London Ambulance Service
NHS Trust

NHS

Clinical Governance Annual Report

OCTOBER 2007

FINAL DRAFT

CLINICAL GOVERNANCE ANNUAL REPORT

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EXECUTIVE SUMMARY

As Medical Director and Clinical Governance Lead I am pleased to be able to introduce this report that reflects continued success and ongoing development in Clinical Governance.

During 2006/07 the staff of the London Ambulance Service (LAS) NHS Trust have continued to be innovative and enthusiastic in producing good quality, safe and timely care during a year that was particularly challenging.

Staff have risen to this challenge and supported the Governance Development Unit in improving risk management, and working towards compliance against the new NHS Litigation Authority (NHSLA) standards. They have supported the work needed for the Healthcare Commission Declaration in achieving compliance with the core standards, and produce evidence for providing assurance to the Board.

The report shows excellent progress in Research and Development and in Clinical Audits using Clinical Performance Indicators (CPIs). There is a better clinical governance structure at area level with improved reporting on governance to the committee. This is a product of the enhanced structure of governance provided by the bi-monthly meetings of the Area Assistant Directors and the Deputy Director of Operations. The Operations Report for the Clinical Governance Committee (CGC) provided by the Deputy Director of Operations has given a comprehensive overview of Incident Reporting, Complaints and Serious Untoward Incidents (SUIs) across all areas of the Trust. The Pan London Governance reports have been able to illustrate how clinical governance works on practical level. The governance in Infection Control has been strengthened with compliance against the Code of Hygiene held under continuous review. With the restructuring of the Complaints and PALS teams under the leadership of the Patient Services Manager, the Trust is preparing to develop further its response system for answering complaints and concerns.

The Complaints Panel has taken an overarching role in policy and procedure leading to the development of an upgraded Complaints Policy and Procedure, SUI Policy and the introduction of a new Being Open Policy. The Trust has also contributed to the National Audit Office Value for Money study on handling complaints about Health and Social Care.

The dramatic improvement in ‘out of hospital’ cardiac arrest survival, increased conveyance of patients who have suffered a heart attack to primary angioplasty centres and evidence of more effective pain management are some of the clinical achievements of the Service, these were among the items I presented at the Chief Executive’s Consultation meetings, to all 26 complexes within the service.

Dr Fionna Moore
Clinical Medical Director and Trust Lead for Clinical Governance and Infection Control

INTRODUCTION

The LAS is committed to working throughout the organisation to provide the highest standards of care for our patients. The Trust is progressing well towards implementation of a clinical governance approach which is evidence based, supported by a robust clinical audit and research programme.

Committee and reporting structures have been revised to assure the Trust Board on all service development, quality and patient safety issues. During 2007/08 the focus will be on strengthening the accountability and integration of the existing internal arrangements to provide a clear alignment to the Healthcare Commission's Standards for Better Health, and to provide a framework for further improvement and compliance.

A notable change during 2006/07 was the emergence of Area Governance Groups with reporting mechanisms to the committee. Through the review of terms of reference and reporting sub-committees, the new CGC has played a central role in reinforcing and embedding all aspects of quality and patient safety.

The CGC is the overarching committee to provide the Trust Board with assurance on all aspects of clinical practice through the implementation of the Risk Management Policy and the Clinical Development work led by the Medical Directorate.

The committee is accountable to the Trust Board for the consistent implementation of good systems of clinical governance, clinical effectiveness and risk within the Trust. It monitors action plans derived from external audits, reviews and assessments of clinical services while ensuring compliance with the Clinical Governance aspects of requirements set out in 'Standards for Better Health'.

This report is presented using the 'Standards for Better Health' headings and will indicate some of the key achievements in patient care provided by the LAS for the year 2006/07. This report also makes reference to other reports and action plans, and readers are directed towards these for more specific information. The Trust has been fully compliant with the core standards of the Annual Health Check for the second successive year.

There are seven "domains" used in this report, designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The domains encompass all facets of health care; the seven domains are:

1) Safety
2) Clinical and Cost Effectiveness
3) Governance
4) Patient Focus
5) Accessible and Responsive Care
6) Care Environment and Amenities
7) Public Health

The Board has also received a report on the implications of the Mental Capacity Act implemented from April 1st 2007.

The Trust hosted a national conference, 'Frontline Cardiac Care for the Paramedic', in April 2007. Organisation of the event which was organised by the Clinical Practice Manager was successful and more than 260 delegates attended.

Progress was monitored by the CGC through the regular reports provided by the Area Clinical Governance meetings.

The report will give, in more detail, improvements achieved to the Trust's clinical governance processes for incident reporting and cardiac services.

The Trust continues to be actively involved in assessment and accreditation process. The NHSLA pilot assessment for the new risk management standards and the Trust received a rating of 'good' Quality of Services from the Healthcare Commission in 2006/07 ratings. The Trust has responded to the Urgent and Emergency Care Services review undertaken by the Healthcare Commission. The Trust's performance was rated by the Healthcare Commission as the best ambulance service trust in the country.

With the development of the Trust Clinical Governance Committee and Risk Compliance and Assurance Group (RCAG) improved reporting structure, the Trust will not continue to produce a separate clinical governance development plan as this is now accomplished through the Healthcare Standards assessment process aligned with the Trust Assurance Framework and the Risk Register.

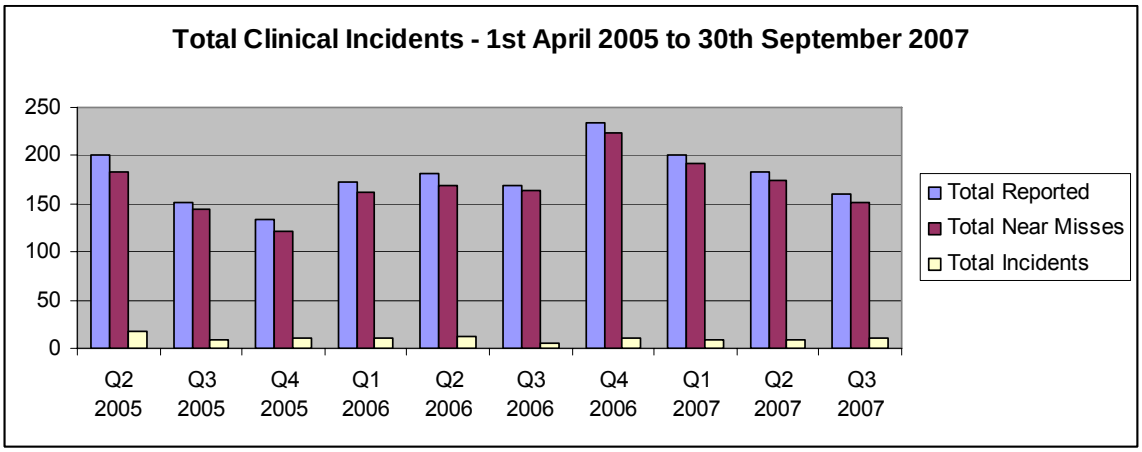
John Wilkins
Head of Governance

1. SAFETY

'Patient safety is enhanced by the use of health care processes, working practices and systematic activities that prevent or reduce the risk of harm to patients.'[1]

1.1 Incident Reporting

A new development of the Trust, attempting to demonstrate the effectiveness of the LAS Clinical Governance arrangements is the Risk Information Report. It aims to prompt actions necessary to demonstrate that governance arrangements are sufficiently robust. This quarterly report provided for the CGC covers Complaints, Claims, PALS, Diversity and Incident Reporting. The Diversity Team has changed managerial leadership during the course of the year, and is now evaluating the Race Quality Scheme, including the Trust's approach to Equality Impact Assessment.



The total number of incidents for the period 1st October 06 – 30th September 07 is 779 of these, 38 were recorded as having an impact on the patient. The average number of incidents being reported per quarter is approximately 194. The information is based on the detail provided by the Trust's incident report form (LA52), completed by both the reporting member of staff and the investigating manager. The level or result of the impact is not clearly identified on the incident report form at the time of completion.

Actions Arising Out of Incident Investigation

	Sectors:	Q4: 1 Oct 06 – 31 Dec 06	Q1: 1 Jan 07 – 31 Mar 07	Q2: 1 Apr 07 – 30 Jun 07	Q3: 1 Jul 07 – 30 Sep 07	
1	Clinical Outcome identified	9	8	10	8	35
2	Counselling, Welfare and Occupational Health Services offered	95	91	95	88	369
3	Discussion with Staff Member	8	12	4	1	25
4	Equipment Isolated	91	61	58	53	263
5	Equipment Sent for Service - Fault Found	1	0	0	0	1
6	Estates Department Informed	3	2	0	1	6
7	Fleet Informed	14	17	18	9	58
8	Investigation completed	131	119	104	99	453
9	No Clinical Outcome Identified	214	168	158	146	689
10	Police Informed	2	1	0	0	3
11	Referral for Additional Training	2	8	4	5	19
	Totals:	570	487	451	410	1918

[1] Emboldened paragraphs are taken from the Standards for Better Health 2006/07

When a clinical incident has been investigated and an action plan developed, that plan is presented to the most appropriate committee for action. Within that action plan there is discussion on the best method of communicating information to staff. In the main, this is achieved by the existing information structures such as the Medical Director's Bulletin and Operational Bulletin system. However, if there is a need to change existing education and training, the plan goes to the Service's Training Group, (chaired by the HR Director). This group discusses how the change(s) will be effected and monitored. Use is made of the annual Team Leader Conferences, the regular Senior Managers' Conferences and other events, to communicate changes of clinical practice that have arisen as a result of clinical incidents. The monitoring of clinical practice is undertaken via the CPI checks done by Team Leaders using the Patient Report Form (PRF). If required a specific check on an aspect of care can be done using this method as well.

The local area clinical governance meetings discuss all their relevant incident reports and issues. Recommendations for change are made to the (corporate) Health and Safety Committee and the RCAG and actions are addressed. The Trust CGC and the RCAG monitors the actions on a regular basis within the set reporting schedule.

Overall there seems to be no significant issue in isolation. The reported clinical incidents reveal a downward trend over the last four quarters. The figures seem stable with some suggested decrease in incidents.

In response to the National Patient Safety Agency's (NPSA) request for additional clinical incident reporting, the following measures have been put in place:

- Health and Safety Bulletin issued – Recording of Untoward Incidents,
- Medical Directorate Bulletin article – Clinical Incident Reporting,
- PRF amended, highlighting the requirement to complete an LA52 following clinical incident.

In addition the Senior Health and Safety Advisor has held review meetings with the local managers.

1.2 Risk Register

The purpose of the Trust Risk Register is to provide the Trust Board with confidence that the Trust's risks are being managed appropriately at every level of the organisation, and that acceptable controls are in place and operating effectively.

The Trust Risk Register has been developed to include all Trust-wide risks, including clinical, financial, operational, strategic, and all risks with a high score of 15 and above (using the New Zealand 5x5 matrix). The Register is being revised to reflect new risks from the process of the Trust-wide Risk Assessment. This process allows the Assurance Framework to provide the Board with assurance of compliance with healthcare standards.

The RCAG, on behalf of the Trust Board, reviews and scrutinises the risk register to monitor the proposed acceptability of risks and explanatory actions. The Risk Register is a means for the Trust to record identified risks and is used as a tool for monitoring actions and share learning. This process is now embedded across the Trust, and CGC and Area Governance meetings are regularly held to update and report risks. However it should be recognised that communication and feedback does need to be improved to ensure all frontline staff are kept fully informed.

1.3 Annual Health Check

The Use of Resources component of the Annual Health Check has been collated by the Audit Commission using the Auditors Local Evaluation (ALE) process. Last year's score of "good" has been retained.

The Clinical Audit and Research Unit monitored the Trust's compliance with the thrombolysis target. We have complied with the low numbers rule for the 2006/07 assessment period and the data on the MINAP database has been verified by the team as mostly accurate. As the low numbers rule has been applied by the Healthcare Commission we improved on last year's performance score for the Quality of Care component of the Annual Health Check. The Trust's rating by the Healthcare Commission for 2006/07 was issued on 18th October 2007, with 'good' being achieved for both Quality of Care and Use of Resources.

The Final Declaration of the Annual Health Check for 2006/07 has been completed. The Trust is fully compliant with the twenty four healthcare standards for the second successive year.

In addition, this year a statement was submitted as part of the Declaration explaining the Trust's arrangements for complying with the Code of Hygiene. These include the infection control audits and the self assessment day previously reported to the Board as part of the Annual Infection Control Report.

Five London Borough Overview and Scrutiny Committees provided a commentary for the Final Declaration, an improvement on last year. The Patients' Forum also provided a commentary on the Trust's performance against some of the standards. The Trust followed the guidance provided by the Healthcare Commission and set out the background context to these comments in the introduction to the Declaration. The Final Declaration was presented to the Patients' Forum at their meeting on 1st May by the Finance Director.

Progress with the 2007/08 Annual Health Check Assessment is monitored by the Standards for Better Health Group.

1.4 NHSLA – Risk Assessment

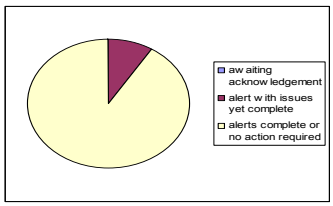
The NHS Litigation Authority (NHSLA) Risk Management Standards and assessment criteria have been undergoing a major review. The Trust participated in the newly developed pilot of the NHSLA Risk Management Standards for Ambulance Trusts in August 2007. This was a valuable exercise as our risk management systems were reviewed against the new standards. As one of two ambulance trusts holding Level 2 rating, participating in the pilot study did not change our existing accreditation. Nevertheless, the lessons learnt from the pilot study have enabled us to develop an action plan which will focus on systems and processes that require further development in preparation for the next formal assessment after April 2008.

1.5 Safety Alert Broadcasting System

The Safety Alert Broadcasting System (SABS) is run by The Medicines and Healthcare products Regulatory Agency (MHRA). When a SAB is issued by the MHRA the LAS is required to inform the MHRA through a reporting system of the actions that it has taken to comply with the action required. The Trust Board receives a report on progress against action recommended. If no action is deemed necessary a "nil" return is still required.

NHS London Reports and Statistics indicate that since July 2007 the trust has received 22 alerts;

- 0 awaiting acknowledgement,
- 2 alerts with issues not yet complete,
- 20 alerts complete or no action required.



The alerts with issues not yet completed are continually monitored. All alerts are being addressed and progress is continually monitored by the Trust Board. Of the alerts currently outstanding there is no breach of deadline for the completion of actions.

1.6 Serious Untoward Incidents

The Trust has an established process for monitoring and reviewing all SUI's, this process is supported by staff who have the necessary skills to undertake a thorough investigation. Monitoring of agreed action measures will be undertaken as part of the wider Incident Reporting System arrangements via the RCAG and/or the CGC and Complaints Panel in order to keep these committees advised of progress against agreed action plans. The STEIS system has been introduced by the SHA.

The LAS experience relatively few incidents that result in being formally declared as SUIs. We are more frequently requested to contribute to a totality of care approach, as well as being in a position to raise concerns. We also work closely with relevant agencies in respect of vulnerable adult and child protection issues, residential care provision, etc.

1.6.1 Learning from Experience

The following are examples of SUIs which have resulted in improvements to internal and external practice.

<u>'Born Before Arrival' Care</u>
A patient gave birth to a premature baby at home. Sadly, owing to complications, the baby subsequently died in hospital. A multi-agency totality of care review was conducted to ascertain if improvements could be made to the care provided in such circumstances. This case has been cited as part of the evidence supporting proposed changes to practice:

1. A bulletin was issued reminding staff of need to prevent hypothermia in premature babies,
2. A request was made that the JRCALC Guidelines subcommittee amend their guidance around precautionary cannulation (in Medical Directors update).

<u>Child Protection</u>
PALS facilitated LAS assistance in respect of a child protection investigation. The Medical Director responded to the subsequent report to provide assurances about the LAS child protection procedure and to recommend LAS be invited to participate at the instigation of any investigation, a factor that was recognised in the report as not being adhered to in this case. The Medical Director has also suggested that LAS be invited to participate in borough Area Child Protection Committees. Both of these recommendations were approved by the agencies concerned.

EOC verification of location

PALS assisted the family of a patient who died of an overdose where LAS attended an incorrect location. The case highlighted concerns about the LAS SUI procedure and the specific issues arising were highlighted in the review of the SUI procedure that was undertaken, resulting in policy and practice being revised.

The recommendations arising from the enquiry included a procedure be developed for EOC which clearly outlines the steps to be taken when a call is identified as 'no reply' and 'no trace'. This includes the specific roles for staff and requires the concurrent reporting of such incidents to the Senior Officer on duty in the control room. Additionally, a robust procedure was introduced to govern the use of the tape machine in the control room, covering who uses the facility, documentation of use and the process to be employed. Consideration was also given to where the tapes are accessed, including areas outside the main control room, to provide a more secure and quiet area.

1.7 Infection Control

The Infection Control Steering Group (ICSG) work is monitored by the CGC. The LAS has well developed infection control procedures which were originally introduced throughout the organisation during 2001 and have been continuously updated to reflect advances in clinical practice. They have all been incorporated into an easy to use reference manual, which integrates relevant background information with procedural instructions for all operational staff and managers of the Service. The manual has been provided on an individual issue basis, and was designed both as the key training tool in the procedures, as well as a follow-up reference source for staff whilst on duty.

The topic of Infection Control is included as an integral element of all LAS clinical training programmes, and also forms part of the Corporate Induction programme for all new members of staff. Furthermore, the subject is introduced within the new entrant selection process for candidates wishing to enter the Emergency Medical Technician (EMT) grades of staff.

An LAS Infection Control Workshop was held in January 2007, and attended by members of the ICSG and supported by managers from the DH MRSA and Cleaner Hospitals Team. A self-assessment tool applied to our procedures demonstrated 55% compliance and highlighted 7 key challenges. These require urgent work around the implementation of our audit findings, education of staff, best practice design for healthcare environments and cleaning services, and decontamination of reusable medical devices. The risk of infection through insertion and care of peripheral venous access lines was also highlighted. The action plan was submitted to the Board as part of the Annual Infection Control Report and will be taken forward during Autumn 2007.

Representatives from the Corporate Logistics Department have attended a networking event in Birmingham recently looking at infection control. The event was attended by representatives from the acute sector and the LAS were the only Ambulance Trust represented. We will be looking to build on the information and the contacts made at this event to further develop our expertise in this area.

The Governance Unit are formulating their plans for audit of Infection Control with clinical audit and operational staff input to produce a more analytical format for the audit tool. This will enhance clinical ownership and evidence improvement through detailed outcome reports. The audit will tie in closely with the

action plan prepared following the 'Essential Steps to Safe Clean Care' self assessment.

The ICSG has initiated a range of projects to improve practical infection control arrangements. These include the following:

- Disposable laryngoscope blades, masks and bacterial filters added to consumables catalogue,
- Disposable Bag and Mask kit rolled out early in 2007 following evaluation,
- Introduction of new safety cannulae and new latex free gloves,
- Inoculation storage fridges purchased for local sites,
- New contractor appointed to collect clinical waste measured against KPIs.

The ICSG will continue to work closely with the Vehicle and Equipment Working Group to identify suitable products. New arrangements have been introduced for streamlining product assessment, dispensing with lengthy trials where there is a low clinical risk. Better use will also be made of products which have been assessed and approved by the NHS Purchasing and Supply Agency. An infection control programme for 2007/08 will be monitored by the ICSG and the Medical Director, including the action plan to address the issues raised by the self-assessment exercise.

The Department of Health provides a self assessment tool for Ambulance Services to assess their compliance with infection control measures. The assessment is based on seven key challenges and as a result of the assessment the following action plan has been identified:-

- Responsibility for Infection Control to be included in all job descriptions,
- Ensure Infection Control leads have appropriate training,
- To formally develop an Infection Control Prevention Programme and record work carried out,
- Formalise systems to review policies and procedures every two years,
- Review results of infection control audits and incorporate these in improvement plans,
- Instigate ongoing training programme for infection prevention and control,
- Ensure infection control is included in all staff induction programmes, in annual mandatory training programmes, and in staff appraisals/PDRs,
- Ensure that infection control issues are taken into consideration at the planning, design, and procurement stage of buildings and vehicles by representation on project groups,
- Check LAS is compliant with national scheduled vehicle cleaning guidelines,
- Roll Out Make Ready Scheme to PTS and RRU vehicles,
- Check LAS is cleaning ambulances in line with national guidelines,
- Ensure that cleaning staff have infection control training,
- Ensure that there is an appropriately trained decontamination lead for reusable medical devices in the LAS,
- Ensure that the Vehicle and Equipment Working Group takes account of infection control issues when considering procurement of medical devices.

These actions will form the basis of the Infection Control Programme for 2007/08. This will be co-ordinated as a Prince 2 project with formal milestones and objectives set and regularly monitored. To enhance our infection control arrangements, a business case was submitted to the SHA. As a result £156k was awarded to enable infection control co-ordinators to be recruited.

1.8 Medicines Management

Medicines Management is reported to the CGC. For this year Medicines Management was audited by Bentley-Jennison as part of our Internal Audit Programme, and the results discussed by the Trust's Audit Committee.

The Prescription Only Medicines (Human Drugs) Order 1997 (Statutory Instrument 1997 number 1830), as amended, empowers a person who is registered via the Health Profession Council, to administer parentally, on their own initiative certain prescription only medicines for the immediate treatment of the sick or injured. This order is commonly referred to as the 'POMS' order; and also provides;

- A list of drugs and infusion fluids approved for use by Paramedics,
- A means by which Glucagon, Salbutamol and GTN may be lawfully administered by all Ambulance Staff,
- A means by which drugs can be added to the above lists / categories administered by all qualified ambulance staff or registered paramedics only, once they have been approved for use by the Clinical Steering Committee and, in certain instances, by the Medicines & Healthcare Products Regulations Agency.

All staff who are involved in the ordering, storage, carriage, use and administration of drugs held by the LAS are under an explicit obligation to report any discrepancies, no matter how minor, as soon as possible to either an Ambulance Operations Manager (AOM) / Duty Station Officer / Emergency Operations Centre (EOC) or other appropriate manager, in order that the matter can be quickly and thoroughly investigated. All discrepancies are recorded in the Station Occurrence Book as well. In addition, if any drug in the possession of any person by virtue of his/her authority to store, carry or administer that drug is stolen or otherwise lost, the loss shall be reported by that person as soon as possible to EOC and then to the local police station. As soon as possible thereafter a full L.A.S. Loss/Theft Report (LA154) must be submitted to the AOM for full investigation. At the same time the AOM must also inform the Chief Inspector, at the Home Office branch. AOMs have delegated responsibility to attend Local Intelligence Network (LIN) meetings.

The procedure covering the issue and use of drugs has been in place for some years but is regularly updated. Under this scheme sealed drug packs are prepared at the LAS Logistics Support Unit and delivered on a daily basis to all ambulance stations. One pack is used by Paramedics, and one for general use by Paramedics and Technicians. A small number of commonly used drugs continue to be stored on stations, and kept on vehicles in the Primary Response Pack (PRP) within a new black fabric bag. A Paediatric Advanced Life Support Pack (PALS) pack is also available and is carried on all response vehicles. Equipment Support Personnel (ESP) pack and deliver the drug bags to stations. New packs are exchanged for used packs. Staff need to sign for the packs at commencement of shift, and packs can be returned to use at the end of shift if they have not been used and are in date. Used packs are "posted" into a separate locker. The PALS packs are changed on demand by the ESP or in consultation with the Logistics Support Unit in cases where there are a number to be exchanged at once. The scheme is carefully controlled and monitored by a system of checks and audits. The Logistics Support Unit and Station Management carry out regular audits of drugs and packs.

Sample audits of packed paramedic and general drugs packs are carried out at the Logistics Support Units. A daily sample of 5% of packs is carried out by the Logistics Manager (Supply & Materials Management), or a designated member of staff and the

result of the audit is recorded on the Stores Drug Sampling Form (LA283). A further 5% sample audit of packs held at the Logistics Support Unit is carried out on a quarterly basis, by an outside agency appointed by the LAS.

All drugs and fluids must be stored in a locked cupboard in a room/area to which access is denied by persons not having reasonable cause to enter that room/area. This means that it is acceptable for the drug / fluid store to be in the Station Office or garage area, provided that it is capable of being locked or secured. When formulating individual Station policies the need for staff to have reasonable access to drugs outside office hours must be considered.

It is the responsibility of all Ambulance Staff to ensure that drugs / fluids are securely stored on any ambulance vehicle they are responsible for during their shift. In reality this means that when the vehicle is unattended the doors are shut and no drugs are left lying about in view. All drugs are to be left in their sealed packs until required for administration to a patient. The theft / loss of any drug must be reported immediately. All staff are held personally responsible for all equipment / drugs / fluids issued to them and will ensure that reasonable access is denied to anyone not having reasonable right of access to them.

During 2006/07 the LAS employed a pharmacist on a part-time basis to assist in the development of Patient Group Directions (PGDs) for medications prescribed by ECPs.

2. CLINICAL AND COST EFFECTIVENESS

'Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes'.

2.1 National Clinical Practice Guidelines

The Trust has an established process for monitoring the implementation of National Clinical Practice guidance - Joint Royal Collages Ambulance Liaison Committee (JRCALC) Guidelines. The CGC monitors this by reviewing the minutes of the Training Services Committee. Updates are given to the Board by the Medical Director as part of her routine reports.

Version 2006 of the JRCALC Guidelines is now in use across the Service with manuals distributed to front line staff. Copies of the pocket book were distributed in mid February. Unfortunately some errors were identified in the section on drug dosages leading to reprinting of the affected pages. The corrected pages have now been circulated to staff for insertion. Some concern has been expressed about the quality of this edition of the pocket book, as the print has shown a tendency to smudge when wet. The publishers have agreed to replace any pocket books where pages have become illegible.

As with the previous edition of the guidelines, there are a small number of areas where the LAS is not fully compliant with the advice given. The most significant issue is around the concentration of oxygen administered to patients with medical conditions, including acute myocardial infarction and stroke, where provided there is no evidence of hypoxia, as evidenced by normal oxygen saturation levels, LAS policy is to give medium rather than high flow oxygen. The LAS plan to implement the advice contained in the British Thoracic Society Guidelines on Emergency Oxygen Therapy which are due for publication later this year.

An updated PRF was made available from March. The major change to note is the replacement of the pink (second) copy with a further white copy to assist those Emergency Departments who are moving to a paperless system and scanning their documents. A box has also been included on the form to enable crews to document the absence of heart sounds, to ensure compliance with the Recognition of Life Extinct (ROLE) procedure.

Drugs now available to EMTs (naloxone and hydrocortisone) have been moved from the paramedic bag to the Technician bag, freeing up space to allow the inclusion of chlorphenamine (piriton) for paramedics.

We are planning to introduce an oral solution of morphine later this year and to introduce drug stickers, similar to those in routine use in hospitals, initially for use with morphine.

JRCALC is hosting a debate on the optimal method of advanced airway management in pre hospital care. Hitherto endotracheal intubation has been accepted as the gold standard. However, the evidence largely gathered in the United States, suggests an unacceptable complication rate. In addition many ambulance trusts are having difficulty in accessing training slots in operating theatres. With the increasing popularity of the laryngeal mask airway (LMA), available to both paramedics, and EMT4s (in London), there is an increasing move nationally towards the LMA being the standard advanced airway. In London it will provide an advanced adjunct to experienced EMT's and an option for paramedics in the event of a difficult or failed intubation. While the JRCALC subcommittee gathers evidence around UK practice the LAS will undertake an audit to determine the average number of intubations undertaken by paramedics each year and produce good practice guidelines for the verification of endotracheal tube placement and skill retention.

As in previous years, the Medical Director has given a presentation to staff at the Chief Executive's consultation meetings on current clinical successes that the Service has achieved and the challenges we anticipate over the coming five years. The improvement in 'out of hospital' cardiac arrest survival, increased conveyance of patients who have suffered a heart attack to primary angioplasty centres and evidence of more effective pain management are highlighted as significant achievements by the LAS. The potential for taking other patients to the most appropriate destination, whether this is to a specialist centre, as in stroke, major trauma or severe head injury, or to a Minor Injury Unit, or local referral pathway is discussed.

The move from classroom based courses to a more flexible modular delivery of education which focuses on patient assessment and covers more of the common conditions staff manage on a daily basis has been led by the Department of Education and Development.

The feedback from staff on clinical issues at the initial meetings has focussed largely on the limited availability of training at Complex level, their frustration with cancellation of courses and the variable quality of the standard of training delivered. The issue of EMTs being unable to supply diazepam has been brought up at each meeting.

The Service was among a number of agencies to give evidence at a meeting of the London Assembly's Health and Public Services Review Committee chaired in March. The Committee wanted to investigate how emergency life support training is

delivered in London and how the number of Londoners trained could best be increased.

The meeting, held at City Hall, also heard from representatives from other organisations such as, St John Ambulance, British Heart Foundation, Resuscitation Council UK, and Saving Londoners Lives.

The LAS had previously provided evidence about its involvement in the training of Londoners in emergency life support, public awareness campaigns and the National Defibrillator Project. The meeting focused on additional schemes and initiatives which might improve survival in out of hospital cardiac arrest. The Committee's report has been published and the LAS is submitting a bid to the Mayor to organise training at a borough level.

2.1 Clinical Audit

The LAS Clinical Audit and Research Unit (CARU), which is part of the Medical Directorate, is responsible for undertaking an annual programme of clinical audit. The aim of the clinical audit programme is to ensure that the LAS delivers high quality care to all its patients in line with best practice. Quality of care is measured in a number of ways including: adherence to clinical practice guidelines; delivery of patients to appropriate care providers; speed of response; health outcomes, and patient satisfaction. The results of all our clinical audits are used to develop recommendations for enhancing patient care. The programme is overseen by the Clinical Audit and Research Steering Group who ensure that the areas of care audited are of relevance to the strategic objectives of the LAS and current priorities in pre-hospital care and the wider NHS. The findings of all audits are disseminated to the CGC, and Clinical Steering Committee, Trust Board and widely across the Service. Reports are also distributed externally to other UK ambulance services, local hospitals and other interested parties.

During the past year, CARU has been involved in a diverse range of audit projects, including a series of clinical audits undertaken on behalf of the Department of Health (DH) to examine the appropriateness of the level of response allocated to some 999 calls. The results of these audits informed a number of changes to call categorisation and the recent recruitment of a Priority Dispatch Clinical Auditor will ensure that the LAS continue its work in this area.

In November 2006, we published the findings from two snapshot clinical audits: pain management in children audit and an audit of the care given to overdose patients. As a result of the pain management in children audit, the LAS introduced a paediatric pain management card to assist in the assessment and treatment of children in pain. In addition, we have submitted the findings to the MHRA and the Department of Health's (DH) Paediatric Advisor as evidence of the need to introduce more child-friendly analgesics for use by ambulance services. Following the overdose audit, there has been a communication campaign to remind LAS operational staff of the appropriate care for overdose patients.

We are currently undertaking clinical audits examining the use of morphine, the care given to stroke patients and the use of benzylpenicillin for the treatment of meningococcal septicaemia. The findings of these audits are expected to be published in late 2007. We have also developed and finalised a protocol for a large-scale multidisciplinary audit looking at the care given to both routine and emergency obstetric patients. For this audit, we will collaborate with four maternity units in London to find out what happened to each patient after hospital admission. A

questionnaire will also be sent to patients to explore their views of the service provided by the LAS. The audit will commence in late 2007 following ethical approval, with the findings expected to be published in early 2009.

The LAS also has a comprehensive programme of cardiac clinical audit, the findings of which are used to enhance the care we deliver to both cardiac arrest and myocardial infarction patients. To support the dissemination of cardiac information and enable local monitoring of cardiac care, CARU produce a monthly Cardiac Care Pack, which was designed in consultation with local management teams at each Complex. CARU also produces the LAS Cardiac Arrest Annual Report that presents, along with other important information, our cardiac arrest survival rate, which for the period 2006-07 stands at 15.8%.

Over the last year, CARU has implemented a series of key developments to our ongoing CPIs programme. The CPIs are undertaken by Team Leaders and enable the Trust to assess basic standards of PRF documentation and the quality of care provided in six specific clinical areas. The LAS monitors the completion of the CPI audits, the level of staff compliance with clinical care standards and the number of clinical feedback sessions given to staff by Team Leaders. During the past year we have rolled out a programme of CPI refresher training for all Team Leaders, implemented a quality assurance process, upgraded the CPI database to enhance its functionality, and produced quarterly posters aimed at increasing staff awareness of the areas of good practice and those that require improvement at each Complex. We also provide monthly CPI reports and Complex Progress Charts for use by local management teams to enable clinical performance monitoring at a local level and inform local improvement initiatives.

The LAS has participated in a number of regional clinical audits and continues to contribute to national audit projects. We are also involved in the current re-designing of the national cardiac arrest and myocardial infarction audits and the formulation of a national CPI dataset.

3. GOVERNANCE

'Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.'

3.1 Training, Education and Development

Over recent years, the LAS has delivered its Continuing Professional Development (CPD) programme for A&E staff within the traditional 'Training Centre' setting and delivered it in one week blocks.

In order to improve accessibility and attendance the Department of Education and Development is currently developing a modular based programme in areas covered by the CPD Course thus providing a more flexible and responsive delivery of educational services.

The benefits integrate fully with the new PDR process, where the responsibility for identifying the training needs of individual members of staff has now largely moved to operational line management teams. The proposed methodology of delivery will provide a varied prospectus which is appropriate to the clinical grade of staff accessing it.

The Training Services Group, which reports to the CGC, met on 10th April 2007 and reports to CGC, requested that the mandatory attendance modules for the financial year 2007/08 were:

- Resuscitation [BLS/ALS],
- Manual Handling,
- Patient Assessment [Intermediate & Advanced].

The delivery of these modules began in May 2007 with additional modules planning later in the year.

Feedback at the consultation meetings focussed very heavily on concerns and access to regular training. We have been sharing with staff the proposed modular format and feedback has been positive. We now need to finalise the training plan for the year ahead and ensure we deliver against it. A further more detailed paper on education and development will be shared with the Board.

Members of the Medical Directorate and the Department of Education and Development have now participated in meetings with all the Complex clinical teams, focusing on local issues such as rates of return of spontaneous circulation, time to first shock, rates of successful endotracheal intubation, end tidal carbon dioxide monitoring, pain management and completion of clinical performance indicators. We have sought feedback on complex based training, selection for paramedic training and alternative methods of delivering the education agenda.

Plans to develop a CPD module are still being pursued. A CPD module would be deliverable either at a university site or at one of our own education and development centres. A six week interactive CPD module programme with web based support has been considered in partnership with Kingston University.

A programme of service wide training is still underway to familiarise staff with the “six steps” hand washing technique. This is reinforced by the poster campaign being undertaken throughout the service

The ICSG has identified the need for local infection control “champions” to be established on each Complex. This could be a member of staff or a local manager. The “champion” would develop an expertise in infection control issues and act as co-ordinator for promoting the CPD programme and as a link for other corporate initiatives and audit activities. This objective will be a key part of the Infection Control programme for 2007/08.

Statutory/Mandatory Training:
The Training Needs Analysis, monitored by the CGC, is being held under continuous review so that it sets out all clinical mandatory training requirements and is up to date with risk management training for Board and Senior Managers.

Other In-House Activity:
Learning & Development have continued to provide staff development courses to meet aspects of the KSF Core competencies, in subjects such as assertive communication, customer care, meeting administration. In addition, to support personal development, courses have been provided in Applying for Promotion and Return to Study skills.

Management development has continued for specific management groups such as team leaders and ambulance operations managers. In addition the LAS middle

management programme Exploring Leadership and Self Awareness (ELSA) has continued throughout the year. Personal Development Review (PDR) training has been delivered to all managers during 2007 and a new in-house coaching skills course was piloted in October 06, which will now become a regular course.

3.1.1 Equality and Diversity

The Equality and Diversity approach of the Trust has been under review with the change of post holders in the key role of Equality and Diversity Manager. The new manager is conducting a baseline review of equality and diversity work throughout the Trust. Initial results from the review indicate Equality Impact Assessments (EQIA) as being an area where the Trust will take further action.

As part of this action plan, an EQIA programme is being developed using the mechanism of a series of training workshops over the next six months. The first briefing session for Service Improvement Programme Managers was facilitated and gave an overview and introduction to EQIAs and the tools that have been developed to guide and support those involved in the process.

Meetings have been held with the Head of Governance, Head of Records Management, and Head of Planning and Programme Management, to scope how best to mainstream the governance of equality and diversity and on the most effective way to embed the EQIA process through the Trust.

SMG and SSG Committees are closely monitoring the diversity baseline findings and EQIA initiative.

Other Equality and Diversity Initiatives

- Single Equality Scheme – All the Trust's Equality schemes are being reviewed to facilitate the transition to a Single Equality Scheme as anticipated in legislation.
- Community Engagement Pack – 'Working together' will shortly be published and available for other NHS Ambulance trusts to purchase.
- Save a Life Pocket Cards – New artwork was commissioned for a series of new cards that prioritise community ethnic groups who have been previously identified to be at high risk from coronary heart disease.

3.2 Research and Development

In order to ensure that new practices and treatments are going to provide the most effective care and best outcomes for patients, they must be based on research evidence. Research and development is an integral part of LAS core business and we are committed to using the findings of research to inform and influence our practices and patient care.

The LAS has a comprehensive programme of research that focuses on remodelling the way the ambulance service responds to patients. It aims to provide a greater understanding of the demands (and changes in demands) on the ambulance service and the clinical effectiveness of pre-hospital care. The overall objective is to provide an evidence base to inform changes in the delivery of pre-hospital treatment, with a particular focus on: improving cardiac care; providing alternative responses for non-emergency patients; eliminating unnecessary ambulance journeys and A&E attendances, and improving patient outcomes and experiences.

We are currently running a number of cardiac research trials in collaboration with international partners including Seattle Emergency Medical Service, University of

Washington and New York City Emergency Medical Service, examining various aspects of care, from telephone CPR instructions to the use of defibrillators in the field. We are also currently developing two cardiac drug trials in collaboration with some London hospitals and drug manufacturers.

Other research projects in the programme encompass areas of care such as stroke, older people who fall, and the role of ECPs. All research projects undertaken as part of our programme have resulted in (or are expected to lead to) publications in peer - reviewed journals and presentations at national and international conferences.

All LAS research is compliant with relevant legislation (such as the Research Governance Framework, Mental Capacity Act 2005, Data Protection Act 1998, and the Medicines for Human Use (Clinical Trials) Regulations 2004) and we have robust review and approval processes in place to ensure high quality data and ongoing compliance with such legislation.

In order to support and encourage awareness of evidence-based practice throughout the LAS, we hold bi-monthly Evidence for Practice Seminars with invited internal and external speakers. We also hold a bi-monthly Journal Club where staff with no or limited research backgrounds have the opportunity to read and critically appraise published research papers and discuss the implications of the findings on their day-to-day practices.

The LAS is a member of various local and national research networks and is actively working with other UK ambulance services to raise the profile of research nationally and encourage collaborative working.

3.3 Information Governance

Information Governance allows organisations and individuals to ensure that personal information is handled legally, securely, efficiently and effectively. The Department of Health and NHS Connecting for Health require all NHS Trusts to measure their compliance with information-handling requirements using a self-assessment based toolkit. This assessment is then annually returned to the DoH for approval.

The toolkit has been updated to incorporate the evolving information security landscape and Airwave security requirements.

The revised toolkit has 44 requirements and has been built upon initiatives that group controls by management, people, processes and systems.

The Trust achieved an overall score of 83%. This is broken down into the initiatives shown below.

Initiative	Results (based on requirements version 4)
Clinical Information Assurance	**100%** (GREEN)
Confidentiality and Data Protection Assurance	**91%** (GREEN)
Corporate Information Assurance	**75%** (GREEN)
Information Governance Management	**82%** (GREEN)
Information Security Assurance	**78%** (GREEN)

4. PATIENT FOCUS

'Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.'

4.1 Patient Information

Reports to the CGC are received from the Records Manager. CPI audits also focus on completion of the PRFs. Concise, accurate and legible patient care record keeping is an integral part of all healthcare practice. It is a tool of professional practice and one which contributes to the care of the patient. It is not separate from the care process and is not an 'optional extra' to be fitted in if circumstances allow. LAS staff that have responsibility for creating and/or managing patient care records are not exempt from these principles.

The LAS receives requests for access to and information about calls and other records ("Patient Information") from, among others, patients, patients' relatives, solicitors pursuing civil claims, solicitors defending criminal prosecutions, and the police. In addition requests for information about calls to patients are received from other groups including the press / media, other NHS bodies, local authorities, and members of the public.

Records retained by and held under the control of the LAS are held by the Management Information Manager (Accident & Emergency records except LA1s), PTS Business Manager (PTS records) and on main stations (LA1s). PTS is considered to be a "data processor" and not a "data controller" under the terms of the Data Protection Act, and the records therefore belong to the organisation which provided the data. Where requests are received for access to this information we will co-operate with the data controller organisation in making the information available.

There is a special relationship between a healthcare professional and his/her patient which means that the common law duty of confidence attaches to personal details (including his/her medical details) provided by the patient about himself/herself. The information is likely to be of a sensitive nature and passed on in the expectation that it will not be provided to any third party. It has long been accepted that information disclosed by an individual to a healthcare professional in the course of his or her work is covered by a duty of confidence. Consequently, Patient Information held by the LAS is covered by that duty.

4.2 Complaints and Claims

Complaints and claims are reported as part of the Risk Information Report presented to the CGC.

4.2.1 Complaints

The NHS Complaints Procedure states that 85% of complainants (new complaints) should receive a full written response by the Chief Executive within 25 working days. At the end of the financial year, 78% complainants received a Trust response within 25 working days.

Complaints are analysed by; Type (e.g. health or social care), Severity (e.g. near misses, patient safety incidents), Complexity (e.g. service user has a number of needs), Location, Person complained about, Date received, Subject (e.g. delayed

response, attitude and behaviour etc). The Complaints Panel monitors the Trusts management of complaints. Membership of the panel includes the Chairman of the Patients Forum, the Non-Executive Director who is chair of the CGC, and the PPI Manager.

The Trust's Patient Advice and Liaison Service (PALS) are integrated with the Complaints team under the leadership of the Patient Services Manager. The PALS team are able to resolve many concerns before these escalate to complaints, including driving agreed outcomes. Acting as the gateway to complaints procedures and independent advocacy, the PALS team assists staff to develop a responsive culture.

The Trust has a clearly defined system to learn from complaints, such as the adoption of reflective practice as a complaints strategy. Also, routine completion of outcome reports as part of complaints handling management and regular reporting to CGC, Complaints Panel, local area Clinical Governance Forums, Senior Management Group and Trust Board. The publication of outcomes and learning points in Trust-wide media including electronic and hard copy dissemination. However, we are proposing improved implementation, monitoring and evaluation systems as part of the change management review.

Learning is demonstrated through follow-up action by the Patient Services Manager and the Chief Executive/Board, and as part of an integrated risk management system (i.e. a system which examines issues arising from complaints, patient safety incidents, clinical litigation etc). The Patient Services Manager is a member of the CGC and submits information as part of the Risk Information Report.

Changes have been made to Trust policies and procedures as a result of complaints, such as Control Room call triage practice in relation to resources to be dispatched where the patient presents as having experienced a seizure.

The Trust now employs a Consultant Midwife on a part-time basis to advise on obstetric issues, an area of great concern for our staff and an identified risk for the organisation.

We continue to further implement and evaluate improvements identified via an integrated approach. Further, we are embedding a whole systems approach across the Trust for answering concern and complaints and to ensure more robust dissemination mechanisms. The Trust is committed to offering our full cooperation to partner agencies via a range of feedback mechanisms i.e. SUI, totality of care reviews, incident reporting.

4.2.2 Claims

The Head of Legal Services supported by the Claims Co-ordinators and Road Traffic Accident Claims Assessor and Administrator Incidents / Claims is responsible for managing litigation in clinical negligence, employer / public liability, and motor liability in accordance with the Trust's Policy and Procedures for such claims.

The Head of Estates is responsible for the handling of claims under the Property Expenses Scheme for damage, loss, or destruction of the Trust's property or estate and will report and investigate such claims in accordance with the rules of the Scheme.

The Financial Controller, supported by the Senior Financial Accountant, is responsible for submitting a summary loss report, which includes below excess losses to the Trust property and estate under the Property Expenses Scheme.

The LAS Trust Board and Directors through the RCAG, receive a report every six months which provides:

- the number, classification, and aggregate value of clinical negligence, personal injury and other liability claims against the Trust,
- summary information on the final outcome of clinical negligence, personal injury, and other liability claims against the Trust and remedial actions taken or proposed as a consequence of those claims.

When a significant litigation risk is established for which indemnity is available by the NHS Litigation Authority Clinical Negligence Scheme for Trusts, Liabilities to Third Parties or Property Expenses Schemes and the valuation of the possible claim is above the Trust's excess limits, the matter becomes reportable to the NHS Litigation Authority.

5. ACCESSIBLE AND RESPONSIVE CARE

'Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway'.

5.1 Patient and Public Involvement

The Patient & Public Involvement (PPI) Manager has been in post since July 2005, and is a member of the CGC and reports to it. She holds a database of reported PPI activity across the Trust and is responsible for implementing the PPI Strategy. She encourages and supports LAS colleagues to involve patients in their developments and activities. Currently the PPI strategy is being updated, to include a range of activities and strategic developments over the next four years.

A presentation was given to the LAS Patients' Forum in early 2006 about the Make Ready Scheme. Forum members were supportive of the Scheme. Information about the Scheme has also been presented to the Deptford Care of the Elderly Action Group.

During the summer months the LAS has been involved in a number of public events, such as Child Safety Week in Kingston town centre, an event for young people in Norwood Green, events at two schools in Newham, a community event in Blackfriars, a health day in St. Helier and an event in East Ham to mark the second anniversary of the London bombings. The London Mela festival was held in Gunnersbury Park the LAS was also involved in the Lambeth Show, promoting road safety.
Junior Citizens' schemes have been held across London, with LAS staff running information sessions for children over periods of two weeks. LAS staff from Oval were involved in an open day at King's College Hospital.

One of the Community Resuscitation Training Officers has spoken on an Asian radio station about Heartstart training.

The Public Education Strategy Steering Group has conducted a survey of staff engaged in public education activity and is planning two workshops for them in November 2007. Once funding has been allocated to the Strategy, its implementation will ensure that staff doing this important work have the right information about the Service, and the right skills and knowledge to represent the Trust appropriately.

A Patient Transport Service (PTS) Listening Event was held at the Brit Oval in May. 70 patients, carers, other PTS providers, commissioners and representatives from voluntary sector organisations attended and took part in facilitated discussions to share their views and experiences and consider the issues affecting PTS provision. The event was filmed and a report has been prepared which outlines the main findings and describes how developments in PTS will be taken forward. It is likely that a number of working groups will be formed from those attending, to progress the ideas discussed on the day.

The NHS Centre for Involvement (NCI) carried out a baseline assessment of patient and public involvement in the LAS. Whilst they identified the LAS as having made significant progress in its patient and public involvement work, the NCI has produced a report with four key recommendations for the Trust so that it can move from "good" to "great". The recommendations, which will be presented to the Service Development Committee at the end of October, were discussed in detail at a Learning Event in June. They have also been incorporated into the new PPI Strategy.

With the support of the NCI, the Trust has undertaken a project focusing on the Bangladeshi community in Tower Hamlets. This project aims to improve health outcomes, to build links between the LAS and the Bangladeshi community, and to increase recruitment to the LAS from members of this community. The project is focusing on maternity, children and young people, and working with the PCT to produce a health education pack.

The Head of Communications attended the June Patients' Forum meeting and presented the findings of the Ipsos MORI research on public opinions of the LAS. The Director of Information Management & Technology attended the October meeting to discuss plans for CAD 2010 and improving access to the Service for deaf and speech-impaired people. He has also held separate meetings with the three deaf members of the Patients' Forum, as part of the project focusing on this issue within the Access Programme of the Strategic Plan.

The Trust is currently considering the impact of a decision to apply for Foundation Status, and how its membership might be developed. Other significant changes to patient and public involvement will come later in 2008, when the Local Government and Public Involvement in Health Bill is likely to become law. This will lead to the abolition of Patients' Forums and the establishment of Local Involvement Networks (or LINks) in each borough. This is a potentially exciting development and will allow local management teams throughout the LAS to take a proactive role in PPI in their area.

6. CARE ENVIRONMENT AND AMENITIES

'Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.'

6.1 Safe and Secure Environment

The Trust is committed to providing a safe and secure working environment for all staff, all professionals, stakeholders, volunteers and visitors. With the implementation of the Local Security work plan the Trust is creating a pro-security culture.

The Trust recognises the importance of providing a safe working environment to its staff, patients and other members of the public who come into contact with the organisation. Exclusive Make Ready cleaning schemes work across all complexes. The Trust will ensure that specific responsibilities are fulfilled by carrying out risk assessments of the organisation's activities, controlling identified hazards, providing information, training and instruction to allow staff to carry out their duties safely, and auditing systems to ensure policies and procedures have been implemented.

The Workplace (Health and Safety and Welfare) Regulations 1992 place duties on employers, to undertake regular work place inspections, with a written record being taken of such inspections.

It is the responsibility of the Ambulance Operations Managers, to carry out inspections of stations/premises within their unit together with a local Health and Safety Representative, on a quarterly basis.

The Estates Department is responsible for arranging the maintenance or repair of hazards or items identified during inspections.

6.2 Clean Environment

To assess the compliance of the Service with the Code of Practice, a self assessment exercise was carried out by the Trust's ICSG. The Department of Health "Essential Steps to Safe, Clean Care" was utilised. This highlighted a number of areas which the Service needs to address. These include audits, education and training, the health care environment and decontamination of reusable medical devices. The areas identified will be addressed as part of the Infection Control programme.

The Make Ready Scheme is the method by which the Trust ensures that ambulances are clean, fully equipped and ready for operation. The scheme was fully rolled out to all 25 station complexes in the Spring of last year.

The scheme is monitored through a set of 13 Key Performance Indicators. Weekly performance data against KPIs is produced. Make Ready performance is reported to the Make Ready Contract Group on a monthly basis. The Operational Support Units also monitor performance on a local basis at their weekly meetings. Operational Support Forums have been established in each of the three areas. These Forums, which provide a platform for support departments and operational colleagues to plan and discuss issues of mutual concern, have been expanded to include discussion of Make Ready issues.

Four of the 13 KPIs are directly relevant to the ICSG:

- KPI 1 – Every available ambulance 'Made Ready' once every 24 hours
- KPI 2 – Standard of ambulance cleanliness
- KPI 3 – Conformity to ambulance inventory
- KPI 5 – Standards of station cleanliness

*All KPI targets are set at 100%.

Additional performance measurements have also been developed to monitor the number of vehicles made ready from total allocation. These help to maintain an oversight as to any factors which are restricting the numbers of vehicles being made

available to the Make Ready Teams. This may be due to vehicles having insufficient equipment, being in Workshops, or not being released by Operations.

Performance against the KPIs remains robust. Additional effort is being made to ensure a higher percentage of vehicles from the total allocation are made ready every night. Consideration is also being given to adding Rapid Response and PTS vehicles to the scheme during 2007/08.

Regular swab tests are taken on vehicles subject to Make Ready from four fixed locations subject to change every three months. The swabs are processed by an independent laboratory and reported on monthly.

Results indicate that the total viable count of all bacterial types on the rear drop down step of an ambulance dropped from more than 30,000 to 3,000. The range of bacteria including E Coli and Salmonella on the trolley bed dropped from 510 to less than 10. All swabbed areas effectively indicated a zero count of staphylococcus bacteria (MRSA) both before and after Make Ready cleaning.

7. PUBLIC HEALTH

'Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas'.

7.1 Pandemic Flu

The Medical Director and the Senior Clinical Advisor to the Medical Director are continuing to give advice, along with a range of other healthcare professionals, to the Department of Health with regard to Pandemic Flu plans and the call prioritisation, should Pandemic Flu occur.

7.2 National Service Frameworks (NSF)

The National Service Frameworks are national standards for developing services and making sure that high quality care is available and accessible to everyone who needs it. The NSFs lay out a set of national standards for the treatments which have the objective of both raising the quality of NHS services and reducing unacceptable variations between different parts of the country. All NSFs involve working with London PCTs and community services.

Policies and service developments have been updated and implemented in the following NSF areas during 2007:

7.2.1 Mental Health

The Service has worked closely with the London Development Centre for Mental Health in anticipating the implications of the amendments to the Mental Health Act (1983) for providers throughout London. The amended Act received royal assent this summer with a likely implementation date of October 2008. Amongst other areas, the work has focused on anticipating Delivering Racial Equality (DRE) issues, partnership working and developing the Code Of Practice.

Standards two and three: Primary care and access to services

- The Service has worked with police and social workers to set up a trial around Mental Health Assessments in Camden & Islington. The trial, which is not yet complete, involves deploying Urgent Care resources to all but the most high risk assessments in order to:
  - Deliver a more timely service to stakeholders
  - Offer a more efficient use of resources.

- The Service has also trialled a pathway offering direct access to a mental health unit at Oxleas Mental Health Trust, for patients known to the Trust. Discussions are ongoing regarding making this trial permanent.

The Service is also reviewing its mental health strategy, and protocols on conveying mentally ill patients, in line with the amendments to the Act.

7.2.2 Older People

Standard five: Stroke

The Service has taken the lead in implementing a London-wide model with the aim of providing 24-7 access to CT scans and, where appropriate, thrombolysis for patients who are FAST +. South West and North Central London have engaged with us so far on this project.

Standard six: Falls

Across London, the Service has engaged with a variety of teams who provide access to falls pathways in their PCTs. These protocols, once agreed by the medical director, offer information on how to access services which address the hazards and combination of prescriptions which may have contributed to patients falling, with the intention of reducing such incidents in future.

7.2.3 Long Term Conditions

Case Management

Due to be trialled this autumn, the Service has been working with Hackney and Tower Hamlets PCTs to develop a pathway whereby crews can consult GPs regarding the care of their patients. This will allow crews to discuss cases with a fellow professional who knows the patient well, and agree the best pathway for them to access the care they require. The trial will be evaluated to establish whether it improves A&E conveyance for non urgent calls and offers better value for money for PCTs.