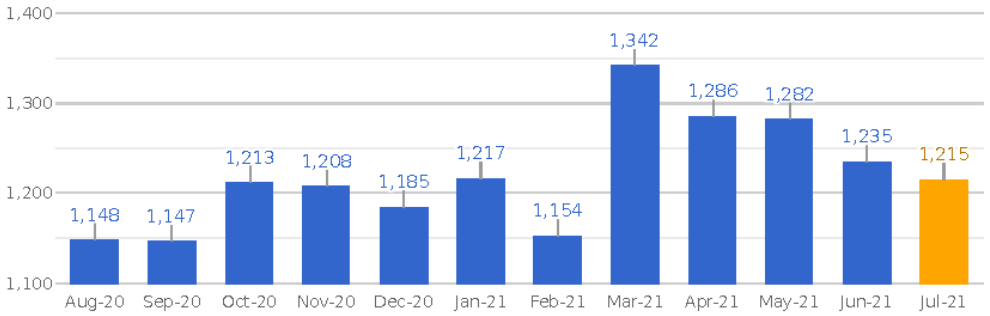
1. Safe - Medicine Management Audits

London Ambulance Service NHS Trust

Owner: Gavin Mooney | Exec Lead: Dr. Fenella Wrigley

This month we have carried out 1215 inspections across 49 areas – an average of 24.80 inspections per area.

Total monthly inspections (last 12 months)

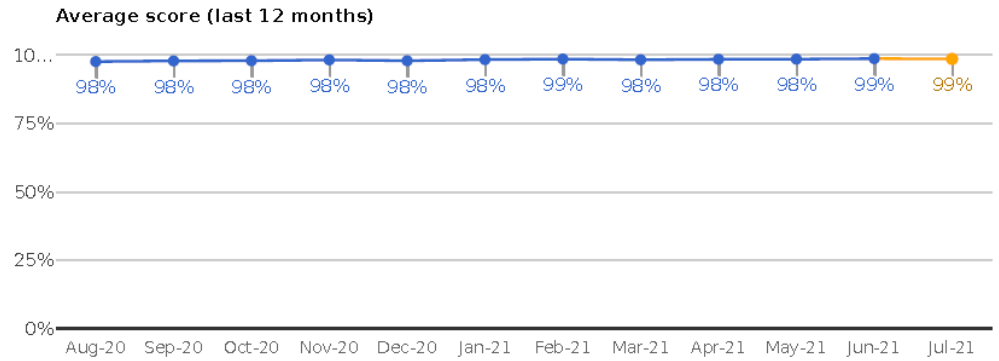


The inspection results are based on the numbers of inspections which take place only. Year on year comparison shows notable difference since station consolidation; inspection trends on the decline since increase of REAP and redeployment of CTM/IROs/APPs. Likely to remain steady in lieu of REAP4 currently. Average score improved by 1% compared last reporting period.

Action plans for lowest scoring stations / areas sit with respective SMT / QGAMs

The average score across the organisation this month was 99%.

Average score (last 12 months)



Highest Scoring Clinical Areas

Rank	Area	Score this month	Score last 12
1	Heathrow Airport	100% (12)	100% (139)
2	APP Westminster	100% (5)	99% (43)
3	North Kensington	100% (12)	98% (193)
4	Forest Hill	100% (31)	99% (338)
5	APP Croydon	100% (2)	100% (24)

Lowest Scoring Clinical Areas

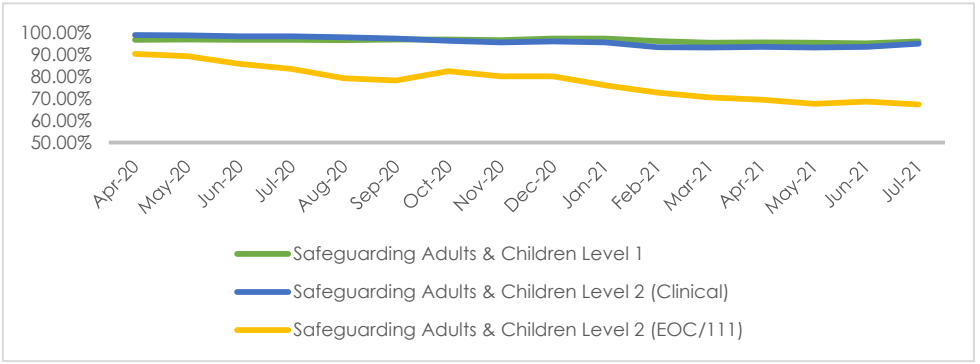
Rank	Area	Score this month	Score last 12
45	Fulham	97% (12)	97% (158)
46	Islington	97% (26)	99% (334)
47	Greenwich	97% (31)	97% (365)
48	APP Ilford	96% (3)	99% (33)
49	Deptford	95% (26)	95% (318)

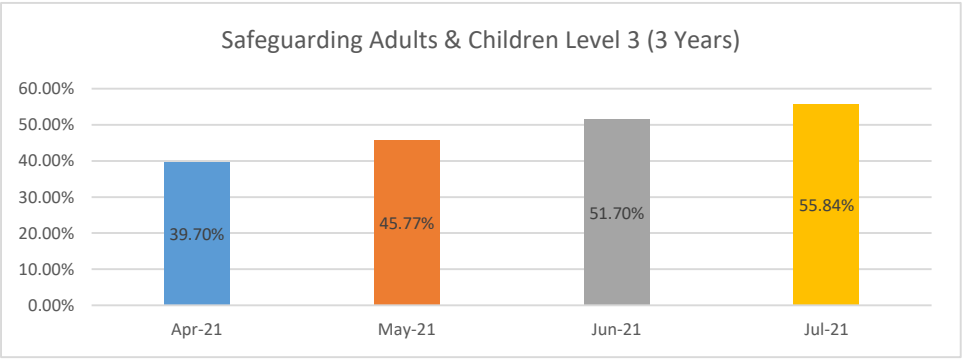
Numbers in brackets show number of inspections score is calculated from.

1. Safe -Safeguarding

Owner: Alan Taylor | Exec Lead: Dr. John Martin

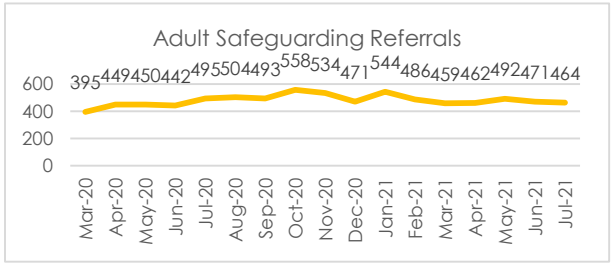
Delivery of Training

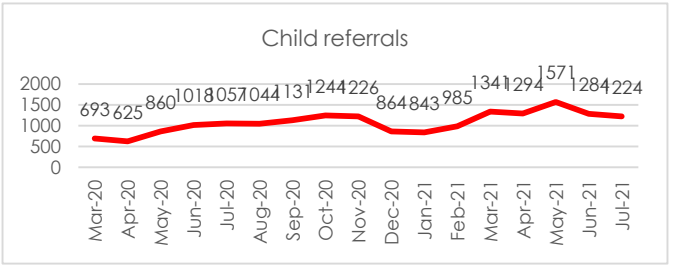


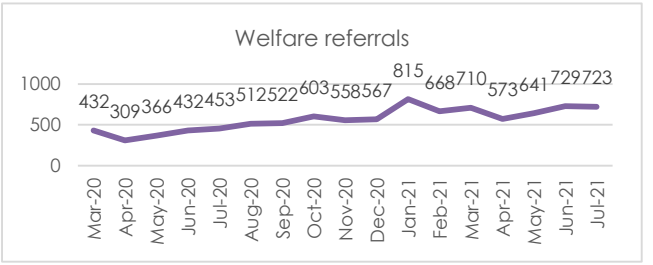


Safeguarding Level 3 training has restarted following the COVID19 break with a steady take up by staff which is monitored by the safeguarding team. The safeguarding Level 2 (EOC/111) has been decreasing over the past few months, this is because IUC have not established CSR hours for their staff. Conversations have been had with IUC management who are working to get people on courses.

Referrals





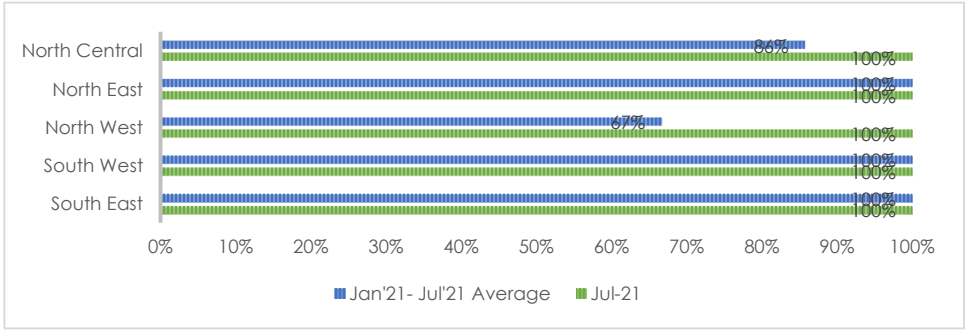


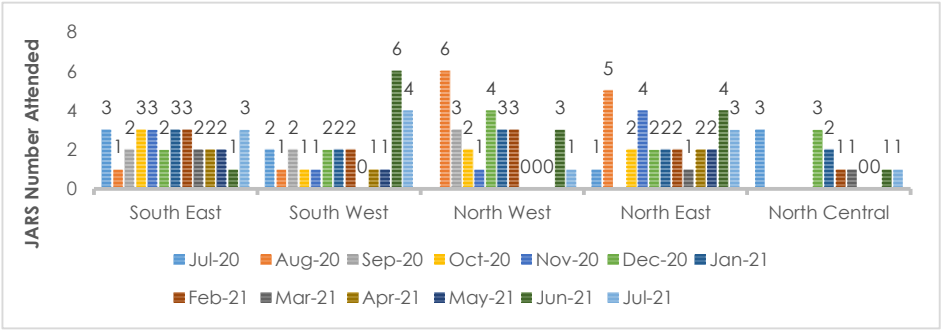
Adult safeguarding referral remain within normal range

Child referrals are increasing and remain high

Welfare concerns are within normal reporting numbers.

Joint Agency Response Service





The Joint Agency response meetings are now managed directly by the Safeguarding Team. These are now virtual and as a result we have so far been able to attend 100% of these Multi agency meetings a majority of the time.

1. Safe – Safeguarding DBS Checks

London Ambulance Service NHS Trust

Owner: Alan Taylor | Exec Lead: Dr. John Martin

DBS Checks Assurance Template - As at 31st July 2021								
	Total number requiring DBS checks	Total number of recorded DBS checks	Percentage	Starters	DBS Rechecking - Non compliant	May 2021 position	Change from previous month	Comment
Ambulance Services	4129	4120	99.8%	9	21	25	-4	- We have had confirmation from HR teams that they have contacted all those who have a DBS check which is older than 3 years to complete the DBS process and check IDs - bank staff will not be booked for shifts without a DBS check - there are 27 Emergency Responders out of the 43 required checks for non-clinical teams
Integrated Patient Care	1284	1278	99.5%	6	2	7	-5	
Non-Clinical (Corporate Teams) (inc. ERs)	408	365	89.5%	43	1	1	0	
Ambulance Services (Bank)	395	393	99.5%	2				
Total	**6216**	**6156**	**99.0%**	**60**	**24**	**33**	**-9**	

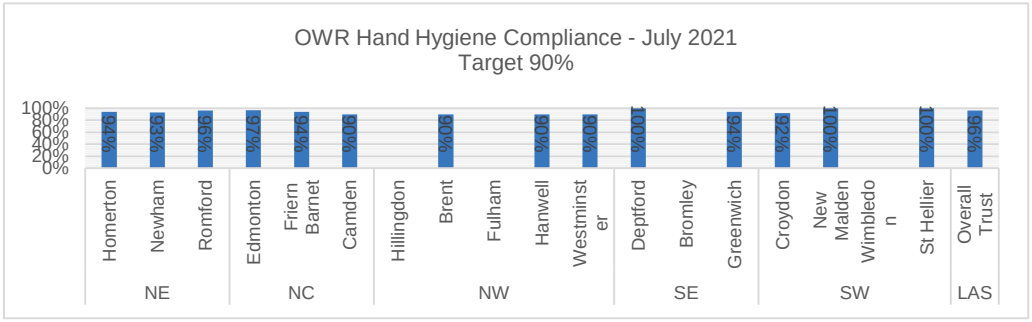
Non-Clinical

308 C&E Communications & Engagement L4
308 CHX Chief Executive L4
308 COO Chief Operating Officer Management L4
308 ITS IT & Technical Services L4
308 P&P Programmes & Projects L4
308 PER Performance L4
308 SAP Strategic Assets & Property L4
308 CORP Corporate Governance L4
308 FIN Finance L4
308 MED Medical L4
308 NED Chairman & Non Executive L4
308 P&C People & Culture L4
308 Q&A Quality & Assurance L4
308 S&T Strategy & Transformation L4

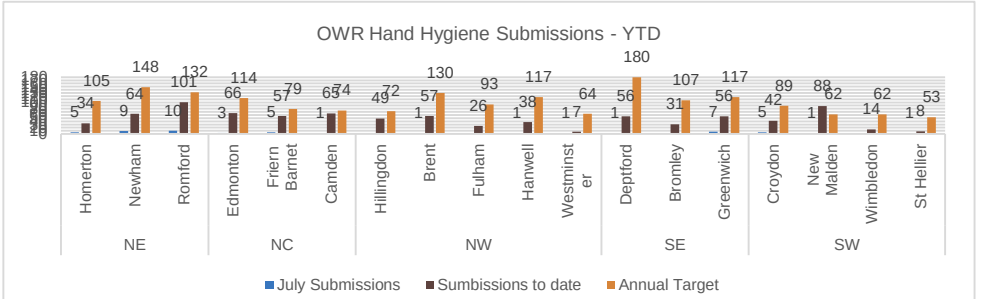
1. Safe - Infection Prevention and Control

London Ambulance Service NHS Trust

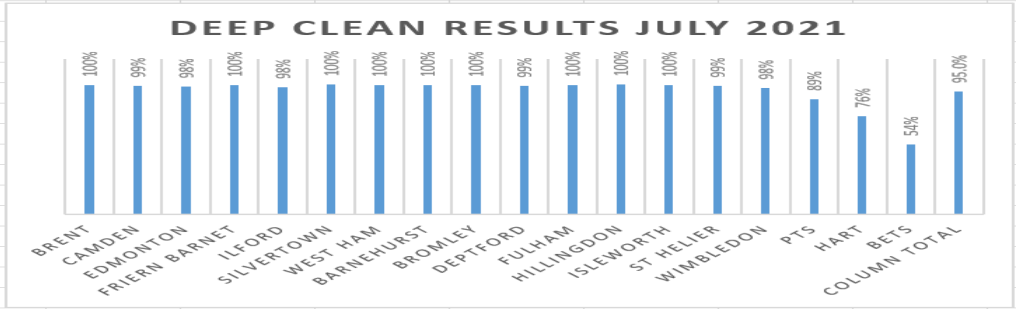
Owner: Claire Brown | Exec Lead: Dr. Fenella Wrigley



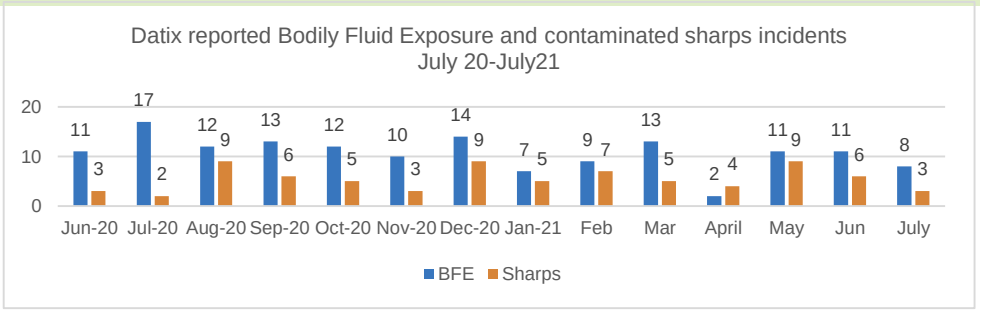
Overall the Trust OWR hand hygiene compliance for July 2021 is 96%.
Compliance exceeds the expected Trust target of 90% for the group station that submitted data
Actions: Reinforcing the importance of compliant Hand Hygiene practice has been communicated as part of the IPC programme of work
Hand Hygiene audits as part of the OWR process were reviewed as part of the COVID-19 secure process. An adapted measure was implemented for audits to take place at A&Es.



14/18 group stations submitted OWR data for July 2021. Overall submissions totalled 51 during July, this decrease is expected as the quarterly targets have been met. Following an in-depth review of last years audit programme and presentation of these findings to IPCC, COG & QAC, the OWR hand hygiene element submission targets were lowered to 55% of staff count per station as of April 21.
Actions: Highlighted at IPCC and QOG the importance of continued audit for preparedness and prevention.
Review of auditing targets and future proposal for presenting at QOG – Accepted April 2021



Trust compliance for July is reported at 95%, meeting the Trust target of 95%. In response to COVID-19, 6 vehicle decontamination hubs were organised at: Brent – NW Sector, Isleworth – NW Sector, Bromley – SE Sector, St Helier – SW Sector, Ilford – NE Sector & Silvertown – NE Sector - was the hub where the Nightingale vehicles were cleaned.



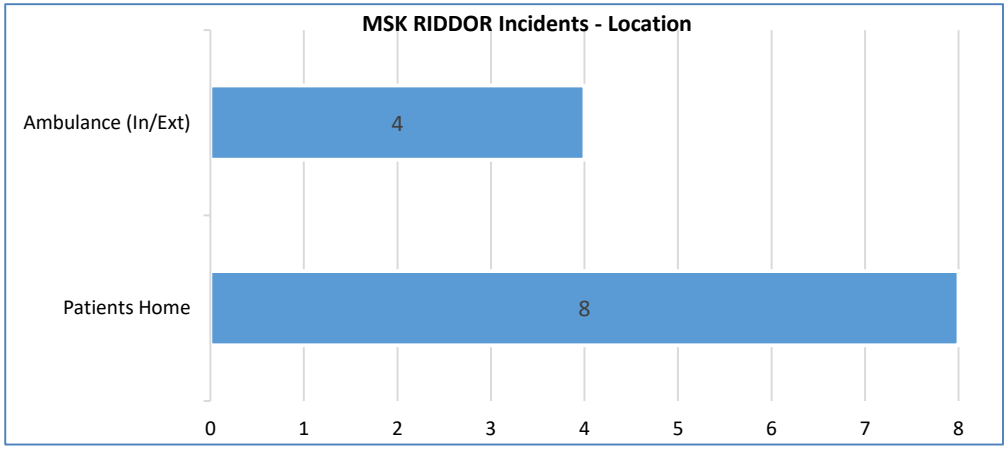
A total of 11 incidents were reported via Datix for contaminated sharps injuries and exposure to BFE in July 2021.
- 4/8 BFE incidents reported this month were as a result of true exposure to body fluids (BFE)
- All 3 incidents reported this month were as a result of true contaminated sharps injuries

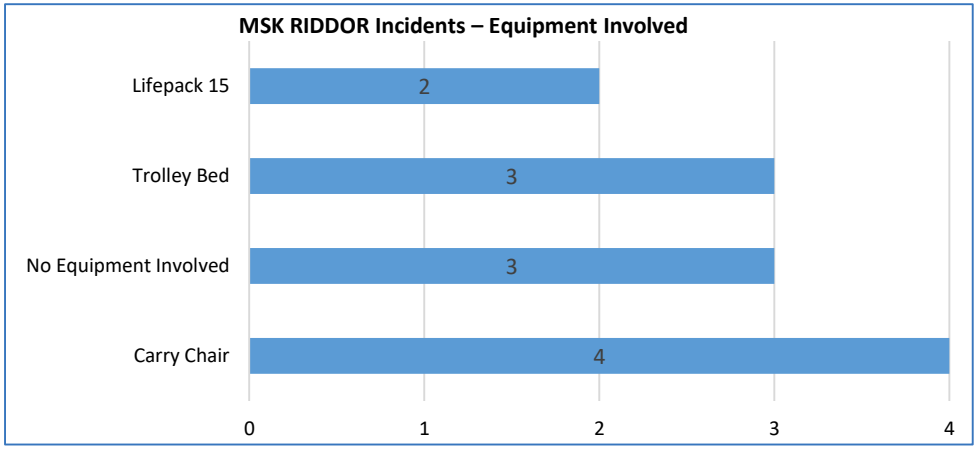
15/ 18 Group Stations and 1 IUC Services submitted data for analysis in July 2021.Overall Trust compliance for July is 96%. This score continues to exceed the Trust performance target of 90%. In response to the COVID-19 situation, some Ambulance station premises have been temporarily closed to consolidate resources and therefore not all group stations were occupied. In those instances cleaning audits were not carried out. Stations that failed to achieve the required performance target of 90% have been escalated to the facilities manager , who has been asked to establish why this has happened and what remedial actions have been put in place by the contractor, Lakethorne. Westminster has not submitted data since May, this has been escalated to the facilities manager **Actions: Scores below 90% escalated to facilities manager**

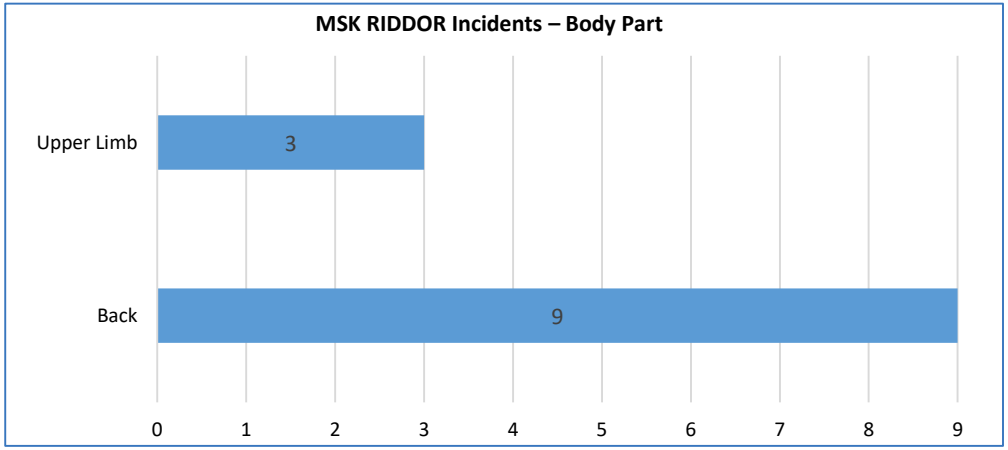
1. Safe – Health and Safety

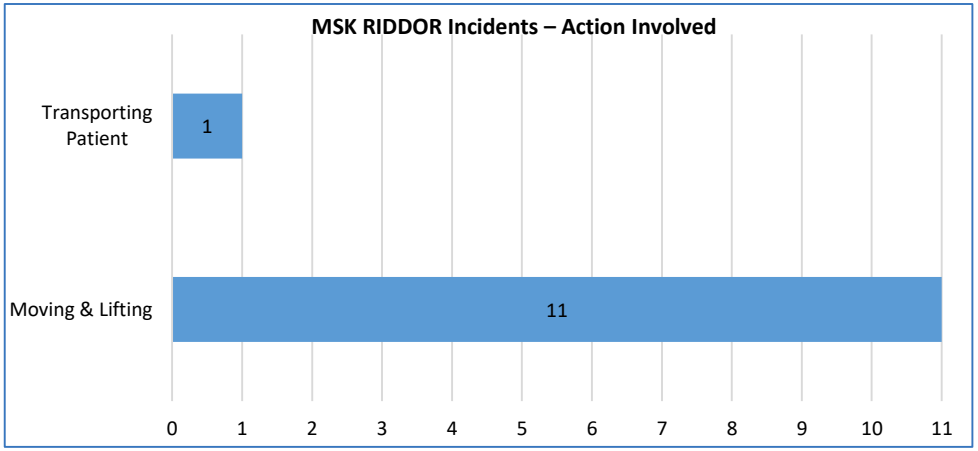
Owner: Edmund Jacobs | Exec Lead: Diane Scott

Reported RIDDORs related to Manual Handling (MSK) Incidents (Thematic Analysis) – July 2021





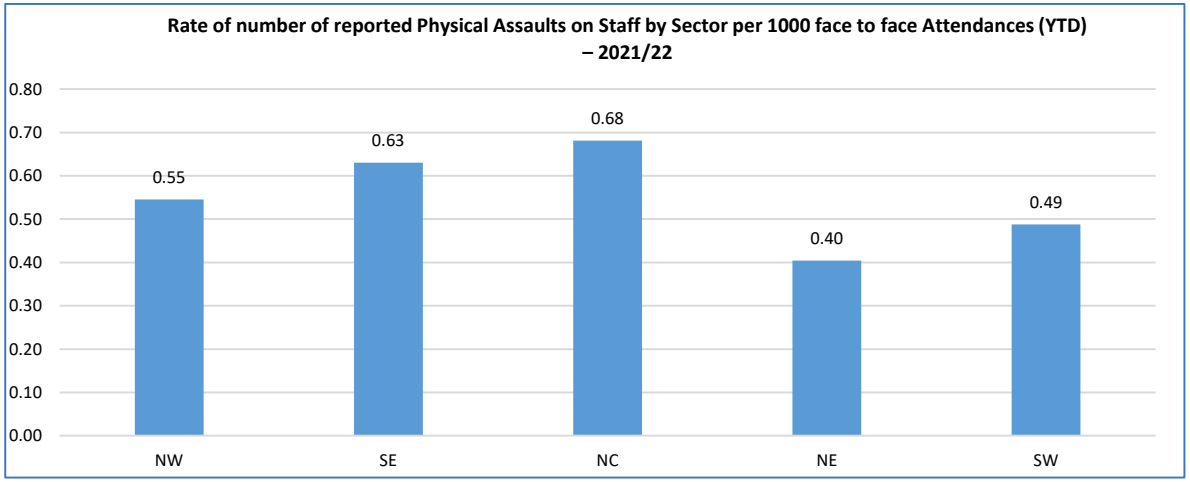




The above graphs provide details from the thematic analysis of 9 reported RIDDOR incidents in July'21 (1 incident was occurred in February'21, 6 incidents were occurred in June'21 & 5 incidents were occurred in July'21). These relate to Manual Handling (MSK):

1. 8 reported RIDDOR incidents occurred in Patients Home (n=8), 4 incidents occurred in Ambulance In/Ext (n=4).
2. 4 reported RIDDOR incidents involved Carry Chair (n=4), 3 incidents involved Trolley Bed (n=3), 2 incidents involved Life Pack 15(n=2), and 3 other incidents involved no equipment (n=3).
3. 9 reported RIDDOR incidents resulted in Back injury (n=9) and 3 incidents were resulted in Upper Limb injury (n=3).
4. 11 reported RIDDOR incidents occurred during Moving & Handling (n=11) and 1 incident was occurred Transporting Patient on the Ambulance (n=1).

1. Safe – Health and Safety



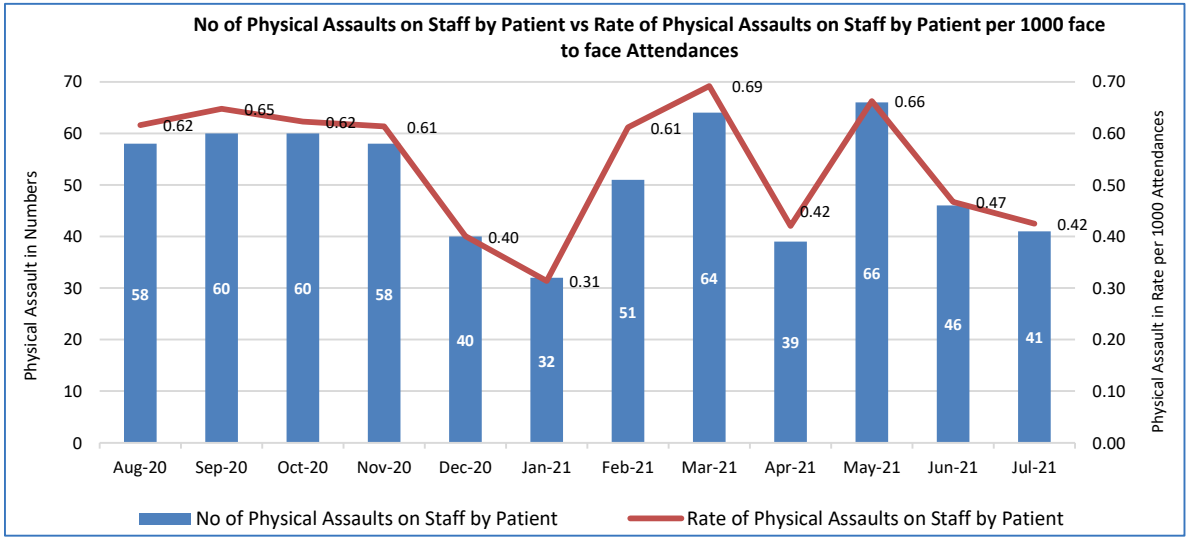
Sector	Rate of Physical Assaults on Staff
NW	0.55
SE	0.63
NC	0.68
NE	0.40
SW	0.49

Notes:

- **The graph and dashboard (left side) provides the Rate of reported Physical Assault on Staff by Sector per 1000 face to face Attendances.**
- **According to the number of reported incidents: In all 5 sectors, approximately one physical assault incident occurred per every 2000 face to face attendances.**

Key Update:

- **3 RIDDOR reportable Violence & Aggression related incidents were recorded during 2021/22 (up to end July'21) .**



Month	No of Physical Assault on Staff by Patient	Rate of Physical Assault on Staff by Patient
Aug-20	58	0.62
Sep-20	60	0.65
Oct-20	60	0.62
Nov-20	58	0.61
Dec-20	40	0.40
Jan-21	32	0.31
Feb-21	51	0.61
Mar-21	64	0.69
Apr-21	39	0.42
May-21	66	0.66
June-21	46	0.47
July-21	41	0.42

Notes:

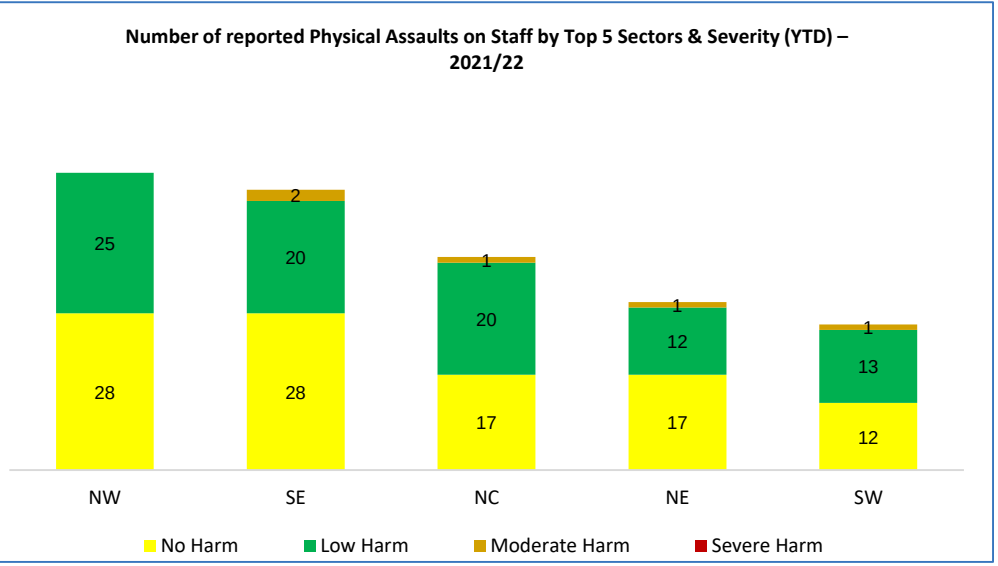
- **The graph and dash board (above) provides the Number of reported Physical Assault on Staff by Patient & the Rate of reported Physical Assault on Staff by Patient per 1000 face to face Attendances over the last 12 months (August'20 to July'21).**

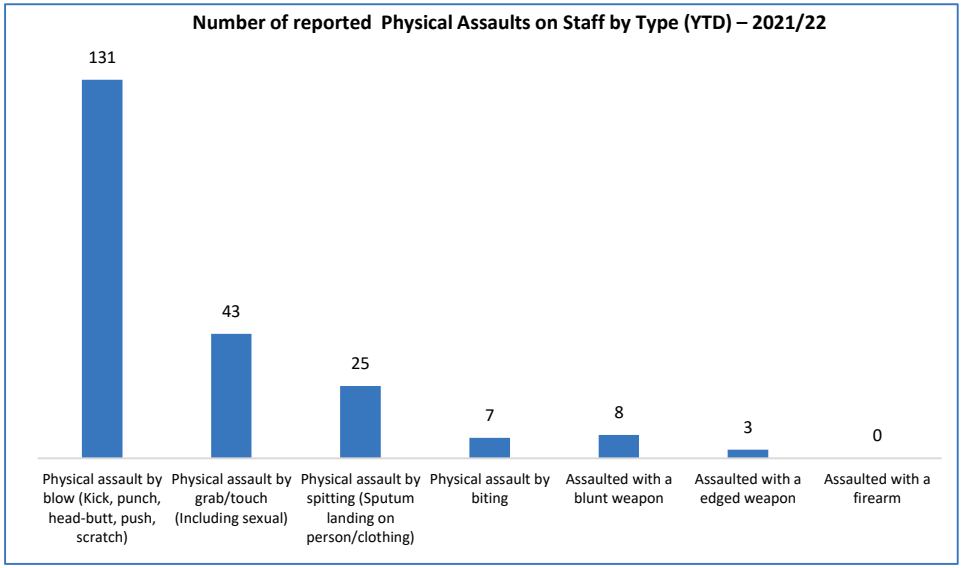
NHS definitions of assault:
Physical assault – *"the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort"* (NHS Protect / NHS Employers).

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 July result from such things including the effects of prescribed medication, mental health issues, and post-ictal state.

1. Safe – Health and Safety



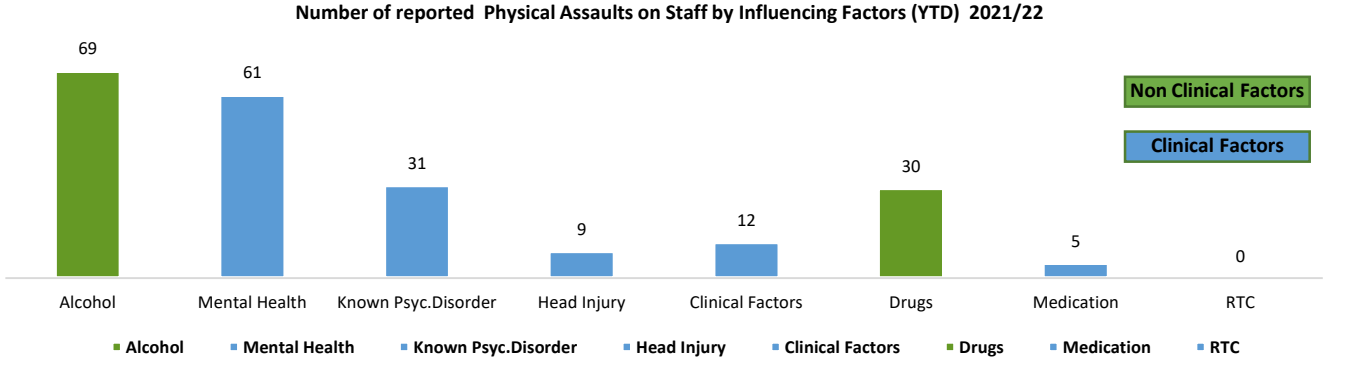


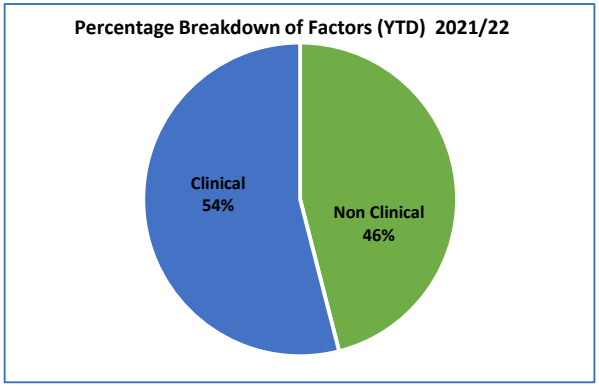
Notes:

- **A total of 217 Physical Assaults on Staff were reported during 2021/22 (up to end July'21).**
- **114 (53%) of the incidents were reported as 'No Harm/Near Miss incidents, whilst 103 incidents resulted in Harm. 98 (45%) of the harm related incidents were reported as 'Low Harm and 5 (2%) incidents were resulted in Moderate Harm.**
- **22 out of the 217 Physical Assaults on Staff were caused by others (ex: family member of the patient / by standers etc.).**

Notes:

- **Physical Assault – by blows, kicks/ assault to staff (60% , n=131) accounted for the highest number of incidents reported during 2021/22 (up to end July'21).**





Notes:

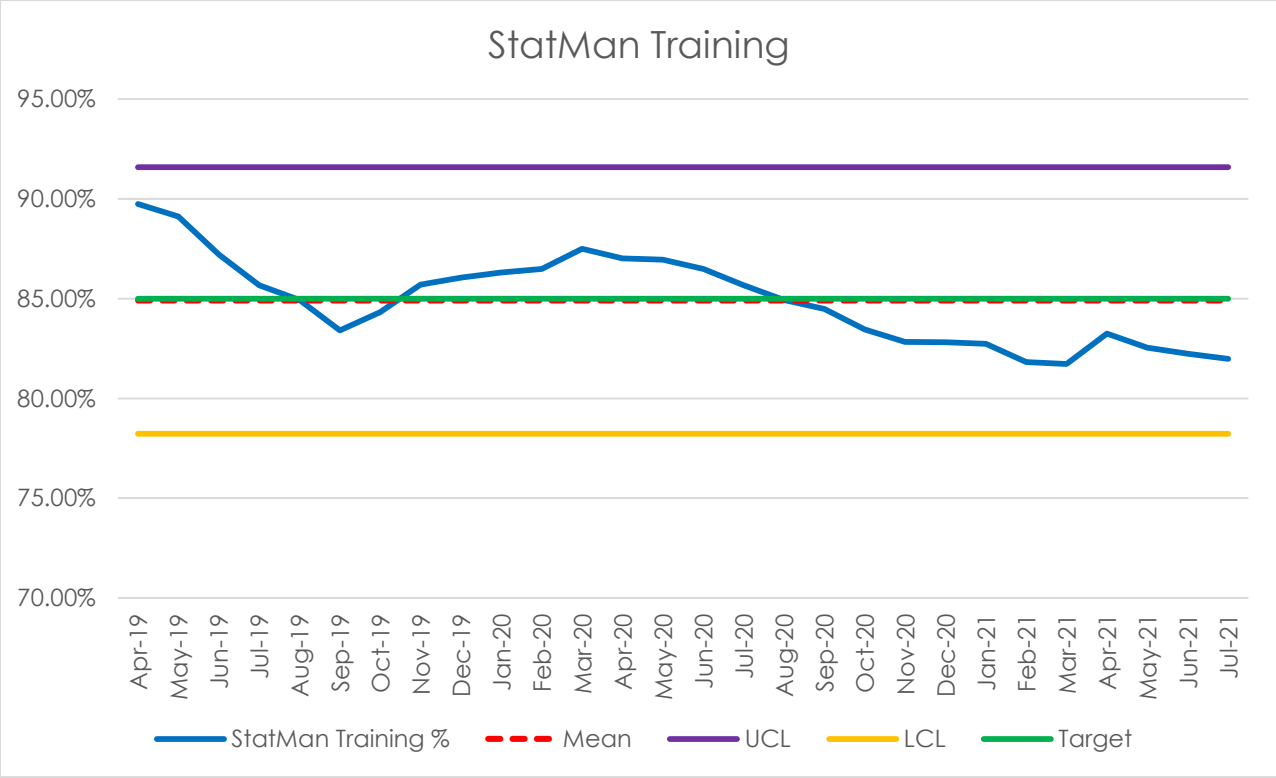
- **Clinical Factor: 118 (54%) of the incidents occurred due to Clinical Factors, such as Mental Health (n=61), Known Psyc.Disorder (n=31), Head Injury (n=9), Clinical Factors (n=12), Medication (n=5).**
- **Non Clinical Factor: 99 (46%) of the incidents occurred due to Non Clinical Factors, such as Alcohol (n=69), and Drug (n=30).**

1. Safe - Statutory & Mandatory Training

London Ambulance Service NHS Trust

Owner: Chris Randall | Exec Lead: Damian McGuinness

Stat & Man Training



In July, both statutory and mandatory training and PDR compliance has been affected by the REAP 4 level. PDRs are stood down at this extreme level of pressure.

Statutory and mandatory training – as at 31st July we are currently tracking below our 85% target at 82%.

Actions:
Regular reports are sent to mangers and individuals highlighting those who have any expired training as well as those who are due to expire in the coming three month period.

Type	Jul-21
Display Screen Equipment (3 Years)	84.38%
Duty of Candour (3 Years)	94.52%
EPRR Incident Response (Clinical) (1 Year)	40.26%
EPRR Incident Response (EOC) (1 Year)	70.52%
EPRR JESIP Awareness E-Learning (1 Year)	86.20%
EPRR JESIP Commander Classroom (3 Years)	54.90%
EPRR LAS Operational Commander Foundation (3 Years)	52.84%
EPRR LAS Tactical Commander Foundation Course (3 Years)	71.43%
EPRR Tactical Commanders (Old Course) (3 Years)	0.00%
Equality, Diversity & Human Rights (3 Years)	90.41%
Fire Safety (2 Years)	93.24%
Fraud Awareness (No Renewal)	83.23%
Health & Safety Trust Board (1 Year)	66.67%
Health, Safety & Welfare (3 Years)	92.73%
Infection Prevention & Control Level 1 (3 Years)	95.25%
Infection Prevention & Control Level 2 (1 Year)	91.50%
Information Governance (1 Year)	92.56%
Medicines Management (1 Year)	90.99%
Medicines Management (NETS) (1 Year)	0.00%
Mental Capacity Act Level 1 (3 Years)	93.30%
Moving & Handling Level 1 (3 Years)	92.88%
Moving & Handling Level 2 (Load Handling) (3 Years)	69.81%
Moving & Handling Level 2 (People Handling) (1 Year)	65.45%
NHS Conflict Resolution (3 Years)	88.60%
Prevent Level 1 (3 Years)	83.26%
Prevent Level 2 (3 Years)	35.99%
Resuscitation Level 1 (1 Year)	77.00%
Resuscitation Level 2 Adults (1 Year)	84.62%
Resuscitation Level 2 Paediatrics (1 Year)	84.62%
Resuscitation Level 3 Adults (1 Year)	68.86%
Resuscitation Level 3 Newborn (1 Year)	68.83%
Resuscitation Level 3 Paediatrics (1 Year)	68.86%
Safeguarding Adults & Children Level 1 (3 Years)	96.06%
Safeguarding Adults & Children Level 2 (Clinical) (3 Years)	95.11%
Safeguarding Adults & Children Level 2 (EOC/111) (3 Years)	67.38%
Safeguarding Adults & Children Level 3 (3 Years)	55.85%
Safeguarding Trust Board (3 Years)	28.57%

1. Safe - Outcome of Quality Visits (Environmental & Equipment)

London Ambulance Service NHS Trust

Owner: Jeni Mwebaze | Exec Lead: Dr John Martin

3 Key Priority Areas Trust-wide:

- **Infection Control** - *CQC standards / In-direct impact on patient care / Impact on staff safety and wellbeing*
- **Security** – *Linked to an area on the risk register / CQC standards / In-direct impact on patient care / Impact on staff safety and wellbeing*
- **Noticeboards/Communications** – *CQC standards / Impact on staff safety and wellbeing / Aligned to Trust Quality Strategy*

Key:
Red = Achieving below 85% compliance
Amber = Achieving between 85% - 90% compliance
Target = 90% compliance
Variation = Q1 score compared to Q3 (20/21) score. No Quality Visits were conducted in Q4 due to REAP 4 and national lockdown.

IPC	Dirty linen is segregated correctly & in appropriate bags	66.67%	-30.33%
	There is evidence that frequent touch points are cleaned repeatedly throughout the day	76.47%	-13.77%
	There is no unwrapped communal food available (on display)	83.02%	-1.60%
	Buckets are hanging upside down and air drying?	84.00%	10.23%
	There is non-clinical waste in the clinical waste bin	77.27%	-11.25%
	Staff members are adhering to Coronavirus PPE guidance	88.24%	-3.06%

IPC actions to support during REAP 4:
- Quality Support Officers to ensure dirty linen poster is displayed
- QGAMs to highlight IPC concerns during Sector Quality Meetings
- IPC Team to communicate key concerns/expectations through RIB
- IPC Team to communicate key concerns/expectations with IPC Link Practitioners
- Local Teams to share key concerns/expectations via their Facebook groups
- Facilities Team to communicate concerns re: buckets to Contractors (SW & NE Sectors)
- Quality Compliance Manager to conduct spot Quality Visits

Secuirty	There is access control to enter through the station site perimeter	76.32%	-19.83%
	LAS marked vehicles inside the perimeter/garage are locked	78.79%	8.79%
	All LAS marked vehicles parked outside the site perimeter are locked	83.33%	-3.63%

Security actions to support during REAP 4:
- QGAMs to highlight security concerns during Sector Quality Meetings
- H&S Team to communicate key concerns/expectations through RIB
- Local Teams to share key concerns/expectations via their Facebook groups
- Quality Compliance Manager to conduct spot Quality Visits
- H&S Team to re-instate “Mystery Shopper” visits to compliment Quality Visit findings

Noticeboards	Information is displayed about the outcome of the latest staff survey	27.03%	-17.97%
	Local risks are displayed	50.00%	2.00%
	The freedom to speak up poster is visible	67.92%	6.92%
	The current version of COVID-19 Top Tips for infection control advice is displayed	73.58%	-17.46%
	Maximum occupancy signs are displayed for all rooms and adhered to	75.47%	-3.63%
	The Fire Marshall is named and displayed	75.47%	2.45%
	There is information on who the local team are	76.00%	26.00%
	The contractor cleaning audit results are displayed for the previous month	81.13%	-6.56%
	"Staying Covid -19 secure in 2020" is displayed	81.13%	-9.91%
	Notice boards are clear/tidy and displaying up to date/relevant information.	86.27%	1.65%

Noticeboard/Communications actions to support during REAP 4:
- Quality Compliance Manager to amend audit to reflect remedial action taken
- Quality Compliance Manager to create noticeboard “pack”
- Quality Support Officers to review noticeboards at each site starting Sept ’21

2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Clinical Ambulance Quality Indicators
- NICE and JRCALC Guidance Updates
- Clinical Audit Performance
- Handover to Green
- PDR & MCA Training

Outstanding Characteristic: *Outcomes for people who use services are consistently better than expected when compared with other similar services.*

Owner: Jaqualine Lindridge Exec Lead: Dr. Fenella Wrigley

National Institute for Health and Care Excellence (NICE) Guidance: Update Report - August 2021

May 2021

- The 'Clinical guide for the management of emergency department patients during the coronavirus pandemic' and 'Reference guide for emergency medicine' were both updated and merged to create a single document. On review by Consultant Paramedic, there were no changes requiring any local actions. The guidance continues to be consistent with LAS Patient Facing Guidance for patients presenting with COVID-19.
- Guidance on the management of patients with a learning disability, autism or both has been updated, which was review by the Trust LD Lead. Following this review, the opportunity to improve the LAS Patient Facing Guidance for patients presenting with COVID-19 was identified, and an update prepared.
- Clinical Guideline 137, Epilepsies: diagnosis and managements has been reviewed, with no actions arising for Ambulance Services, a review is pending to identify if any actions are required for Integrated Patient Care Services.

June 2021

- The Shared decision making guideline (NG197) makes a number of recommendations on shared decision-making which are likely to be relevant to both Ambulance Services and Integrated Patient Care. Currently being reviewed by Consultant Paramedics to determine the actions required.
- NICE recommend that azithromycin is not used to treat COVID-19, either in the community or in-hospital setting (NG191). This information has been cascaded to the Medicines Management Committee, Integrated Patient Care Clinical Leadership, and Ambulance Services prescribing clinicians.
- NICE have added new recommendations in section 1.7 of the Autism spectrum disorder in under 19s clinical guideline (CG170) to highlight the need for assessment and referral for children and young people with feeding problems and restricted diets. The guidance has been reviewed by the Trust LD lead, and a clinical update article to raise awareness of this issue is being prepared.

July 2021

- The NHS Sheffield CCG summary of NICE guidance for July 2021 is the process of being reviewed.

2. Effective - Clinical Ambulance Quality Indicators

London Ambulance Service NHS Trust

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

Measures	Target / Range	RAG	YTD 20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Movement	Trend	Business Plan	Schedule 4 LQ Ref.	Quality Account	Data Quality
ROSC at Hospital (AQI)	31%	G	26%	24%	35%					↔			LQ1a		
ROSC at Hospital UTSTEIN (AQI)	55%	R	51%	50%	52%					↔			LQ1b		
STEMI Care Bundle (AQI) (Reported every 4 months)	74%		77%	-	-					↔			LQ2c		
Stroke Care Bundle (AQI) (Reported every 4 months)	98%		98%	-	-					↔			LQ3b		
Stroke on scene duration (CARU continual audit)	00:30	G	34	31	33					↔					
Survival to Discharge (AQI)			4%	0%	0%					↔					
Survival to Discharge UTSTEIN (AQI)			16%	0%	0%					↔					
STEMI On scene duration (CARU continual audit)			39	37	39					↓					
Call to Angiography - Mean (hh:mm)	02:10		02:09	02:01	02:00										
Stroke - Call to Arrival at Hospital - Mean (hh:mm)	01:10		01:10	01:09	01:08										
CPI - Completion Rate (% of CPI audits undertaken)	95%	R	-	96%	95%	93%	96%	84%		↓		✓	LQ12	✓	
CPI - Percentage of Staff receiving two feedback sessions YTD			-	17%	21%	0%	0%	0%		↔			LQ12		
Documented Care - Cardiac Arrest Compliance (CPI audit)	95%	G	-	98%	98%	98%	98%	99%		↑		✓	LQ12		
Documented Care - Discharged at Scene Compliance (CPI audit)	95%	G	-	94%	93%	92%	95%	96%		↑		✓	LQ12		
Documented Care - Mental Health Compliance (CPI audit)	95%	G	-	94%	-	94%	-	95%		↓		✓	LQ12		
Documented Care - Severe Sepsis Compliance (CPI audit)	95%	G	-	95%	96%	97%	96%	97%		↑		✓	LQ12		
Documented Care - Difficulty In Breathing Compliance (CPI audit)	95%	G	-	97%	-	96%	-	96%		↔		✓	LQ12		
Documented Care - Elderly Falls Compliance (CPI audit)	95%	R	-	93%	93%	94%	94%	94%		↔					

Clinical AQIs

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

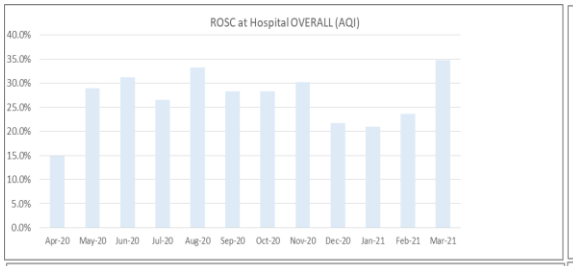
AQI: Narrative

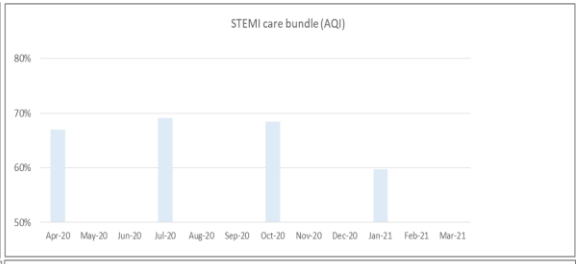
Cardiac Arrest:
In March 2021, the LAS was the best performing trust in three out of four AQI metrics: ROSC to hospital (overall; 34.7%), 30 day survival (overall; 12.7%) and 30 day survival (Utstein; 41.9%). LAS placed 3rd for ROSC to hospital in the Utstein group at 52.2%, well above the national average of 46.9%. This is a significant improvement on February 2021 where LAS ranked 10th for overall survival and 9th for Utstein survival.

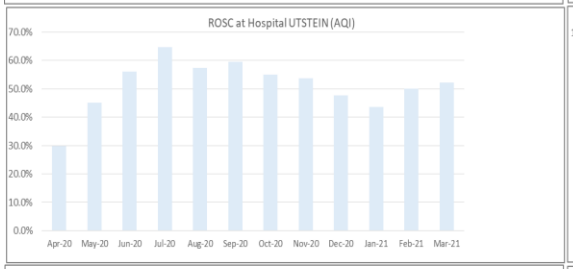
Stroke:
The LAS ranked 1st for the mean call to hospital for suspected stroke patients (01:08) in March 2021, well above the national average of 01:22. This position is maintained from February 2021 when the LAS ranked 1st in England (with a mean call to hospital time of 01:09).

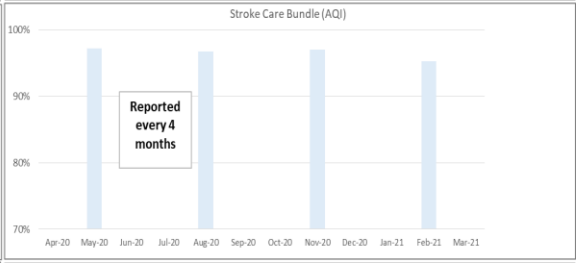
STEMI:
In March 2021, the LAS achieved an average call to balloon time of 02:00, 16 minutes shorter than the national average. This result ranked the LAS 1st nationally for the second month running. Year to date rankings continue to place LAS in 3rd overall, with an average time of 02:13 (4 minutes shorter than the national average, and 17 minutes below than the national target of 02:30).

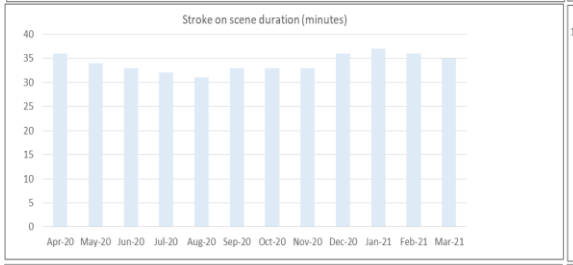
Sepsis:
Despite a fall of 3.1% since December 2020 when it was last reported, in March 2021 LAS were once again the top performing trust for the Sepsis Care Bundle nationally with 90.9% compliance. Whilst we are consistently the top performing trust in this area, this is the lowest figure we have reported since June 2019 (89.9%).

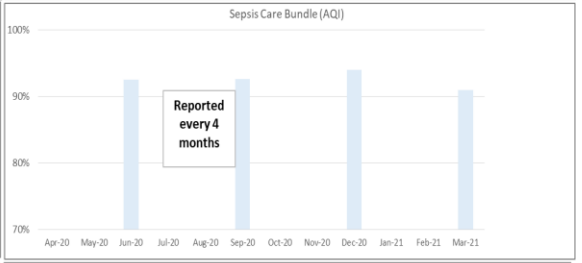


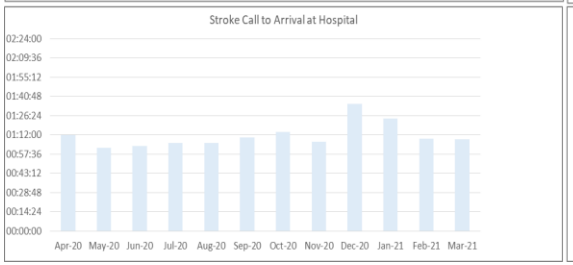


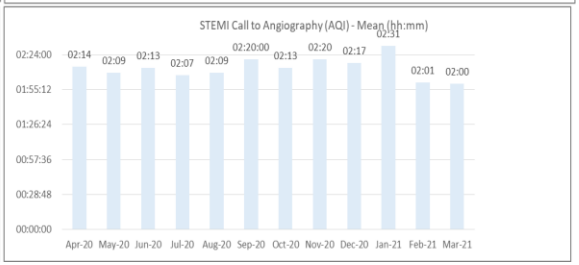












Clinical Audit Performance & Research Update

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

Clinical Audit Update

Notting Hill Carnival Clinical Audit:
As a result of our recently published Notting Hill Carnival Clinical Audit, we have recommended a process be developed to ensure safeguarding referrals can be undertaken in these challenging event environments. We will also ensure that future event briefing include the need to complete clinical paperwork every time a crew arrives on scene and the importance of illness/injury code documentation, use of the capacity tool and safeguarding referrals for intoxicated minors.

Sickle Cell Crisis Re-audit:
Our most recent re-audit which focuses on the management of sickle cell crisis shows that since the initial clinical audit in 2004, the care provided to patients in sickle cell crisis has improved. This re-audit, along with those undertaken in previous years, has allowed us to demonstrate areas of excellence, such as Entonox administration, as well as areas in need of improvement, such as using equipment to assist patients to the ambulance. We have shared these findings with clinicians via the attached infographic and will write a Clinical Update article, highlighting the importance of obtaining two pain assessments and providing pain management, specifically morphine (and for non-paramedic crews to consider requesting a paramedic to administer morphine, where appropriate). We will also recommend the JRCALC Guideline Development Group reduce the risk of misinterpretation for both supplemental oxygen and preferred route of morphine administration and approach the Sickle Cell Centres to ensure that, were relevant, patients have a treatment plan. Finally, although this clinical audit has demonstrated some good practice for patients in sickle cell crisis, despite several repetitions of the clinical audit cycle, there remains areas for improvement. Therefore we will consider introducing a Sickle Cell Crisis Clinical Performance Indicator (CPI) to allow for continuous monitoring and individualised feedback to clinicians who attend patients in sickle cell crisis.

Dexamethasone Re-audit:
In June, we worked with a paramedic to design and grant approval for a re-audit examining our use of dexamethasone.

The Strategy Process Application of Clinical Audit in the LAS:
We have conducted the annual review of TP071 – The Strategy Process Application of Clinical Audit in the London Ambulance Service and made minor changes to ensure it meets the new policy requirements; updating job titles and reference to clinical records and the LAS Publication Policy, TP150; minor amendments to re-audit requirements and continuous audit, and removal of Volunteer Plan.

Clinical Performance Indicators (CPIs):
We published version 8.4 of the CPI Guidance Notes which includes updates such as the removal of the need to document GP name, time of referral and further ePCR related changes.

In June and July, CPI training was delivered to 11 paramedics on restricted duties, 3 Team Coordinators, 1 OPC Support Manager, 1 OPC Mentor and 1 Clinical Advisor to the Medical Directorate. CPI auditors reported 16 potential patient safety incidents and contacted EBS to discuss the potential for five retrospective safeguarding referrals.

Research Update

CRASH-4:
LAS opened the CRASH-4 study in South West London in July, as only the second ambulance service to participate in this ground-breaking study. We recruited our first patient into this Randomised Controlled Trial on 23rd July.

PRINCIPLE:
We continue to participate in the PRINCIPLE trial (Platform Randomised trial of INterventions against COVID-19 In older peoPLE) Urgent Public Health Study and clinicians in our 999 ECAS screened four new patients in June and three patients for eligibility in July.

OPTIMAL-CARE:
The Optimising Palliative Care through Electronic Co-ordination (OPTIMAL CARE) study continues to remain open at LAS. All LAS staff who use Co-ordinate My Care (CMC) were invited to participant in an online survey as part of the study to contribute to a national picture of current practice and help guide the best approaches to using how Electronic Palliative Care Co-ordination Systems (EPaCCS) as part of NHS service delivery.

10 staff participated in this study in July which is investigating the value and impact of Electronic Palliative Care Co-ordination Systems (e.g. CMC) bringing the total number of LAS participants to 48.

ARREST:
We are making good progress on reopening the ARREST trial following a long pause due to COVID-19 and hope to reopen this important study in August.
We have recruited a new Research & Development Coordinator who will join our team in September 2021.

PROTECTED:
In June we received confirmation that the NIHR-funded PROTECTeD study (Exploring and Improving Resuscitation Decisions in Out of Hospital Cardiac Arrest) is aiming to open at LAS at the end of August. The study aims to answer the question of what is the best approach for deciding when and where to stop resuscitation attempts adult patients who sustain an out of hospital cardiac arrest and will involve interviewing frontline staff.

Publications:
This month the Head of CARU and the Clinical Research Facilitator were authors on a poster presentation ('The Assessment of Impact of Real-time Continuous Glucose Monitoring on people presenting with severe Hypoglycaemia (AIR-CGM) study') at the International Conference on Advanced Technologies & Treatments for Diabetes.

2. Effective – Maximising safe non-conveyance to ED

London Ambulance Service NHS Trust

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 16/08/21 and is subject to change due to data validation processes

Arrival at Hospital to Patient Handover

We saw an increase in hospital delays in June in comparison to May, with the overall number at 1,617 hours lost from our arrival to patient handover over 30 mins. Queens Romford, King Georges, and North Middlesex had the greatest proportion of handovers exceeding 30 minutes. Queens Romford had the had the highest number of lost hours over 30 minutes, at 264 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	1,401	1,299	456	35%	237.7	34.8
	North Middlesex	2,309	2,112	885	42%	228.7	30.2
	Royal Free	1,462	1,265	373	29%	111.0	28.2
	University College	1,470	1,362	89	7%	16.0	16.7
	Whittington	1,322	1,163	347	30%	108.1	27.9
North East	Homerton	1,281	1,124	77	7%	9.7	17.5
	King Georges	1,161	1,007	657	65%	224.1	40.9
	Newham	1,595	1,351	420	31%	54.9	26.1
	Queens Romford	2,513	2,186	1,316	60%	390.9	37.8
	Royal London	1,812	1,575	189	12%	22.7	22.0
	Whipps Cross	1,482	1,246	297	24%	133.3	27.1
North West	Charing Cross	1,272	1,171	8	1%	1.3	12.2
	Chelsea & West	1,305	1,141	32	3%	8.1	16.8
	Ealing	1,349	1,295	95	7%	31.2	15.2
	Hillingdon	1,821	1,653	274	17%	122.9	21.7
	Northwick Park	3,218	3,035	538	18%	286.5	22.3
	St Marys	1,719	1,595	224	14%	37.7	20.1
	West Middlesex	2,133	2,007	185	9%	41.6	18.2
South East	Kings college	1,905	1,697	477	28%	97.9	26.4
	Lewisham	1,428	1,199	185	15%	54.6	21.8
	Princess Royal	1,769	1,455	284	20%	184.2	26.3
	Queen Elizabeth II	2,286	1,981	78	4%	45.0	14.7
	St Thomas'	2,085	1,874	217	12%	36.0	20.1
South West	Croydon	2,067	1,870	130	7%	55.3	20.1
	Kingston	1,582	1,372	77	6%	10.9	19.7
	St Georges	1,852	1,500	268	18%	35.3	21.7
	St Helier	1,228	1,086	103	9%	27.7	20.8
	TOTAL	46,827	41,621	8,281	20%	**2,613**	23.3

Max average breach value
Value >10 mins per breach

Patient Handover to Green

In June, we saw handover to green performance within the target, with 15.0, consistent with recent months. However, over 3,600 hours were lost due to patient handover to green exceeding the 14 minute threshold. Handover to Green received organizational focus through the COVID19 response team and will receive renewed focus as part of planning and recovery.

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	1,937	1,188	61%	226.1	16.5	32.6	11.4
	Edmonton	2,543	1,478	58%	241.2	15.9	30.6	9.8
	Friern Barnet	1,704	1,047	61%	157.6	15.8	28.8	9.0
North East	Homerton	2,181	1,309	60%	228.5	15.4	30.8	10.5
	Newham	2,557	1,580	62%	310.7	16.1	32.8	11.8
	Romford	2,829	1,711	60%	241.7	14.9	28.4	8.5
North West	Brent	3,531	2,102	60%	282.2	15.5	27.5	8.1
	Fulham	2,254	1,394	62%	212.8	16.1	29.9	9.2
	Hanwell	2,893	1,693	59%	214.7	15.3	25.7	7.6
	Hillingdon	1,661	919	55%	108.4	14.6	25.3	7.1
	Westminster	1,334	871	65%	134.4	16.8	29.7	9.3
South East	Bromley	2,133	1,258	59%	157.6	13.6	26.6	7.5
	Deptford	3,518	2,091	59%	274.8	14.8	27.2	7.9
	Greenwich	2,303	1,336	58%	138.0	13.8	24.2	6.2
South West	Croydon	1,915	1,184	62%	149.6	15.1	26.8	7.6
	New Malden	1,512	935	62%	116.6	15.3	27.3	7.5
	St Helier	1,467	930	63%	116.1	15.3	26.5	7.5
	Wimbledon	1,061	693	65%	109.0	12.8	29.7	9.4
Other	NULL	312	245	79%	44.9	14.0	31.8	11.0
	IRO	9	5	56%	2.1	20.2	57.7	25.2
	Other	769	436	57%	61.8	13.1	27.8	8.5
	Training	1,198	616	51%	88.2	13.8	28.0	8.6
	TOTAL	41,621	25,021	60%	3617.0	**15.1**	**28.5**	**8.7**

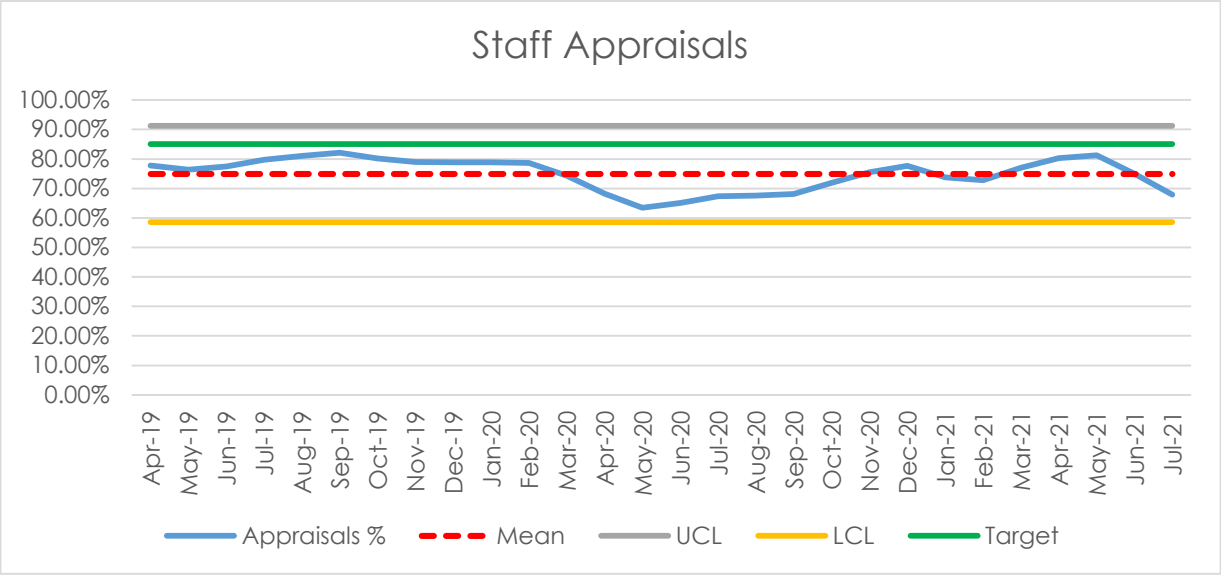
Max average breach value
Value >7 mins per breach

2. Effective – PDR & MCA Training

Owner: Various| Exec Lead: Dr. John Martin & Damian McGuinness

Appraisals

Latest Month: **68%**

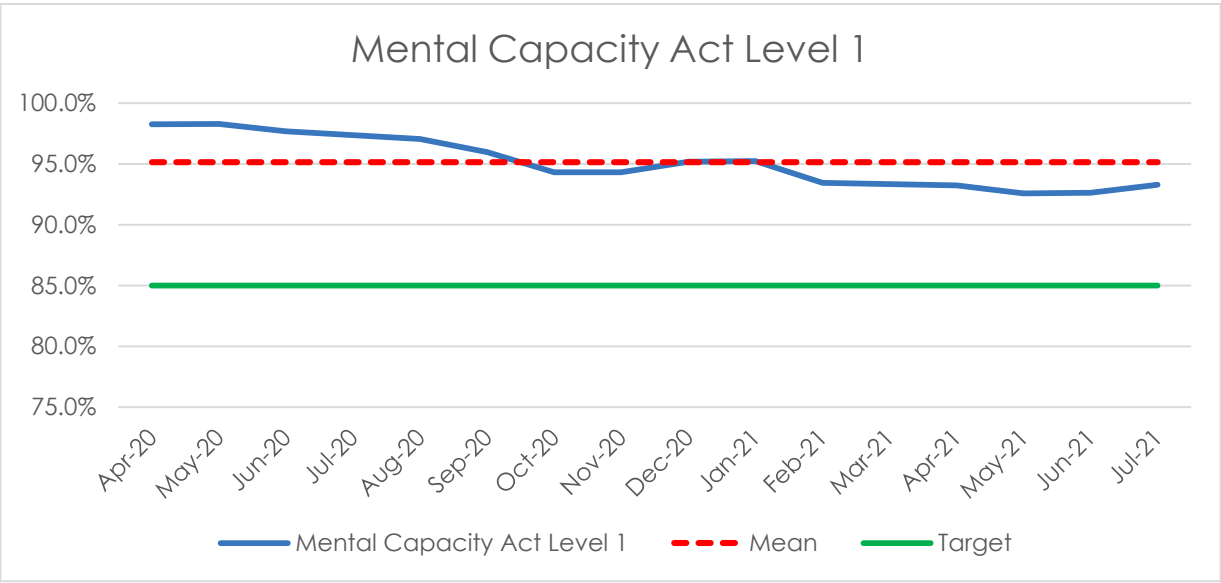


PDRs – as at 31st July the PDR compliance is at 68%, down from 75% in June.

Actions: The weekly PDR compliance report continues to be circulated to all Trust managers to help improve compliance. We are working closely with Corporate teams who have lower compliance levels than frontline teams to improve their compliance levels to the required level of 85%. To support this, Corporate Directors are receiving weekly PDR reports for their teams highlighting those who have an expired PDR date and those who are due to expire in the coming three month period.

MCA Training

Latest Month: **93%**



MCA level 1 – Current compliance is at 93%.

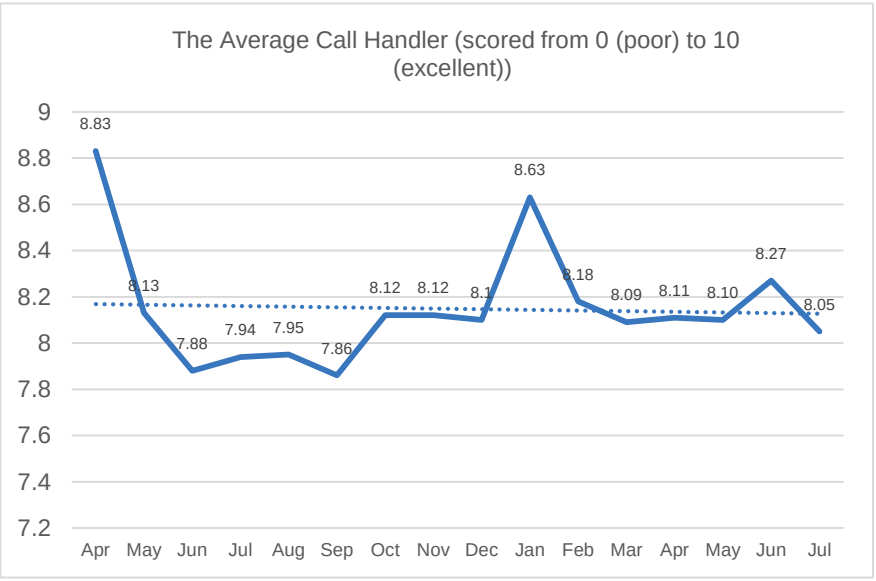
The Trust is currently not delivering Level 2 training. There is a tolerated risk (ID 1044) on the Corporate (Trust Wide) Risk Register.

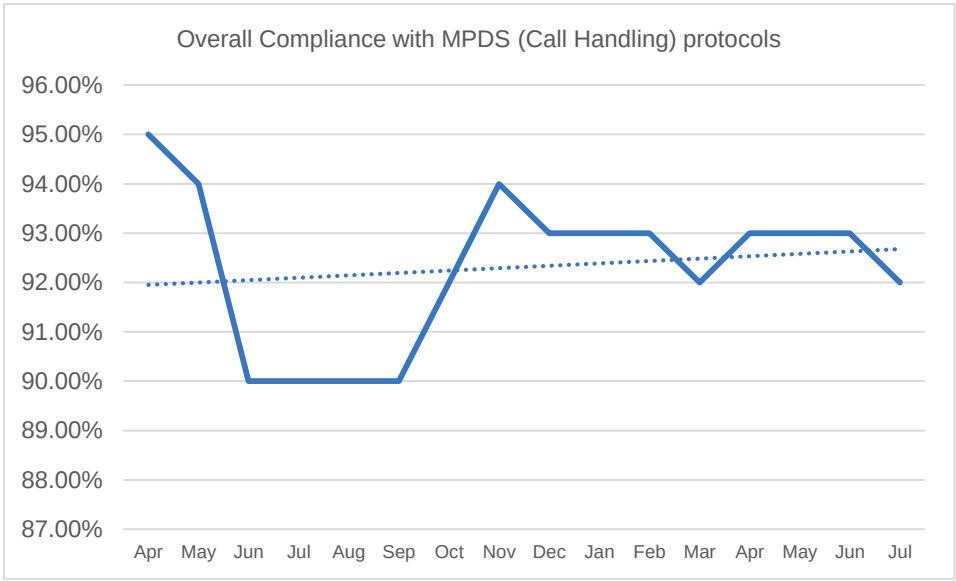
Action: The safeguarding team are working with Clinical Education and plans are underway to include in 2021-22 CSR programme.

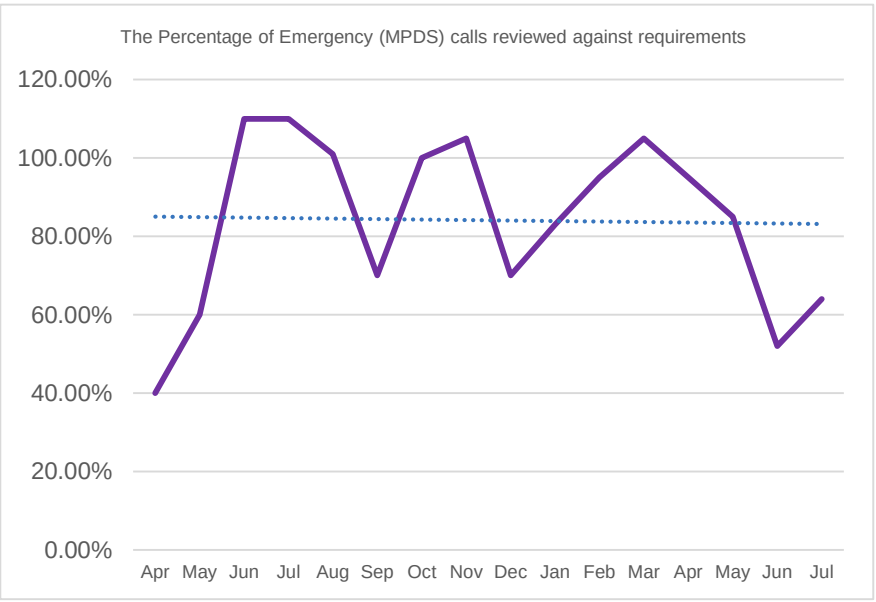
2. Effective – EOC Call Handling Quality Assurance

London Ambulance Service NHS Trust

Owner: Sue Watkins | Exec Lead: Dr. John Martin







Analysis:

The new Quality Assurance Managers (QAMs) were released to the team for training at the end of June 2021, and we will start to see the benefits post their training period. Short staffing and sickness has impacted on our ability to achieve the required audit volumes coinciding with huge surges in call volumes also meant that QAMs were re-deployed to support EOC during this time.

The Trust continues to operate within Centre of Excellence standards with high levels of compliance, resulting in appropriate triage and in turn patient care. Although the trend line shows a slight dip in "average call handler" score, this is still within our expected range and allows for significant outliers to be supported and monitored moving forward.

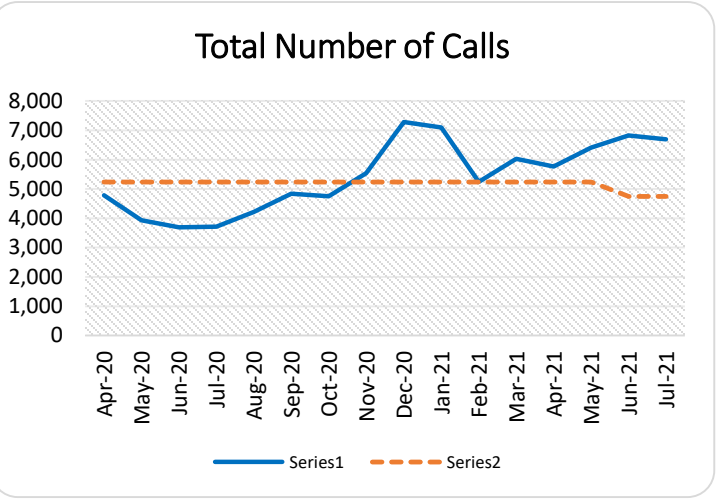
Although the chart showing the required percentages od call reviews indicates a significant drop, the International Academy of Emergency Dispatch (IAED) have implemented the COVID-19 activity measures for all ACE accredited sites, as they understand and fully appreciate the huge challenges being faced in undertaking audit in such challenging times. The revised metrics actually indicate that we have obtained 69& and 89% for June and July 2021 respectively, versus this revised target. (The chart shows against the core 1% of all calls triaged in MPDS. June and July saw huge volumes of call triaged in the EOCs, 109,010 and 116,247 respectively, versus April and May which saw 87,747 and 98, 285.

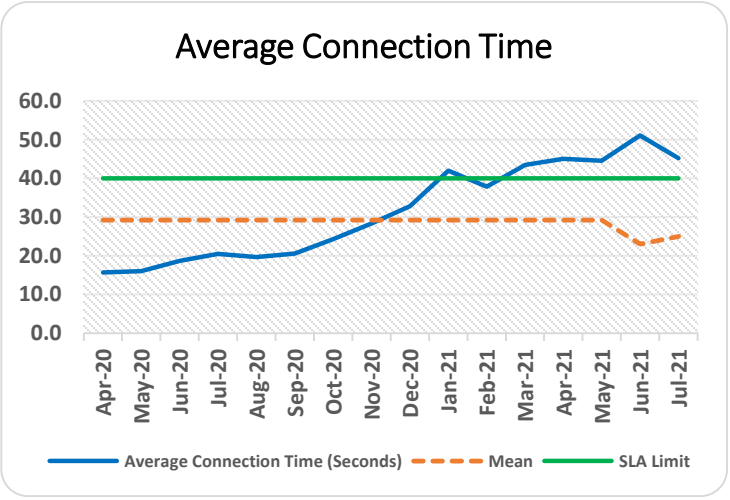
ACE | ACCREDITED CENTER OF EXCELLENCE

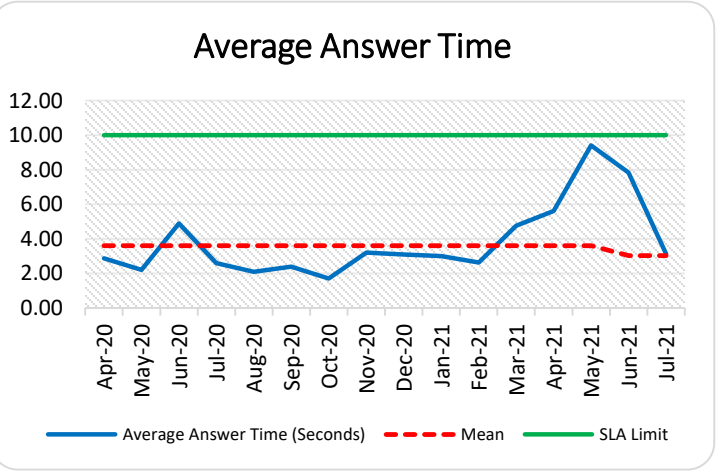
2. Effective – Trust wide Language Line

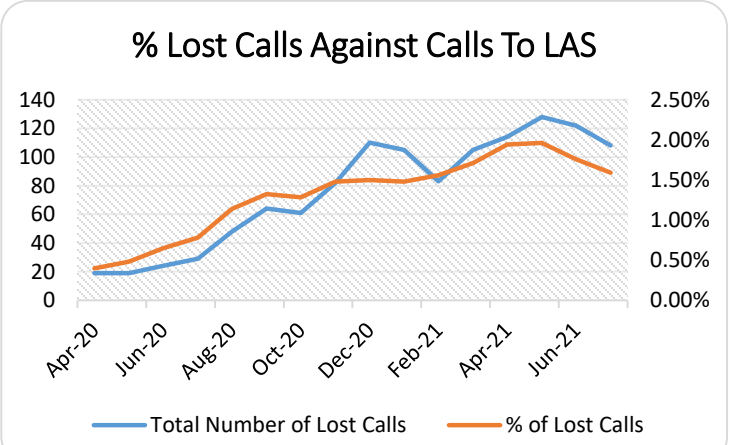
London Ambulance Service NHS Trust

Owner: John Light Exec Lead: Khadir Meer









July 2021 Update

- Language Line (LL) are receiving increased demand for their services, in line with the rising demand across our 999 / 111 services
- New contract entered into with Language Line from 1st June 2021, this includes specific KPI's relating to longest time to answer / language not available metrics
- Work underway with LL to report on above new KPIs
- Monthly contract meetings stood up to review performance / activity
- Process in place to flag any issues directly with language line via VOC (Voice of the Customer) forms
- LL still have a particular issue currently with Romanian interpreters – Deputy Director – Service & Partnership is looking into this and assurance from Language Line re. mitigations in place
- Owing to REAP 4 challenges, this has not changed or been progressed at this time
- Awaiting confirmation from the DDO re the Purchase Order for LL services post July 2021

Month	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Total Number of Lost Calls	19	19	24	29	48	64	61	82	110	105	83	105	114	128	122	108
% of Lost Calls	0.40%	0.48%	0.65%	0.78%	1.14%	1.32%	1.29%	1.48%	1.50%	1.48%	1.56%	1.71%	1.94%	1.96%	1.76%	1.59%

2. Effective – NEL Quality Audit Data

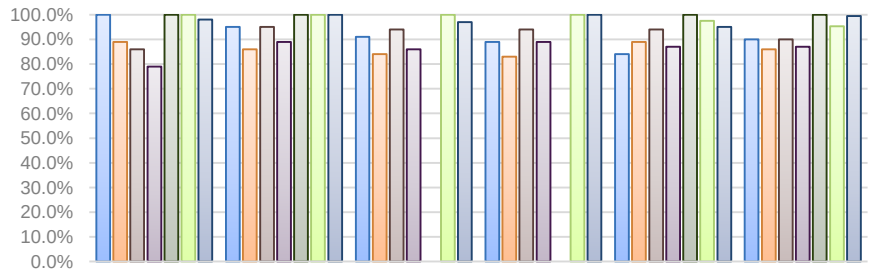
NHS London Ambulance Service NHS Trust

Owner: Jacqui Niner | Exec Lead: Khadir Meer

Role	Required	Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
Service Advisors	144	92	64%	83	90%	• New/worsening symptoms not asked. • Missing out questions on Pathways / losing the Clinical meaning with questions asked.
Health Advisors	844	626	74%	540	86%	• Choosing the wrong Pathway. • Questions missed in Pathways. • No worsening advice given. • Local policy not followed. • Lack of probing • Providing an unsafe disposition/inappropriate disposition reached. • Working outside of remit.

Due to increased call demand, HA shifts have been incentivised, which resulted in auditors working front-end and decreasing the uptake of auditing hours. Also as a direct result of service pressure, Auditors have been taken of auditing shifts to help front end. Due to increased on-boarding program activity, there were a large number of new staff starting as Health Advisors, which resulted in many coach/auditors being utilised for coaching, rendering them unable to complete auditing. In addition to this, we have had quite a large amount of sickness absence / isolation of Auditors which has impacted audits being carried out.

Any Call Handling staff who have audit issues identified are being provided a high level of support and managed under the appropriate policy if needed.



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Service Advisor	100.0%	95.0%	91.0%	89.0%	84.0%	90.0%
Health Advisor	89.0%	86.0%	84.0%	83.0%	89.0%	86.0%
Clinical Navigator	86.0%	95.0%	94.0%	94.0%	94.0%	90.0%
Pathways Clinician	79.0%	89.0%	86.0%	89.0%	87.0%	87.0%
CEC Clinician	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%
ACP	100.0%	100.0%	100.0%	100.0%	97.5%	95.3%
GP	98.0%	100.0%	97.0%	100.0%	95.0%	99.5%

Role	Required	Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
Pathways Clinician	117	71	61%	62	87%	61% Senior Clinical Advisors calls audited (71/117). However all those requiring 5 Audits received 5 Audits. Every SCA received at least one audit & those who scored <95 received another audit. Reasons: Trust is in REAP Level 4 so some auditing days lost to clinical shifts. Clinical Navigator shortages / lack of trained Clinical Navigator auditors also impacted. Main auditor covering annual leave for other Clinical Supervisor Inappropriate referrals & clinical Issues with following process & local policies coaching session due not follow NHSP process of validation Learnings identified: • Inappropriate referrals & clinical • Issues with following process & local policies • coaching session due not follow NHSP process of validation
Clinical Navigator	69	89	100%	63	90%	Consistent High Pass rate following agreed local IUC processes and NHSP - Over 90% - Learnings Identified • Process for patient with declared clinical observations not followed • Process for Refusals of CAT 2 not followed with regard to asking HA's to return to the patient and ask non NHSP / Clinical questions (All calls before the CAT 2 validation process started) • Process for patient with CP-IS not followed • Process for declared abnormal clinical observations not followed • Process for declared medical history not followed as symptoms presented related to medical history declared

Role	Audits Required	Audits Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
CEC Clinician	9	1	11%	1	100%	
ACP	104	73	70%	70	95.3%	
GP	99	99	100%	98	99.48%	• From August 2021 there will be increased auditing hours,. • the reporting for Clinicians this month is for SEL and NEL IUC combined due to changes in the auditing process and the introduction of new software within Adastra.

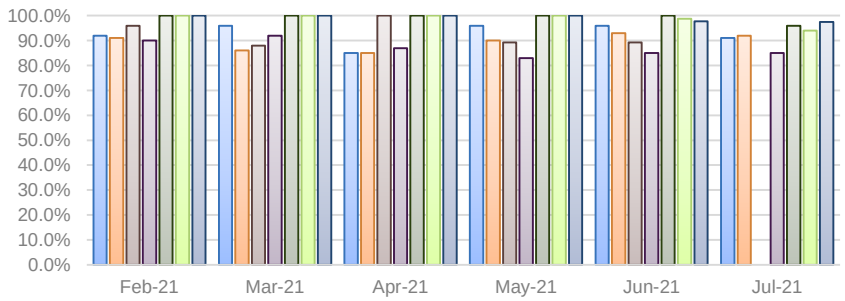
2. Effective – SEL Quality Audit Data

London Ambulance Service NHS Trust

Owner: Jacqui Niner | Exec Lead: Khadir Meer

Role	Required	Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
Service Advisors	162	80	49	73	91	• 7 SA audits fell below the 85% pass rate, all feedback has been given to the members of staff. • Themes identifies from failed audits were; failing to manage the clinical situation and failing to navigate the system safely.
Health Advisors	574	340	59	313	92	• 27 HA audits fell below the 85% pass rate. • Themes identifies from the failed audits were; failing to manage the clinical situation safely, failing to navigate the system safely and failing to operate within the boundary of their role. Feedback has been provided to staff.

Any Call Handling staff who have audit issues identified are being provided a high level of support and managed under the appropriate policy if needed.



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Service Advisor	92.0%	96.0%	85.0%	96.0%	96.0%	91.0%
Health Advisor	91.0%	86.0%	85.0%	90.0%	93.0%	92.0%
Clinical Navigator	96.0%	88.0%	100.0%	89.2%	89.2%	
Pathways Clinician	90.0%	92.0%	87.0%	83.0%	85.0%	85.0%
CEC Clinician	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%
ACP	100.0%	100.0%	100.0%	100.0%	98.8%	94.0%
GP	100.0%	100.0%	100.0%	100.0%	97.7%	97.5%

Role	Audits Required	Audits Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
CEC Clinician	9	1	11%	1	100%	
ACP	104	73	70%	70	95.3%	
GP	99	99	100%	98	99.48%	• From August 2021 there will be increased auditing hours,. • the reporting for Clinicians this month is for SEL and NEL IUC combined due to changes in the auditing process and the introduction of new software within Adastra.

Role	Required	Completed	% Completed	Number Passed	% Passed	Learning / Findings / Action
Pathways Clinician	92	40	43	34	85	• 6 CL audits fell below the 85% pass rate. • Themes identifies from the failed audits were:- failing to obtain appropriate information, failing to convey the questions skilfully and failing to control the flow and pace of the call.

3. Caring

We must ensure that the service involves and treats people with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

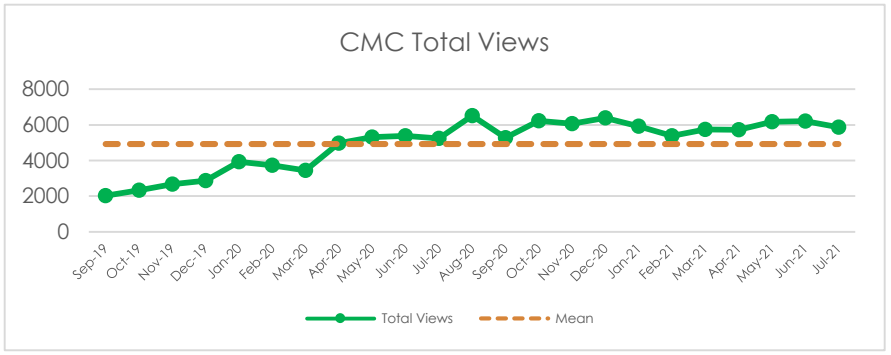
- Mental Health
- Maternity
- End of Life

Outstanding Characteristic: *People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.*

3. Caring - End of Life Care/Mental Health

London Ambulance Service NHS Trust

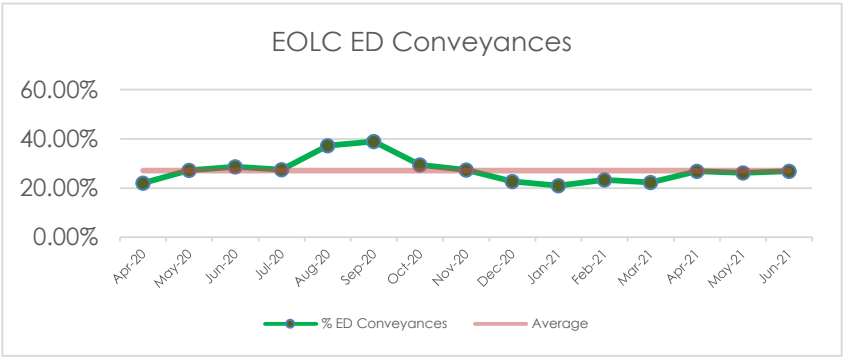
Owner: Various | Exec Lead: Dr. Fenella Wrigley



ED Conveyance

Latest Month (Jun):

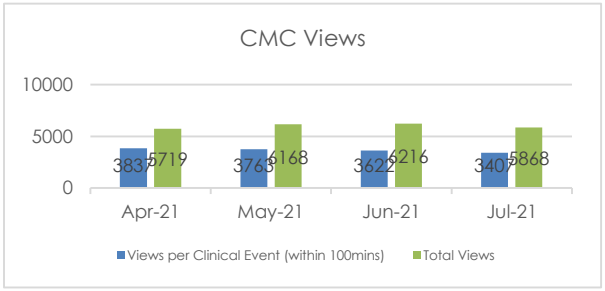
26.8%



The Macmillan Programme won NHS Parliamentary Award in Urgent & Emergency Care

ED conveyance for EoLC patients remains below average

CMC Views



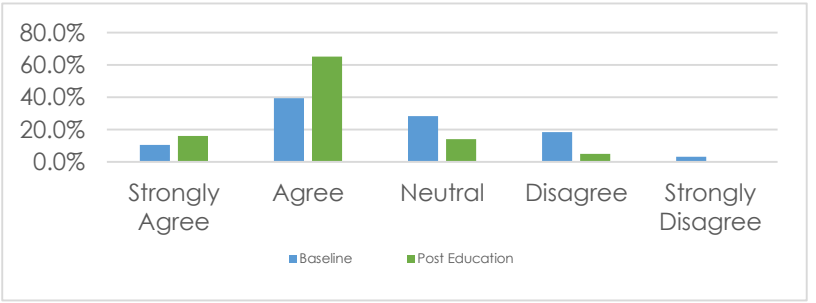
July:
Total views: 5868

Views per clinical event: 3407

Staff Confidence

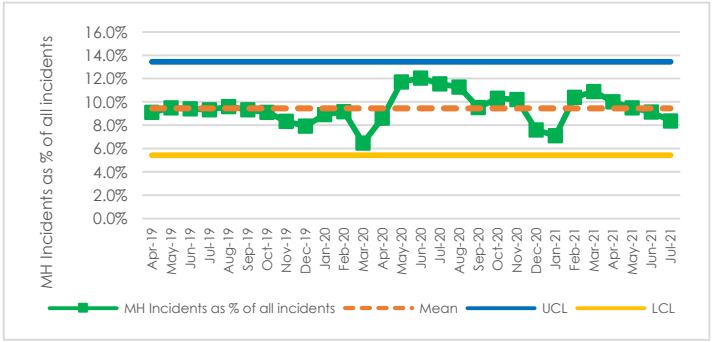
82% staff post education felt confident

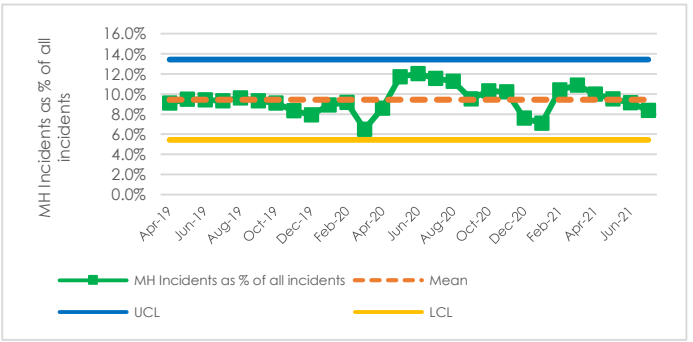
32% increase from baseline

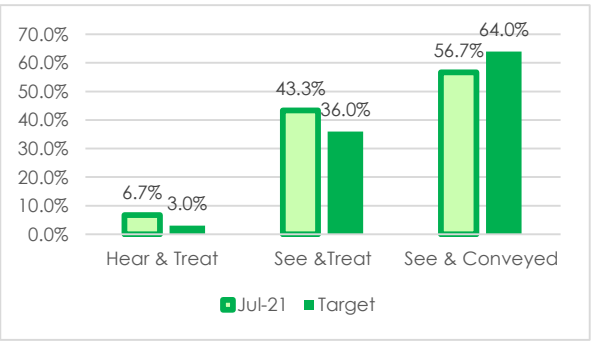


111 IUC CMC data exploration underway

First Team Time ™ hosted at LAS with EoLC Coordinators







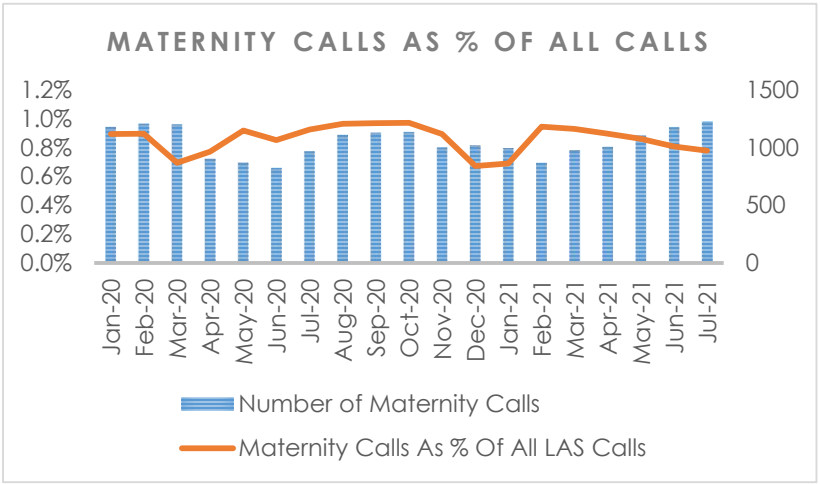
We are maximising patient facing time to support REAP 4 within the Trust. Overtime incentives have been offered to CHUB trained mental health nurses to support hear and treat.
We continue to work with our commissioning team to agree the service specification for the MHJRC

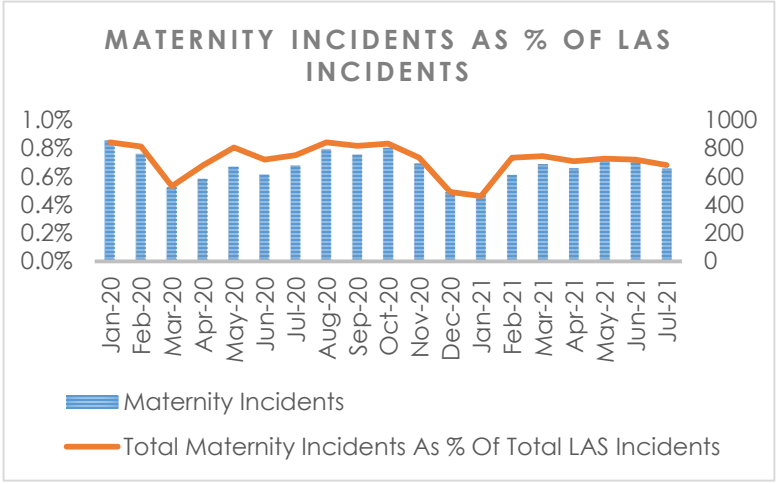
3. Caring - Maternity

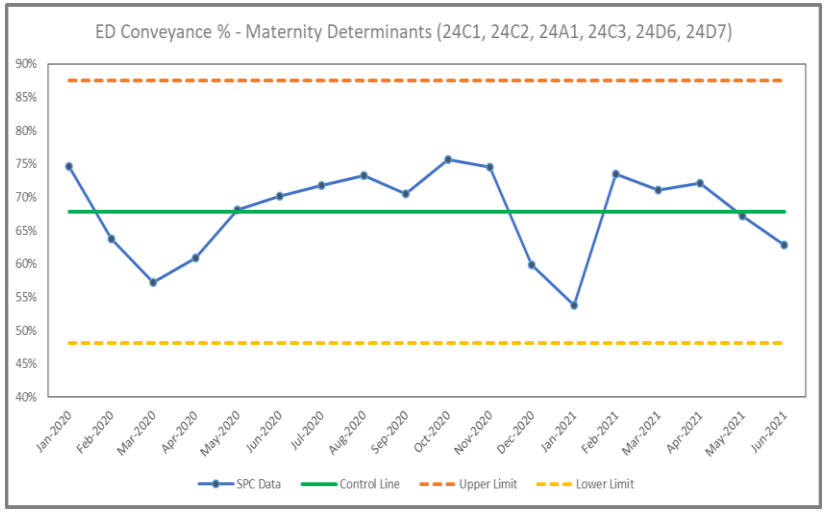
London Ambulance Service NHS Trust

Owner: Amanda Mansfield | Exec Lead: Dr. Fenella Wrigley

Maternity Performance Review Dataset:
The planned performance charts will detail the current focus of improvement in the management of women contacting NHS 111 and 999 with early pregnancy bleeding and vomiting. The Objectives are to increase assessment of women in same day emergency care or through early pregnancy service providers.







Highlights and Our Service Values:

Respectful
On-going debriefs for staff (EOC & Road Staff)

Innovative
COVID19–Launch series of Maternity specific COVID19 screening tool across London Maternity Providers, ED teams and Primary Care

Professional
Consultant Midwife recognised in the Queen's Birthday Honours with MBE.

Collaborative
Joint working on the Pan London Maternity Divert Policy

Exceptions (Improvement required):
HSIB/LAS Standard Operating Procedure to be signed off

Outstanding

- Sign off updated Datix incident trigger list.

Maternity 3 Top Priorities:

1) Pan London SDEC for early pregnancy bleeding and vomiting
2) Test new PPH Screening and Action Tool
3) New Process for Heads of Midwifery to contact LAS reporting maternity diverts

4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Frequent Callers
- Complaints

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*

Owner: John O'Keefe/ Juliette Smyth | Exec Lead: Dr. John Martin

National definition of a **frequent caller** is anyone aged 18+ years who:

- Calls 5+ times in one month from a private dwelling; or
- Calls 12+ times over a three month period from a private dwelling

New & existing callers	726
NHS numbers matched	100%
Stakeholder meetings online	65

Highlights / lowlights

- Individual Dispatch Protocols (IDP) reviewed and new process drafted: all current IDPs reviewed as appropriate.
- Agreed to review process for agreeing and circulating NHS alerts, to involve Caldicott Guardian.
- All outstanding IG issues resolved, London-wide DPIA agreed with trust IG leads, and blocks to sharing in NEL removed.
- Away day / workshop initiated review of OP42
- First round of improvements to Frequent Caller Management Database implemented
- Quarterly FreCANN meeting: review underway of threshold definitions, sharing of electronic support tools, STRETCHED study update.
- FC team given access to EPCR portal.

Sector	CCG	Patients	Jun-21	Calls last quarter	Calls last 12 months	12 month cost	Patients with care plan
NE	CITY AND HACKNEY CCG	40	432	1543	4082	£508,414	16
SE	LEWISHAM CCG	30	484	1647	4550	£432,066	8
NW	BRENT CCG	26	374	1227	2445	£274,863	3
NE	NEWHAM CCG	27	411	1096	2108	£225,322	2
NC	CAMDEN CCG	27	379	1052	2612	£277,346	6
SE	SOUTHWARK CCG	31	232	939	2652	£346,190	5
NC	ENFIELD CCG	21	487	1438	3962	£403,162	2
SE	LAMBETH CCG	29	396	940	3128	£353,485	7
SE	GREENWICH CCG	26	270	1063	2760	£302,592	7
NC	HARINGEY CCG	34	426	1121	3187	£321,988	7
NC	BARNET CCG	21	316	756	1939	£250,232	5
NW	HARROW CCG	21	196	831	2393	£332,545	4
NE	WALTHAM FOREST CCG	25	211	734	2333	£229,073	2
NE	HAVERING CCG	15	203	638	2390	£287,270	3
SW	CROYDON CCG	31	311	756	2285	£370,260	5
NE	TOWER HAMLETS CCG	28	336	1031	2460	£286,115	7
NW	WEST LONDON CCG	26	250	684	2198	£310,842	4
NW	EALING CCG	29	341	815	2406	£309,019	5
SE	BROMLEY CCG	23	188	572	1424	£208,611	5
NW	HILLINGDON CCG	26	387	836	2015	£264,308	1
NW	HOUNSLOW CCG	17	282	701	1986	£224,976	5
NE	REDBRIDGE CCG	16	162	443	1901	£192,229	2
NC	ISLINGTON CCG	28	193	636	1366	£190,563	10
SW	WANDSWORTH CCG	27	149	669	1763	£235,928	2
SW	RICHMOND CCG	17	96	610	1337	£149,819	3
NW	HAMMERSMITH AND FULHAM CCG	9	50	213	576	£89,731	2
NW	CENTRAL LONDON (WESTMINSTER) CCG	13	79	360	1173	£138,276	2
SW	MERTON CCG	18	174	366	864	£137,377	1
SW	SUTTON CCG	15	166	418	1138	£189,961	4
NE	BARKING AND DAGENHAM CCG	8	137	371	1344	£159,637	1
SE	BEXLEY CCG	12	106	276	897	£97,989	5
SW	KINGSTON CCG	8	46	150	321	£54,409	2

4. Responsive - Complaints

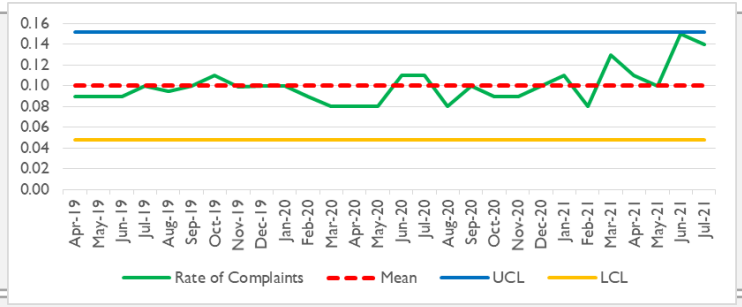
London Ambulance Service NHS Trust

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

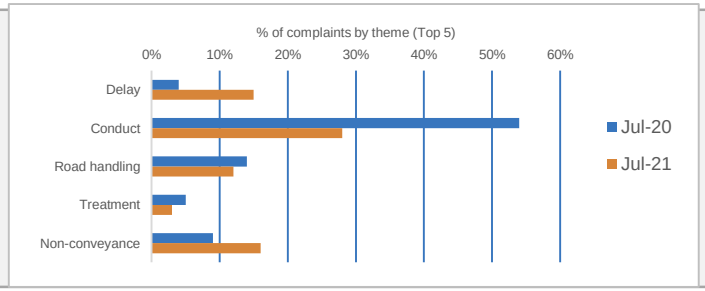
Owner: Gary Bassett | Exec Lead: Dr. Trisha Bain

Rate of Complaints

Latest month: **0.14**



Categorisation



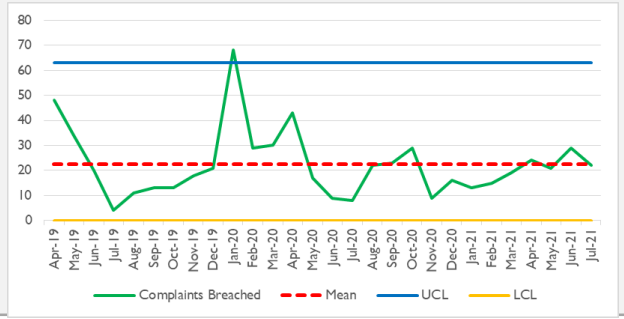
Responding to complaints

Complaint numbers continue to be above the annual average (88) at 134. The percentage of complaints versus the call rates against calls attended has also increased.

There were 489 x PALS enquiries which includes 266 added to the duty spreadsheet that did not require any further actions other then referring the enquirer to the correct team. Slightly lower than June 2021 and the 2020/21 average of 555 per month

We managed 48 Quality Alerts of which 5 were from LAS staff. This is an area that we expect to increase once we have been able to improve the referral process both externally and internally.

Latest Month: 22



Complaints where there was a delayed response and where the patient was either not attended or not conveyed have seen an increase during the extreme pressures to the Trust

We are in liaison with the Quality Assurances Management team to only request a QA report for a complaint when it is essential. The rationale will be explained in our final response to the complainant. A QA report may be obtained at a later date so that we can review such cases.

We are also seeking support from NASPEG (National Ambulance Service Patient Experiences Group) for Ambulance Trusts to adhere to a further 'pause' to the complaints process and to inform the Ombudsman and NHSE/I of the outcome of that.

We are also seeking approval from the Ombudsman to extend the time frames as a pilot site for the Complaints Standard Framework. The implementation of REAP 4 across the Trust has delayed sharing the Maturity Matrix with other LAS colleagues and impacted on our ability to progress this.

The recording of duty phone calls has been approved and functionality will be installed on the duty telephone at HQ post January 2022

Actions and Learning

Patient Experience – July 2021

Despite the pressures to the team, we have maintained a good turnaround. The following examples relate to complaints responded to during July and highlight the complexity of cases:

Example one

We were able to reassure a very worried parent who was concerned about the protracted amount of time the ambulance crew spent on scene with her daughter when she was experiencing a mental health crisis. We explained that the patient had been taken to the ambulance as she felt unsafe but was reluctant to return home or attend A&E. The ambulance crew had acted with the patient's welfare foremost in mind, appropriately requesting the Police for their assistance in applying Section 136 of the Mental Health Act (1983) and liaising with the community mental health Crisis Assessment and Treatment Team (CATT). Ultimately the CATT practitioner attended scene for a face-to-face discussion with the patient and the patient voluntarily agreed to attend A&E to receive the help she needed.

Example two

Following a complaint from a Sickle Cell patient, we were able to explain why the crew were obliged to take her to the nearest hospital rather than her preferred choice. The crew had consulted with the hospital whose care she was under who had a bed on the ward available but the patient needed to be taken to A&E for a COVID-19 test before being transferred on to them. The crew also contacted a clinician based in EOC and a decision was made that the patient should be conveyed to her local hospital as she was presenting with chest pain and that she could be transferred on from there.

Compliments July 2021

As of 3rd August 2021:

June 2021, 47 logged, relating to 115 staff
July 2021, 2 logged, relating to 4 staff

The team are working through a backlog and these numbers will increase

Patient and Public Engagement

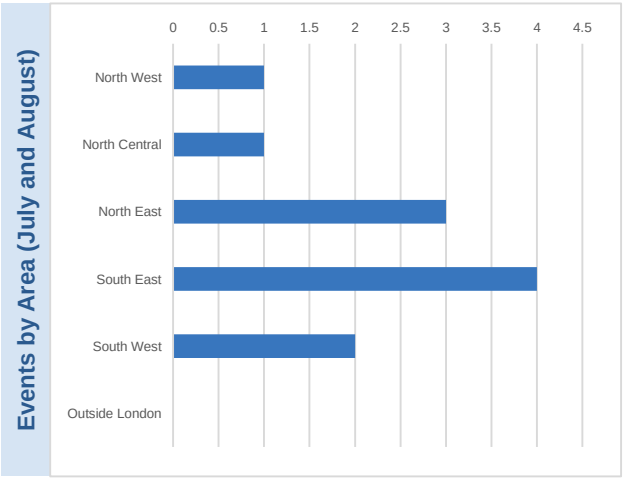
Owner: Philippa Kier | Exec Lead: Antony Tiernan

The work we do through attending public engagement events supports the development of our reputation with patients and members of the public as well as the long term future development of our organisation through raising awareness of career opportunities available as part of the London Ambulance Service.

Public Engagement Events

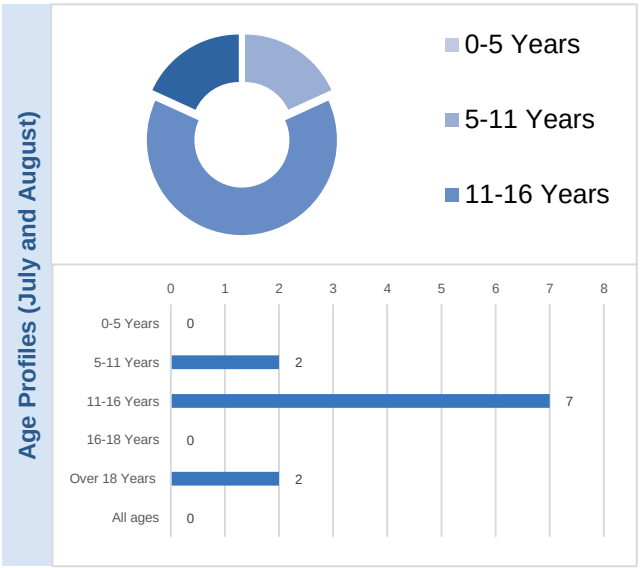
During July 2021, we facilitated 11 events on virtual platforms, covering the following types of activity:

- Visits as part of the **Safety First** project, a blue light collaborative project delivering sessions to year 8 students. LAS input covers Drugs & Alcohol, Knife Crime and Choose Well sessions.
- Assemblies for **primary schools** about what the Ambulance Service does and how to use our service appropriately.
- A session for some elderly care home residents for **Care Home Open Week**.
- Sessions are part of **Prevention for Everyone**, a blue light collaborative project which provides Local Authority staff with increase knowledge to prevent illness and injury.



Public Engagement Activities

Supplementary information	
No. of public engagement events: July 2021	11
Approximate audience numbers: July 2021	2,617
Public engagement: no. of hours: July 21021	22
No. of events: April to July 2021	29
Approximate audience numbers: April to July 2021	4,879
Approximate no. of video views: April to July 2021	14,781



Headlines from July and August

Virtual Junior Citizen's Scheme:

The virtual JCS scheme has now concluded, with a total of 14,341 Year 6 students across London watching our video on how to approach and assess a casualty and call 999 for an Ambulance.

Feedback from Safety First Sessions:

"A huge thank you for your energy and expertise this morning. I have spoken to multiple pupils this afternoon and they very much engaged with the content"
Archbishop Tenison's School

"The children and staff both enjoyed them and found these sessions to be though provoking and useful"
Oasis Academy Shirley Park

Travel Safe virtual package coming soon:

One of our volunteers Natalie Jones (Paramedic, Smithfield) recently filmed a powerful testimony video about the importance of road safety.

This video will be part of a digital education packaged, Travel Safe, designed to replace Safe Drive Stay Alive, which is due to start in the new academic year.

Feedback from Grasmere Rest Home:

"I would just like to say a BIG THANK YOU for the talk you did on the 2nd July for us here at Grasmere. It was very interesting, and gave the opportunity for residents to say thankyou to the Ambulance Service"
Antony (Activities Coordinator)

5. Well Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*

Learning from our actions

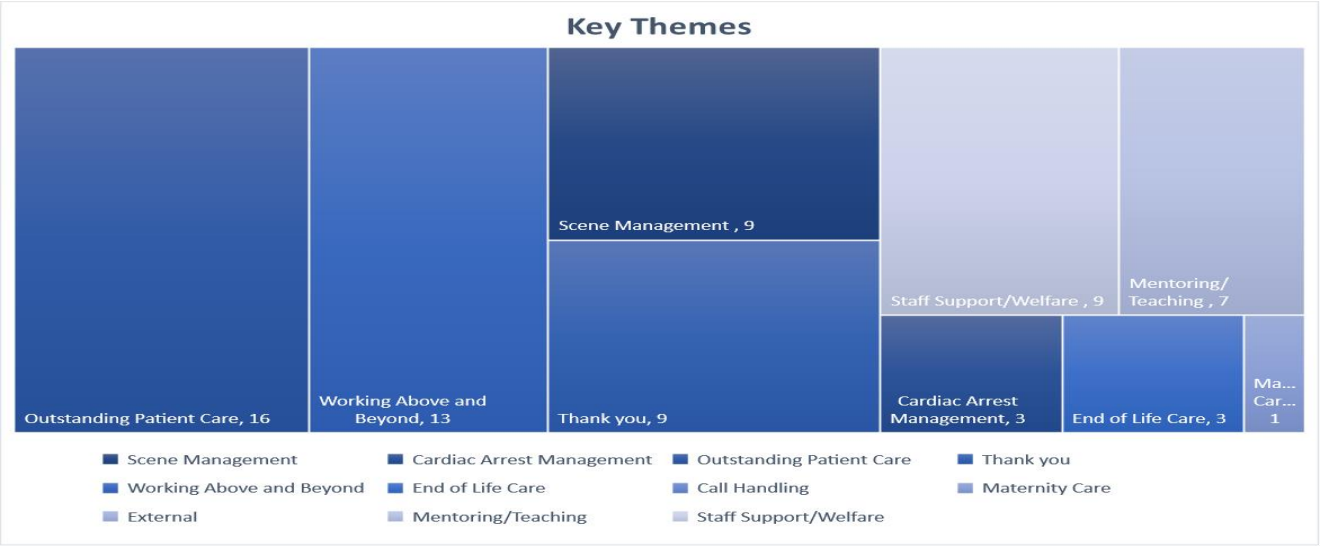
Owner: Helen Woolford | Exec Lead: Dr. John Martin

ER Excellence Reporting
Excellence is everywhere

In July 2021 70 ***Excellence Reports*** submitted were submitted.

Key themes identified from June reports include:

- ❑Outstanding Patient Care
- ❑Working Above and Beyond
- ❑Scene Management



Outstanding Patient Care

He attended an elderly patient as a welfare check whilst working on an FRU. He identified that the patient was incredibly vulnerable and her house was in disrepair with parts of the roof collapsing in. When we arrived as the transporting crew, he was on the phone completing a safeguarding referral, he has already completed thorough documentation, had LFB come assess the patients flat for safety, had raised concerns to the patients social worker, and convinced the patient to come to the hospital. He gave us a detailed handover. His documentation showed a thorough assessment of many of the numerous risks and hazards in the patients house.
He was an excellent advocate for this patient. And did everything he could to ensure this patients best interests were met. It could have been easy for him to just leave the patient when she answered the door and stated she was medically fine and didn't need an ambulance. But he quickly identified and acted upon a number of risks and hazards. The documentation was incredibly thorough and didn't require much to be added by our crew.

They attended a call to a police crime scene where 4 young children had witnessed the event and subsequently needed assessing. I was so impressed with how they demonstrated such professionalism, empathy and skill whilst assessing the patients. The caring way in which they approached the patients allowed them to make a very thorough assessment without distressing them any further. This was an extremely emotive call, but neither of them allowed this to affect the excellent patient care that they delivered. Very well done!

Working Above & Beyond

I had the privilege of working with this individual recently. He is one of the warmest, kindest and knowledgeable colleagues I've come across. They go above and beyond with patients and is incredibly caring and compassionate. He showed great empathy with the number of patients we visited with complex mental health issues. They really are one of the best in the LAS and can be an inspiration to us all.

Since arriving as part of the team, this individual has consistently gone out of his way to support the needs of the Trust and ensure that operational resources have the equipment they need in a timely manner. Nothing is to much trouble; be that at the start of shift or end of shift and his commitment has a direct bearing on the care that ambulance staff ultimately deliver.

This individual was recently appointed into a new secondment in clinical education and standards department. They have gone above and beyond their duties to ensure that the tutors and learners who come to Dockside Education Centre have the best experience. Their attention to detail and passion to creating an excellent centre is a real credit to the department. When Operation Braidwood was delivered, they came in early and stayed late to ensure everything was prepared and ran smoothly. Their organisational skills are outstanding and she should be recognised for all of her hard work over the last two months. Well done, you are an inspiration to all associate tutors.

Scene Management & Thank You

Great leadership on scene, great delegation, great communication. He made sure the scene was calm and it created the best possible atmosphere for success. The manner also how he spoke to the patients family after the arrest was very respectful and the family looked very appreciative of it.

Whilst attending an unwell patient the ambulance keys were accidentally dropped into a drain. This individuals quick thinking using a ring magnet and oxygen tubing allowed him to retrieve the keys and saved considerable time on not waiting for another ambulance.
They showed excellent out of the box thinking and whilst not directly clinical brought significant benefit to the patient. Great work!

This crew were fantastic in assisting with managing the influx of patients and helping to maintain patient and crew safety. This private ambulance crew assessed and managed multiple low acuity patients allowing the LAS crew to focus on their P1 patient. The crew was responsive and supportive towards the senior clinician managing the scene and communicated any changes and priorities they noticed. This crew deserves the recognition of the fantastic work they do and fantastic display of professionalism they bring to their own service and company. It was an absolute pleasure to work with them on this case.

Learning from our actions

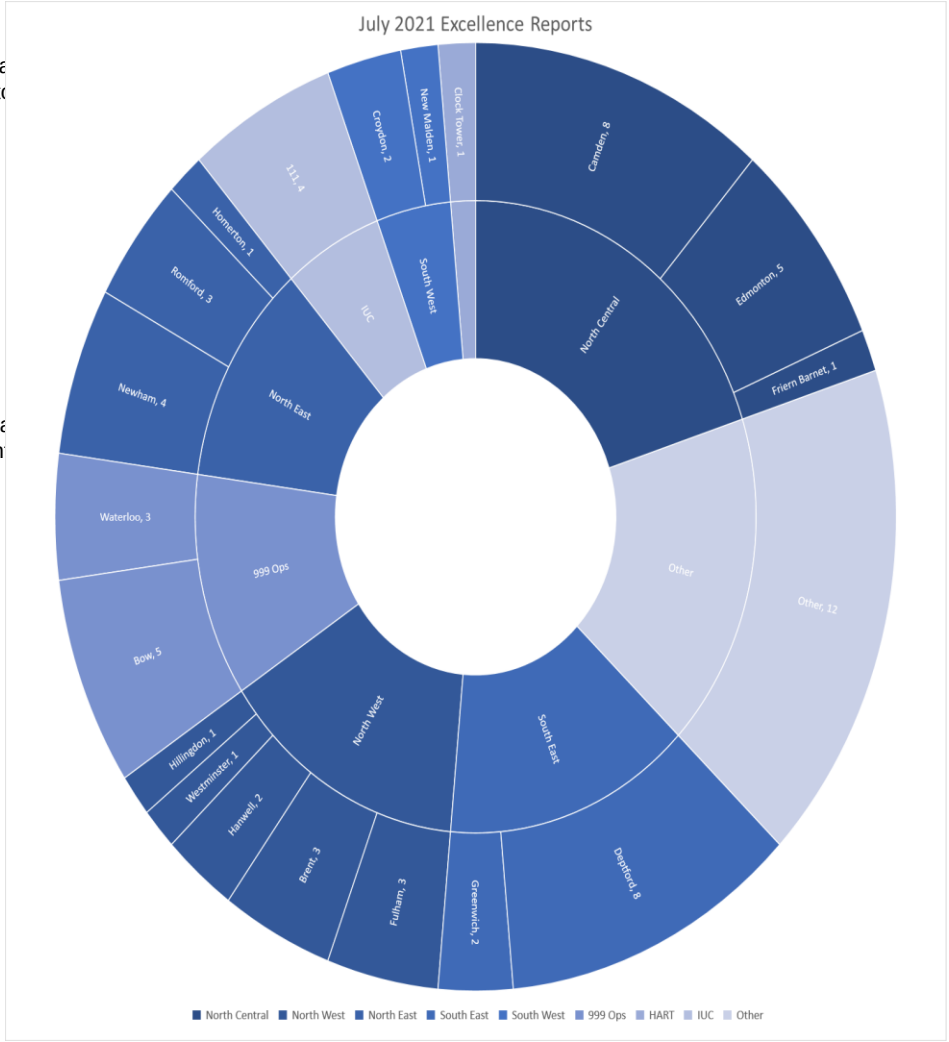
Owner: Helen Woolford | Exec Lead: Dr. John Martin

The LAS has a tiered system for incident learning, which encompasses individual learning via specific support a feedback, sector level monitoring and action on incidents to higher level thematic/ strategic learning within secto and across the Trust.

Excellence reporting and themes are monitored at the Safety Investigation Assurance and Learning Group (SIALG). The Group examines excellence reports alongside themes from serious incidents, complaints, legal cases, patient experiences, and audits to see where learning can be extracted and shared throughout the organisation.

Excellence reports are shared via the following local and Trust wide routes:

- All Excellence reports are shared with individuals, teams and sectors within 48 hour of being reported.
- Used in the Learning events such as the monthly SI learning meeting and the quarterly learning from experience group.
- INSIGHT magazine edition 8 was developed by the Quality Improvement and Learning Team and was relea in February 2021. This included 11 key topic areas which were supported by case studies from SIs, inciden and also *Excellence Reports*.



Some further examples of excellence reports from July:

Maternity Care –
When attending what appeared to be a routine obstetric pain call, the crew correctly predicted an early delivery despite history and appearance of the patient suggesting otherwise. They calmly set up a resus area in limited space and demonstrated a great understanding and clear experience in post delivery assessment.

End of Life Care –
I attended an elderly male with dementia who had unfortunately passed away at home. He had a DNAR in place and was on appropriate pain medications with anticipatory medicines should he need them. He had been attended to on the Wednesday prior by this crew and referred to a hospice who was able to provide this. He was unwell and septic on their attendance. The crew had obviously taken the time, involving the family in what can often be a difficult conversation in order to come up with the above plan and allow him to pass away at home with his family in his own bed with his daughter who had taken on his care. The family spoke highly of the above crew who apparently spent some time with them. The process of his passing and indeed our attendance and role procedure was I'm sure helped by whatever conversations they had.

5. Well led - Risk Management

London Ambulance Service NHS Trust

Owner: Helen Woolford | Exec Lead: Dr. John Martin

Management
The Trust has Risk Management KPIs which are used to monitor compliance against the Trust's Risk Management Strategy and Policy as well as the Risk Management Procedure.

The Trust's compliance in July was:
- 100% of risks reviewed within the last 3 months – target 90%
- 100% of all risks approved within 1 month in July– target 90%

The risk team are liaising with all teams to ensure regular risks review meetings take place and risks are reviewed on a regular basis whilst acknowledging the additional pressures of REAP 4.

Actions and assurance:
The risk manager supports all teams to ensure overdue risk are reviewed promptly.

All risks with a risk score of 15 and above are managed via the Trust's Risk Compliance and Assurance Group (RCAG) monthly to ensure actions are being taken to mitigate against the risk and bring the risk score down to its target level.

Trajectory: The June 2021 data achieved our target of 90% of risks reviewed within the last 3 months with a compliance of 91.9%. The team have continued to focus on this area and the July 2021 data shows 100% compliance for all risks reviewed in the last 3 months.

Corporate (Trust wide) Risk Register

	Negligible	Minor	Moderate	Major	Catastrophic	Total
Almost certain	0	0	1	1	0	2
Likely	0	2	1	2	1	6
Possible	0	0	7	4	1	12
Unlikely	0	0	1	3	2	6
Rare	0	0	0	0	0	0
Total	0	2	10	10	4	26

Risk Assurance and Compliance Group (RCAG)

The RCAG review all red (15 and above) scored risks on a monthly basis, including those held in the Corporate Trust wide Risk Register as well as those held on other risk registers across the Trust.

The group review the risks monthly in terms of movement to ensure that risks are, where relevant, moving as required, tolerated or escalated for actions through the Trust.

In the last month, there were 5 red risks on the Corporate risk register. This is demonstrated in the movement table to the right of this text.

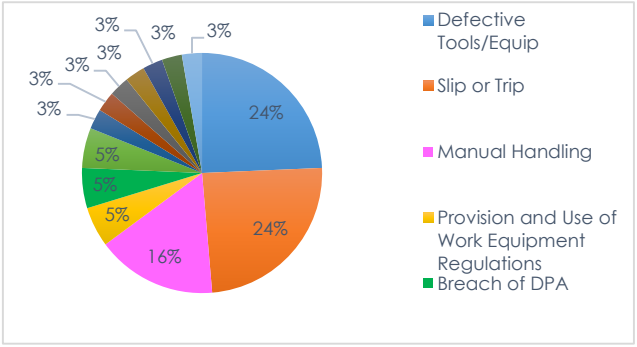
ID	Sector / Department	Description	Opened	Initial Risk Score	February Risk Score	March Risk Score	April Risk Score	May Risk Score	June Risk Score	July Risk Score	Change in Risk Score:	Progress Notes:
1081	Fleet and Logistics	TOLERATED RISK There is a risk of the inability for the Trust to store, pack 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.	25/04/2020	16	16	16	16	16	16	16	→	Tolerated risk
1112	NHS111	There is a risk that a patient will be connected to an unmanned telephone due to the telephone agent having not logged out of the Avaya system when not in a position to take a call leading to a delay in patient care as the patient receives no answer at the end of the line.	05/06/2020	16	16	16	16	16	16	16	→	Following further discussion with Director and Deputy Director of 111/999 Services, the manual-in solution was deemed to be unviable and further solutions are being discussed with the IM&T team
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	04/08/2020	15	15	15	15	15	15	15	→	Tolerated risk
775	Estates	TOLERATED RISK There is a risk that the current UPS which has been upgraded to meet building supply demand will go into safe mode and switch off due to having no isolation transformers to prevent neutral from being lost during a network power outage. Failure of the equipment in normal operation or during a network power outage would cause a service failure. Interruption of electrical supply would impact IM&T data and telephony services and interrupt EOC services independently at Bow and HQ.	16/03/2018	15	15	15	20	20	20	20	→	Tolerated risk
1145	Health and Safety	There is a risk that medical devices issues may not be managed appropriately due to the Trust not employing or contracting the services of a medical device specialist which may lead to equipment not being safe or fit for purpose which could impact on patient and staff safety.	15/09/2020	12	12	12	16	16	20	20	→	Discussed at QAC to confirm the risk remains at 20 until GSTT agree a proposal for a partnership arrangement with their medical physics department.

5. Well led - Legal Clinical & Non Clinical Claims

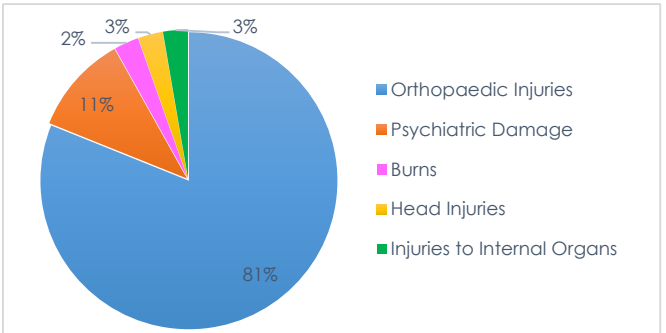
London Ambulance Service NHS Trust

Owner: Tashalee Seejore | Exec Lead: Dr. Trisha Bain

Current Non-Clinical Open Cases by Cause



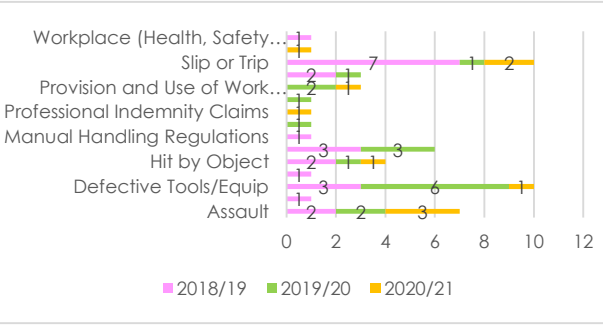
Current Non-Clinical Open Cases by Injury



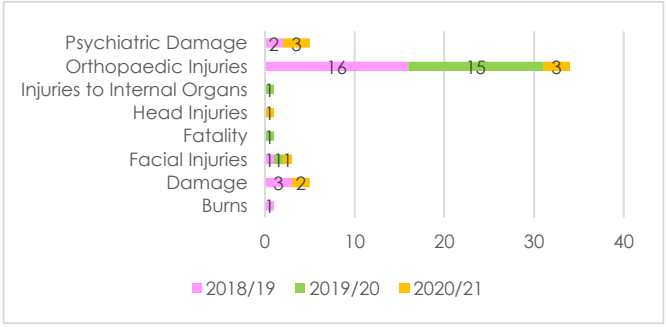
Closed Non-Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	2019/20	Grand Total
Assault	£4,165.00	£0.00	£2,431.00
Breach of DPA	£9,000.00		
Defective Tools/Equip	£3,812.11	£15,036.00	£0.00
Electric Shock	£5,179.00		
Hit by Object	£2,233.30	£0.00	£0.00
Manual Handling	£0.00	£11,184.90	
Manual Handling Regulations	£0.00		
Mgt of H & S at W Regs		£0.00	
Professional Indemnity Claims			£1,064.00
Prov & Use of Personal Prot Equip Regs		£0.00	
Provision and Use of Work Equipment Regulations		£2,822.00	£0.00
Sharps Injury	£10,567.00	£8,298.80	
Slip or Trip	£26,991.60	£0.00	£4,908.00
Theft/Criminal Damage			£0.00
Workplace (Health, Safety and Welfare) Regulations	£11,615.50		
Grand Total	**£73,563.51**	**£37,341.70**	**£8,403.00**

Closed Non-Clinical Claims by Cause



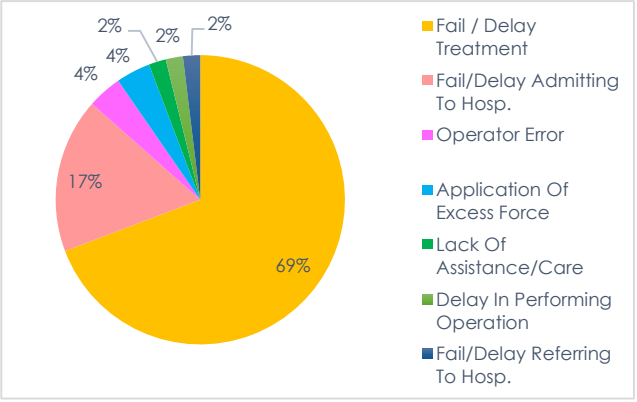
Closed Non-Clinical Claims by Injury



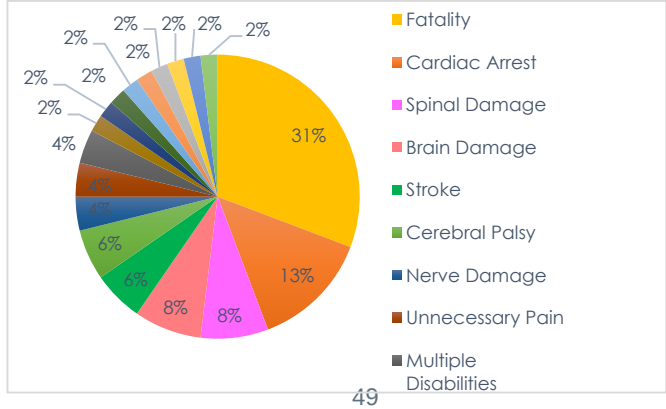
Closed Clinical Claims by Cause and Total Claim Cost

Cause	2018/19	Number of Cases	2018/19	Number of Cases
Fatality	£38,914.75	5	£10,382.15	1
Unnecessary Pain	£0.00	1		
Grand Total	**£38,914.75**	**6**	**£10,382.15**	**1**

Current Clinical Open Cases by Cause



Current Clinical Open Cases by Injury



Highlights

- Following REAP 4 letter sent to Coroner's office and new witness statement template in use – reduction in attendance of live witnesses at hearings.
- Increase in witness statements being read in Court esp. on Level 1 cases.
- The Legal Services Manager and Head of Resolution are in discussion with Procurement to establish contracts with a few Panel firms with a view to reduce professional legal fees.
- Increase in workload from Coroner's Court due to backlog.

Lowlights

- Manager to review current JDs and start recruitment process for substantive posts (3x Band 5 and 1x Band 7).
- Due to staff leaving and increased workload, work is being outsourced to a Panel firm.
- Legal spend increase until contracts with Panel firms established.

5. Well Led - Trust Policies

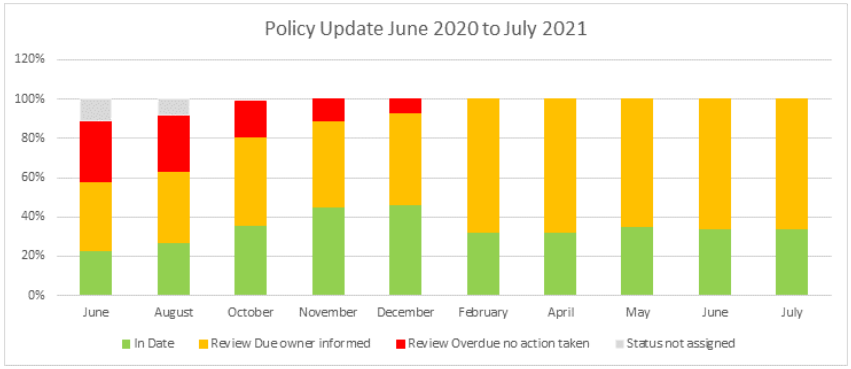
Owner: Victoria Moore | Exec Lead: Dr. Trisha Bain

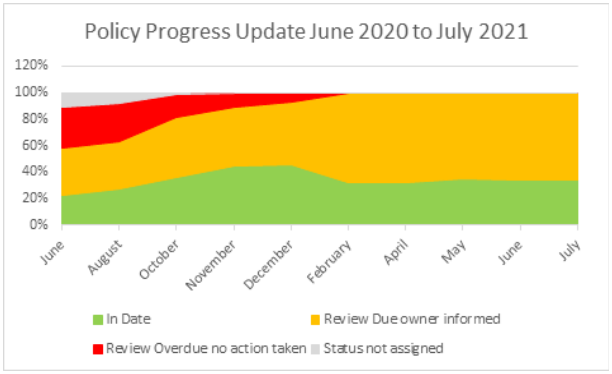
A review of those policies held within Health Assure and on the Pulse has identified 105 Policies, the current status is reported below.

A full review of the position has now been completed and a structured approach is being taken to address the position and to establish a process for recovery.

Progress has been impacted by the recent increased operational activities resulting in responsible owners and stakeholders being required to focus on other tasks. This work has now recommenced and the team are working to progress recovery at pace.

The charts below demonstrate the changing position over the last 11 months against the Trusts target of 90% of policies in date.





The August ExCo will receive a paper which provides an update on the latest position with regard to the review of the Trust's corporate policies.

The Trust currently has 105 policies of which 66% are overdue their regular review.

A significant amount of work has gone into recovering the position both within the Corporate Governance team and across directorates but has been impacted by the Trusts increased REAP position. REAP 4 redirects activity away from the review of policies and as such the recovery position has remained static.

This has enabled the production of a comprehensive register of the Trust's policies and their current status as part of the recovery and ongoing compliance monitoring. It has also seen a number of defunct policies removed to avoid confusion.

The lessons from the first part of this review have been examined with a view to continuing to increase compliance at an increased rate.
As the next stage in the review, following feedback from senior leadership, it is proposed that the number of top level policies is rationalised to:
ensure that all policies are reviewed as part of a regular schedule
streamline the existing review policy process to provide clarity and deliver assurance on current policies in a timely manner
categorise core Trust level polices
rationalise the total number of policies by reviewing policies with a view to ensuring a consistent approach to what is considered a policy and grouping policies on the same subject area together

To this end, the Executive are being asked to support the adoption of an annual (or interim) and full three year review cycle for each policy. The initial review of outstanding policies will utilise a checklist questionnaire which will prompt the rationalisation of polices through combining, grouping and re-categorising as procedures where appropriate.

London Ambulance Service
NHS Trust

Report to:	Trust Board			
Date of meeting:	23 September 2021			
Report title:	Use of the seal			
Agenda item:	For Information			
Report Author(s):	James Stanton, Head of Corporate Governance			
Presented by:	Diane Scott, Interim Director of Corporate Affairs			
History:	N/A			
Purpose:	☐	Assurance	☐	Approval
	☐	Discussion	☒	Noting

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

The Trust Seal has been used as follows since the previous report.

Item No	Date	Detail	Parties	Signed 1	Signed 2
210	17/08/21	Licence to carry out works – Unit 7 Chiltonian Industrial Estate, Manor Lane, Lewisham, London	Diageo Pensions Trust Ltd and London Ambulance Service NHS Trust	Khadir Meer	Lorraine Bewes

Recommendations for the Board:

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		No		
Communications & Engagement	Yes		No		
Strategy	Yes		No		
People & Culture	Yes		No		
Corporate Affairs	Yes	x	No		Interim Director Corporate Affairs