London Ambulance Service NHS
NHS Trust

Quality Account
2011/12

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Part 1. Introductions

Statement by the Chief Executive

We believe London is one of the greatest cities in the world and it is a privilege to provide urgent and emergency health care to this world city.

We are the busiest ambulance service in the UK and probably the world and we respond to the emergency needs of up to eight million London residents, commuters and tourists. The work we undertake is varied and ranges from dealing with major incidents, providing clinical support to large public events to giving advice to those patient not requiring an ambulance. We also provide a transport service for patients who require assistance with their travelling needs when needing healthcare away from home.

This past year has been yet another challenging year. We responded to 1,100,000 calls for assistance. A greater percentage of these incidents were within our highest priority category which means we responded to more patients within eight minutes than ever before. In August 2011 London suffered widespread rioting, looting and arson and we were required to respond quickly to the needs of Londoners at this difficult time. We also saw a day of national industrial action in November which significantly challenged our service. We have looked to learn lessons from these major events.

The past year also saw the introduction of the ambulance clinical quality indicators. This is a set of indicators, which we fully report on in this account, which maintain a focus on the speed of response but also introduce a greater emphasis on other measures such as experience and clinical outcomes. We very much welcome this development as it reinforces our belief that quality and patient safety need to be at the very top of our priority list and is part of our vision to be a world class service.

This is our third quality account and it reports on the quality improvements that we highlighted in our second quality account. We have made considerable progress and have implemented the vast majority of the 51 specific actions that we said we would address. This year is Olympic year and this brings a different challenge to our service. We have identified a smaller number of priorities for the coming year. Nevertheless, some of these are of significant magnitude and when considered alongside our CQUIN priorities it is clear that this is going to be another year where we make further improvements for patients.

To the best of my knowledge the information contained in this report is accurate and reflects a true accurate account of our service.

Peter Bradley CBE
Chief Executive

General Requirements

Welcome to the third quality account from the London Ambulance Service NHS Trust. This account fulfils our legal obligation to make public our achievements on quality during the past year. It reports progress on the four quality objectives identified in last year's quality account and identifies new ones for the coming year.

Last year's priorities were;
Improving mental health care
Improving the care of patients who have fallen
End of life care
Implement a quality dashboard

We have drawn on information from a number of data sources and service areas and many individuals have contributed to the creation of this account. We have also engaged with a wide group of patients in identifying the priorities for the coming year and consequently we believe we have developed objectives that are meaningful to patients and will further improve the quality of the services that we provide.

Next year we will be required to progress the quality account through the same audit pathway as our financial accounts but even now the account sits alongside our Annual Report and has been approved by the Trust Board and its sub committees.

Our lead commissioner and local LINKS groups have had the opportunity to comment on this account and we have presented an overview of quality to two Overview and Scrutiny Committees.

This account has been designed for on line publication on the NHS Choices website. However, printed copies will be made available on request for two years from the Trust headquarters.

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Vision & Values

Our **vision** remains the same for 2012-2013 as it was for 2011-2012. However, our underpinning goals and objectives were reviewed in 2011 and a summary of the changes is attached as Appendix I.

The following diagram illustrates the relationship between our vision, goals and our current objectives

OUR VISION

To be a world-class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.

1st Strategic Goal

To improve the quality of care we provide to patients: to improve our delivery of safe and high quality patient care using all appropriate pathways

2nd Strategic Goal

To deliver care with a highly skilled and representative workforce: to have staff who are skilled, confident, motivated, feel valued and who work in a safe environment

3rd Strategic Goal

To deliver value for money: to be efficient and productive in delivering our commitments and to continually improve

Supporting Corporate Objectives

CO1. To improve the experience and the outcomes for patients who are critically ill or injured

CO2. To improve the experience and provide more appropriate care for patients with less serious illness and injuries

CO3. To meet response times routinely

CO4. To meet all other quality, regulatory and performance targets

Supporting Corporate Objectives

CO5. To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population

CO6. To create a productive and supporting work environment where staff feel safe, valued and influential

Supporting Corporate Objectives

CO7. To use resources more efficiently and effectively

CO8. To maintain service performance during major events, both planned and unplanned, including the 2012 Games

CO9. To improve engagement with key stakeholders

Our **values** remain the same for 2012-2013 as they were for 2011-2012;

We have seven values that underpin the culture of the London Ambulance Service and these are also known as our critical values. They portray the culture of the organisation and reflect the values enshrined in the NHS constitution. Our values are as follows:

- **Clinical excellence** – we will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs.
- **Respect and courtesy** – we will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy.
- **Integrity** – we will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right.
- **Teamwork** – we will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed.
- **Innovation and flexibility** – we will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to.
- **Communication** – we will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on.
- **Accept responsibility** – we will be responsible for our own decisions and actions as we strive to constantly improve.
- **Leadership and direction** – we will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

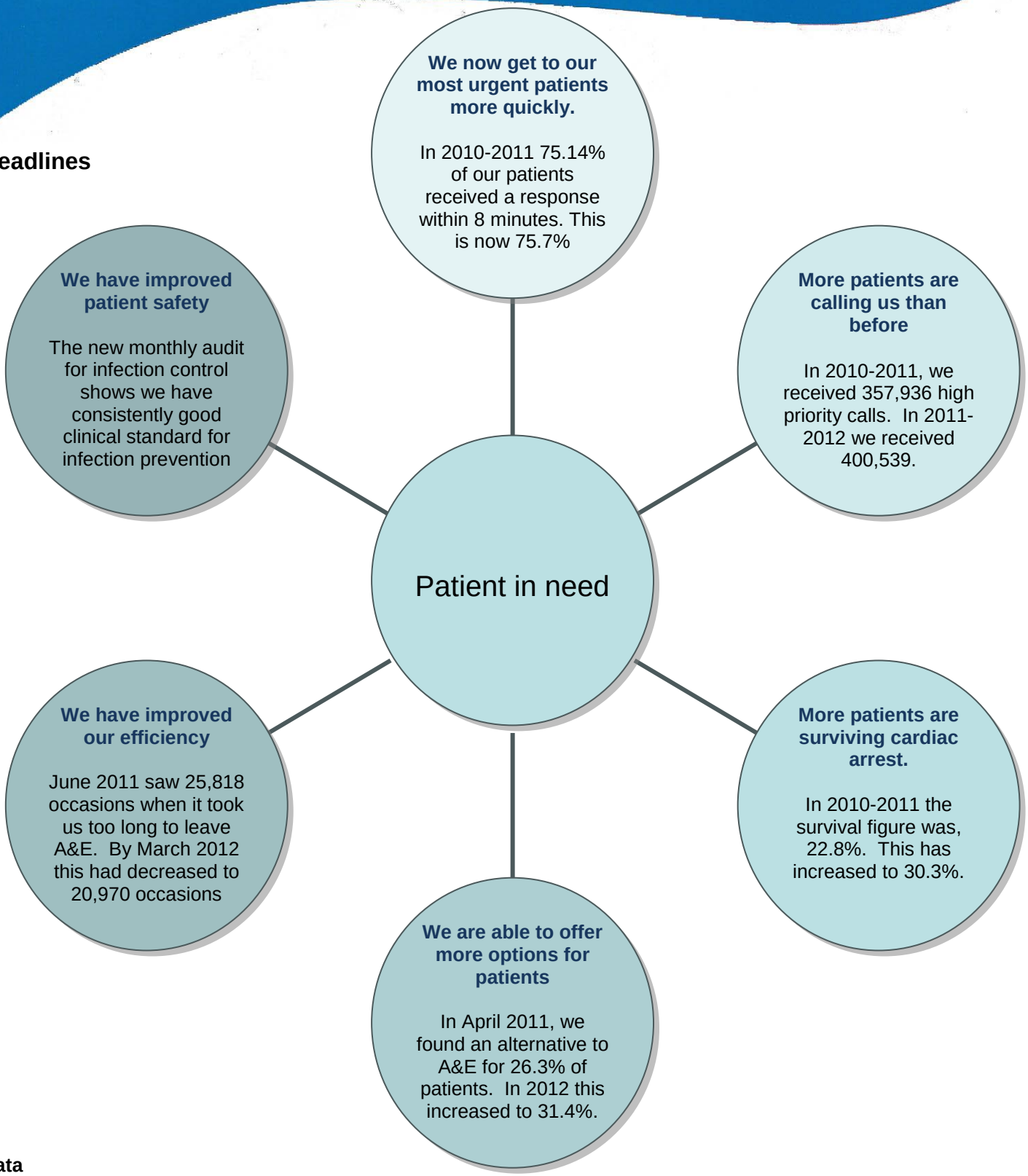
This Quality Account describes some of the progress we have made in 2011-2012 and we believe we are amongst the best ambulance services in the country. However, by delivering our identified objectives and adhering to our critical values we believe that we will deliver our vision to be world class. We have also broadly identified three specific areas that would help us to identify world class;

- **Patient outcomes across a range of conditions benchmarked amongst the best in the world**
- **Highly productive, professional, motivated workforce leading clinical improvements in their communities**
- **Fully integrated healthcare partner leading urgent and emergency care system development and improvement in London**

During the course of the year we will make further clarifications and make contact with other ambulance services in other countries to start comparing, where possible, outcome data. However, to be world class we need to have clinical evidence to support this. We have the aspiration to be upper quartile in all of the Ambulance Clinical Quality Indicators.

Quality Headlines

Headlines



Data

It is important to note that some of the data sources are not the same as data quality improves over time. In addition, some of the 2011-2012 data is for a partial year. This is intended to serve as headline messages. The cardiac arrest survival figures are for those events that are witnessed and the 30.3 per cent is up to December 2011.

Writing the quality account

The overriding principle of the 2011-2012 Quality Account, as in 2010-2011, is that the account should reflect the views of patients.

However, we needed to take a different approach this year as many of the voluntary groups that were approached did not have the capacity to make a contribution. Therefore, we took the opportunity to seek patient views in a more integrated way and asked for feedback at a number of engagement events that were run towards the end of 2011-2012.

We asked people who attended 19 different engagement events and 72 participants made some suggestions. The majority of these people were potential patients rather than people who had previously called an ambulance.

Two suggestions featured highly 1) speed of response and 2) the knowledge of our staff. Otherwise the suggestions were broad in nature. Some participants suggested personal qualities such as kindness and understanding as important factors in determining their experience.

The following table outlines the most popular suggestions.

Speed of the ambulance arrival	64
Competence of the clinical staff	22
Good advice by the call takers	16
Speed taken from scene to hospital	10
Kindness & polite	9
Efficient triage on the telephone	7
Language skills of clinical staff	6

We also asked patients for their views at a number of other opportunities. These included;

- Presentation to Westminster LINKS
- Presentation to Hillingdon External Oversight Committee
- Presentation to the City of London Overview & Scrutiny Committee
- Presentation to London Ambulance Service NHS Trust members
- Interviews with patients who have used our service in Accident & Emergency

The feedback from all of these engagement events has been positive and, with the exception of speed, there were no consistent quality concerns arising from patients. We also undertook a patient survey in 2011-2012 in partnership with North and Central London NHS Foundation Trust and specifically asked for feedback on a number of quality aspects. Most of the respondents, 81.3%, said that our service was as they had expected.

We also approached staff and invited suggestions to be made via a dedicated e-mail account and through engagement with over 80 managers at our internal senior managers conference. In addition, on completion of the Quality Account a number of stakeholders were invited to make comments on the report and their feedback is contained within the report.

How we are prioritising quality

Quality remains the focus of what we do and drives the decision making process. However, it is no longer enough to simply focus on quality. We are increasingly being asked to evidence how quality drives the decision making within the Trust and we need to pay more attention to how quality is recorded and documented throughout our governance structure. In 2011-2012, we had a number of internal and external quality reviews and these assisted us in further strengthening our governance.

The most recent review was undertaken by the Care Quality Commission. They found the Trust to be compliant with the observed standards but non complaint with a specific aspect of controlled drug ordering which we are addressing. We also had a number of additional reviews undertaken as part of the Foundation Trust application process. These have been positive experiences and on each occasion examples of good practice were identified and a number of areas where further improvements could be made have also been raised.

Examples of good practice have included;

A quality dashboard: Having a dashboard in place that reports on a number of quality measures and has the ability to break a number of them down to the level of individual ambulance station.

Clinical performance indicators: Having repetitive measures that are audited monthly and can be broken down to the level of the individual member of staff.

A single data point for evidence: Having a central electronic store to file quality evidence was praised by the CQC.

Opportunities for further strengthening quality included;

Engaging more with staff: It is recognised that communicating across 70 sites is challenging. However, we need to find a way that allows us to do more of this. We also intend to drive the quality dashboard through the organisation which will require stronger communication links with clinical staff.

We believe quality is the responsibility of all of our staff. Each of our areas has a governance mechanism for monitoring quality and uses this as an opportunity to bring together all of the information that is necessary when reviewing quality. This includes; performance measures, quality indicators, lessons learned from complaints, and also the lessons learned from adverse incidents. We are now moving these mechanisms to focus on the quality dashboard and are introducing systems that mirror the ward to board information procedures of Acute Trusts.

In 2011-2012 we stated that we would strengthen the way we learn from serious incidents and we have made significant improvements and now include the lessons in an integrated report that highlights them within the context of other issues. We now also complete serious incident investigations more quickly than in the previous year. However, we now need to roll some of these systems into our less serious incidents so that we have a single robust process.

During 2011-2012, we had a comprehensive cost improvement programme that included a wide range of projects for reducing the cost to the public of running the ambulance service. Each of these projects, no matter how small, had a clinical lead who was actively engaged in

monitoring the impact of the project on patient care. Whilst our two clinical directors maintained an overview each clinical lead was empowered to challenge their project. This was very successful. However, in 2012-2013 we need to strengthen the governance and the evidence of clinical engagement as it is currently only recorded when concerns are raised. We need to be able to demonstrate continual scrutiny of clinical quality.

One of our biggest successes in measuring quality has been the implementation of the quality dashboard. This identifies our priorities for quality within seven domains and is used as one of our key mechanisms for reporting quality to the Trust Board and to our commissioners.

Quality Domain 1: Staff/Workforce

The workforce domain includes a set of measures regarding our workforce. We have had mixed success with these measures. We have some of the lowest absence levels of any ambulance service and have low turnover when comparing us with other NHS employers. However, we need to improve the supervision we offer to staff and be able to evidence training more robustly than our current system allows.

The Service's 2011 staff survey results were published in March 2012. Significant improvements include the percentage of staff who have used e-learning opportunities (72%, up from 12% in 2010) and receive training in how to handle confidential information (80%, up from 55% in 2010). Scores which went down include the percentage of respondents who report that there are not enough staff in the Trust for them to do their job properly (up to 54% from 39% in 2010) and that there are no opportunities for career progression (up to 47% from 36% in 2010).

The Department of Health benchmarked the Service's scores against other Ambulance Trusts, based on a sample of responses. We are significantly better than average for the percentage of staff using flexible working options (48% compared with an average of 44%). However, our overall staff engagement score, taking into account motivation, staff ability to contribute towards improvement at work and staff recommendation of the Trust as a place to work, is below average (3.15/5 compared with an average of 3.23/5). However, the key areas of focus in response to the results will be communication between senior management and staff. 67% reported that this is not effective and 65% said senior managers do not try to involve them in important decisions. We will undertake further analysis in early 2012-2013.

Quality Domain 2: Performance

The performance domain essentially reports the key response time targets and the length of time we wait to hand over to other professionals. In 2011-2012, commissioners focussed on those patients who were the most urgent and need a response within eight minutes. We are delighted that we have met this response time for the ninth consecutive year. However, we now need to turn our attention to those patients that do not require an eight minute response to ensure they get a timely intervention. The quality dashboard for 2012-2013 will include the speed of response for all our patient groups.

Quality Domain 3: Clinical intervention

The clinical intervention domain contains measures that monitor what we actually do to patients whilst in our care, for example, our success at resuscitation following a cardiac arrest. We are very proud that we have made even further improvements on last year's results. Whilst the data collection was only available up to December 2011 for witnessed cardiac arrest survival London was the highest in the country at just over 30%.

Quality Domain 4: Safety

The safety domain monitors key elements to patient safety. One of the measures is how quickly we answer the telephone. We have one of the best emergency call handling services in the world and we consistently have the quickest call answering in the country and the lowest level of dissatisfaction measured through "hanging up" before answering.

We have also made significant improvements to safeguarding. At the end of the previous year we participated in a London-wide review of safeguarding that was led by NHS London. The review was positive and found us to be compliant but identified a number of areas that could be strengthened. As such we have worked through an action plan in collaboration with our commissioners. We have also appointed a named professional and have introduced a safeguarding dashboard that

monitors safeguarding referrals, training and networking. This is monitored at our Safeguarding Committee. We have further work to do in recording and quality assuring our safeguarding training.

Quality Domain 5: Clinical outcomes

The clinical outcomes domain reports on the outcomes of patients. This domain has limitations as we are dependent upon receiving information from other organisations for true outcome measures. However, we have made a number of improvements in this domain during 2011-2012. Most notably the number of patients receiving telephone advice and the satisfaction of this service when measured by the number of patients telephoning us again within 24 hours is amongst the best in the country.

We now also have an infection control dashboard that measures a number of important infection control indicators such as compliance with practice guidelines (hand hygiene), training, and cleaning. This has significantly raised the profile of infection control and has strengthened our ability to evidence that we do all we can to protect patients from the infection risks associated with healthcare.

Quality Domain 6: Dignity

There are a number of measures within the dignity domain that measure the way we treat patients. Last year the essence of our quality priorities, mental health, patients who have fallen, and end of life care fell within this domain and we added these to the dashboard. We have had mixed success in this area and the detail is reported elsewhere in this quality account.

Quality Domain 7: Satisfaction

The satisfaction domain monitors the feedback we receive from patients. We do this through our newly-developed service experience action plan. The actions on the service experience action plan arise from the integrated report and the indictor measures the effectiveness of the action plan by Red, Amber, and Green, rating the indicator based on the delivery of the actions.

Part 2. Quality Priorities

Looking forward

Each year NHS Trusts are asked to identify up to four areas where quality improvements can be made and these should be made explicit within the Quality Account.

When identifying these priorities it is important to turn to a number of sources. For the London Ambulance Service we have identified six main sources to guide our prioritisation.

1. The Operating Framework
2. Patient ideas and experience
3. Staff ideas and experience
4. Learning from incidents, complaints and other feedback
5. Commissioning intentions
6. Our quality indicators

1. The Operating Framework

Each year the Department of Health publishes a framework that identifies the priorities for the NHS in the coming year. The priorities within the framework include issues that have been raised nationally throughout the previous year. They are strategic in nature and rarely include defined actions; although a series of indicators may arise from the framework. For example, the ambulance clinical quality indicators which are fully reported in this Quality Account arose from the 2011/2012 Operating Framework.

There is an expectation that NHS organisations will use this to inform local quality work. We believe our four quality priority areas capture the essence and the relevant specifics of the Operating Framework.

The Operating Framework identified seven areas for prioritisation:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions (including mental health)
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The whole Operating Framework has been used to guide our approach and all areas are relevant to the work of the ambulance service.

2. Patient ideas and experience

As already reported within this account, we have engaged with a wide number of patients and staff when identifying our quality priorities. Many patient groups were supportive of the work we have been undertaking in mental health and expressed a desire that we continue to improve mental health care. This is also supported by our staff who often feel less able to meet the needs of mental health patients who are in crisis. For this reason we will continue to identify mental health as a quality priority next year.

In addition, possibly due to considerable media interest in 2011-2012, some patient groups were also concerned about alcohol. Many patients appear concerned that our need to respond to intoxicated patients has an impact on our resources. Others are concerned that we need to work with other providers to identify an alternative to Accident and Emergency departments for patients who are only vulnerable through alcohol. Therefore, we have made alcohol a priority for the coming year.

Long-term conditions are a high priority nationally and they form a significant part of our

work. We believe that we can make improvements for these patients by not always conveying them to a hospital and by informing other professionals of our interventions. However, to do this with all long term conditions would be overwhelming and we need to take a strategic approach. Last year's work with patients who have fallen gave us a good foundation from which to build. Our patient groups were supportive of our desire to focus on one specific long-term condition. Last year we attended 6,981 patients presenting with a diabetic related incident. We have agreed with our patient groups and commissioners that we should focus on this patient group this coming year.

Finally, the other factor raised was a concern regarding the rest of London during the Olympic period. We are of the view that it is "business as usual" for London during this period and this is reflected in our corporate objectives. However, the fact that this has been identified as an area of concern by patients means we have given the communication of our plans some additional focus.

3. Staff ideas and experience

The views of our staff were not significantly different to those of our patient groups. However, learning through clinical incidents was raised and whilst we have not made this a specific quality priority we intend to strengthen the way we capture lessons from all incidents as part of our governance improvements in 2012-2013.

4. Learning from incidents, complaints and other feedback

We now produce an integrated report called the Service Experience Integrated Report. This collates all the lessons that are to be found from a number of sources. These are:

- Incidents
- Patient Advice and Liaison Service
- Complaints
- Claims and inquests

The report highlights the main themes arising across the Trust and also reports on the supporting action plan.

On the whole the lessons learned are specific to individual cases. However, even with the low numbers that fall into specific categories it is possible to identify the top three issues. These are violence and aggression to staff, delayed response, and medical devices. However, the low numbers means these themes have not been carried into our quality priorities but the measures we are taking to improve these areas will be reported within the Service Experience Integrated Report.

5. Commissioning intentions

Each year our commissioners announce their priority intentions for the following year. This often contains a number of priorities that are wider than just quality.

This year the commissioning intentions were banded into categories. These were as follows:

- Quality
- Productivity
- Prevention
- Clinical engagement
- Financial performance
- Workforce development
- Data reporting
- Service change
- Performance
- Social and environmental
- Emergency preparedness
- Public and patient involvement

The detail within these priorities is captured within our core contract and also within the Commissioning for Quality and Innovation (CQUIN) payment framework. This scheme allows our commissioners to financially reward us for achieving a successful change. This year, alcohol and diabetes are specifically reflected within our CQUINs and our quality priorities for 2012-2013.

6. Quality indicators

The final area for consideration is the quality measures that are reported within the quality dashboard. Overall these measures have revealed a successful year for quality. However, there is an emerging theme that we are increasing the length of time we are spending on scene. This is not necessarily a negative change for some patient groups as it can be translated into a thorough assessment and time spent giving information and advice. However, for some patient groups, such as trauma and stroke the increase in time needs to be understood.

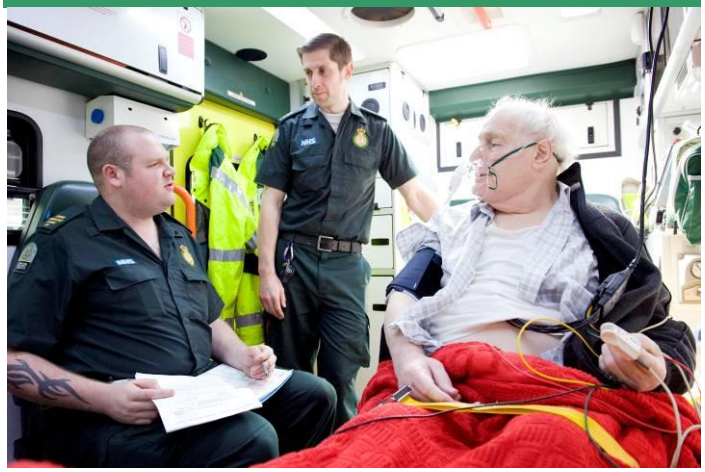
The coming year will see the development of a clinical strategy for the Trust. The learning obtained through the current quality measures, including the lengthening of on-scene time, will be incorporated into this strategy.

Therefore, from summarising the themes arising from the six areas we have identified four quality priority areas for 2012-2013. The four areas are:

1. **Improving mental health care**
2. **Reducing alcohol related harm**
3. **Providing a quality service for the whole of London during the Olympics**
4. **Improving diabetic care**

Having applied the methodology to the selection process we are confident that we have selected areas that are important to patients and consistent with the Operating Framework. They are also consistent with our strategic goals and our corporate objectives.

The following pages outline the case for inclusion in more detail and identify a number of improvements that we intend to make in each of those areas.



Priorities for Improvement: 1 Mental health care

Improving mental health care

Mental health is featured within the Operating Framework and has featured from talking with patients and our staff. It is also supported by our commissioners even though it does not feature specifically within the current CQUINs.

Last year we made considerable improvements to the way we respond and care for mental health patients and this progress is reported later in this account. This year we will further develop the supporting action plan to make even more improvements.

1. Education & training

Education and training is key to any service developments and we have developed a comprehensive training package that includes an element of e-learning, face-to-face training and reflective learning.

Action: To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face-to-face element of training in the coming year.

2. Clinical support

We have a team of senior and experienced clinicians that are responsible for supporting all our staff requiring clinical advice whilst attending patients. The skills and advice given at this point are key to how supported our staff feel and are also key to implementing clinical changes. Therefore, we will give some focus to this group of staff this year.

Action: To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.

3. Patient experience

Last year we undertook a patient survey in conjunction with North Central and West London Foundation NHS Trust. This demonstrated that the vast majority of their mental health patients, that participated in the survey, were happy with our care. However, we need to ask a wider group of patients before we can be confident that our care is meeting patient expectations.

Action: To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.

4. Care pathways

We have started to develop agreements with all of London's mental health providers that allow us to access their specialist teams for advice and support. We now need to roll out these agreements across the Trust so that our staff are aware and understand what is available.

Action: To role out the agreed care pathways across the whole Trust.

Priorities for Improvement: 2 Alcohol related harm

Reducing alcohol related harm

In 2011-2012 alcohol received widespread media attention and it is a high priority across London for a number of other organisations; such as the office of the London Mayor. Our patient groups have also informed us that they are concerned about alcohol. This is supported by our commissioners and is featured within the CQUINs for the coming year.

1. Alcohol recovery service

Over the past few years we have developed an innovative way of managing those at risk from alcohol consumption but without the need to convey them to accident and emergency departments at key times such as New Year. This service, where patients rest under the supervision of one of our clinicians before being discharged, has been financially supported to run for the whole year. This service now needs a full evaluation.

Action: To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy.

2. Recommendations

We need to consider the future service delivery model for alcohol-related calls with our commissioners and with other providers. Following the review of the current alcohol recovery service we will draw together conclusions and make recommendations based on the learning from running the service for a full year.

Action: To make recommendations to our commissioners on the future delivery model for alcohol.

3. Health promotion

We will explore how we can undertake a short assessment of alcohol consumption when attending a broader range of calls and identify what action we can take when a patient triggers the assessment protocol.

Action: To identify three ambulance stations where we can introduce an alcohol assessment protocol.

Action: To identify what course of action can be taken when a patient triggers the assessment.

Priorities for Improvement: 3 Quality during the Olympics

Providing a quality service for the whole of London during the Olympics

We recognise that the public are concerned about the Olympic and Paralympic period and this has featured at a number of our patient meetings.

We are committed to ensuring that London receives a normal service during the Games and will put into place a number of measures that will maximise our ability to deliver a normal service.

We have identified three strategic objectives for the Olympic period:

- Preserve lives, and protect patient care throughout the Games period
- To ensure sufficient resources and management assets are available to manage core activity to national and locally agreed quality standards
- To maintain the reputation of the Trust with the general public and stakeholders

To support the delivery of these three objectives we are developing our operational arrangements which are defined by the following elements.

1. Matching demand with supply

To understand the impact of the Games upon demand during this period a demand profile has been developed. This profile has been overlaid with the timetable of pre-planned events to provide a comprehensive picture of demand by day and by location. Initial assessments of our resourcing against this projected demand profile highlighted some pinch points in our operational cover.

Action: We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic demand and capacity review meeting to review the latest position and initiate actions as required.

2. Managing demand

Consideration is being given to how we can enhance the capacity on our existing Clinical Support Desk and Clinical Telephone Advice departments. These areas are key to our ability to respond to all our patients. These enhancements will ensure that our patients receive the appropriate response from us based on their clinically assessed needs. Ensuring that we optimise the use of these existing services throughout the period of the Games will also ensure we maximise the availability of our ambulance resources to respond to patients requiring additional clinical assessment, intervention and conveyance to definitive care centres.

Action: We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the Games.

3. Emergency Operations Centre (EOC)

Daily call volume demand profiles have been developed and reconciled with incident projections for the Games period. Resourcing levels to match these profiles are currently being populated.

Action: We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.

4. Communications

A communications plan for the Olympics and Paralympics Maintaining Service Delivery is being drawn up and has been divided into 5 key themes:

1. Travelling to and from work
2. Operational staff driving in London
3. Flexible working
4. Annual leave
5. Support services working differently

Action: These messages will be communicated as required and need to be reinforced by robust local messages.

5. Quality and safety indicators

To know that we are providing a high quality service to the rest of London during the Games we need to develop a set of indicators that can be measured in real time. These will inform us of any variation in service so that we can make decisions at the time.

Action: Identify the quality indicators to monitor in real time during the period of the 2012 Games.

Priorities for Improvement: 4 Diabetes

Improving diabetic care

The need to undertake further work on long-term conditions has a high profile within the operating framework and features within the commissioning intentions. Our talks with patients also revealed their wishes for us to consider alternative ways of meeting the needs of these patient groups.

We have chosen to focus clinical development work on the area of diabetes for next year. In particular, those patients who suffered a hypoglycaemic episode and recovered, and also those patients over 40 years of age who on a random blood sugar testing have been identified as having a raised blood sugar level.

It has been identified at a national level that improved early diagnosis and management of patients with diabetic issues can reduce complications and costs to the NHS.

For those having recurrent hypoglycaemic episodes, we plan to refer these patients back to their GP or diabetic team. This will improve care through better, more accurate, management of medications which may prevent/reduce further episodes.

There is an opportunity for us to consider how we manage patients with altered blood sugar levels. Current practice is that, where this reading is raised, the patient is advised to contact their own GP. The work to be implemented this year, will mean that all patients who have a reading above 8mmol will be automatically referred to their GP for follow-up. In many cases, these referrals will lead to further investigations with the aim of early diagnosis and therefore improved management and a reduction in longer-term complications.

Action: Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.

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Part 3. Mandatory Statements

Part 3. Mandatory Assurance Statements

The Department of Health identifies a number of mandatory statements that the Quality Account must report upon. These are predominately regarding data, audit and research and are presented in this section of the report.

Statement Area 1: Data review

During 2011/2012 the London Ambulance Service NHS Trust provided three NHS services and has reviewed the data available to them on the quality of care in all three of these NHS services.

Statement Area 2: Income

The income generated by the NHS services reviewed in 2011-2012 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2011-2012.

Statement Area 3: Clinical audit

During 2011-2012 four national clinical audits and no national confidential enquires covered NHS services that the London Ambulance Service NHS Trust provides. During that period the London Ambulance Service NHS Trust participated in 100% of national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was **eligible** to participate in during 2011-2012 are as follows;

- Department of Health Ambulance Clinical Quality Indicators covering:
  - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
  - Outcome from cardiac arrest – Survival to discharge
  - Outcome from acute ST-elevation myocardial infarction (STEMI)
  - Outcome from stroke
- National Clinical Performance Indicators (CPI) programme covering:
  - STEMI
  - Stroke
  - Hypoglycaemia
  - Asthma
- Ambulance Service Cardiovascular Quality Initiative (ASCQI) covering:
  - STEMI
  - Stroke
- National Ambulance Non-Conveyance Audit (NANA)

The national clinical audits that the London Ambulance Service NHS Trust **participated** in during 2011-2012 are as follows:

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  - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
  - Outcome from cardiac arrest – Survival to discharge
  - Outcome from acute ST-elevation myocardial infarction (STEMI)
  - Outcome from stroke
- National Clinical Performance Indicators (CPI) programme covering:
  - STEMI
  - Stroke
  - Hypoglycaemia
  - Asthma
- Ambulance Service Cardiovascular Quality Initiative (ASCQI) covering:
  - STEMI
  - Stroke
- National Ambulance Non-Conveyance Audit (NANA).

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in

and for which data collection was completed during 2011-2012 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC for: a) Overall group b) Utstein comparator group	 a) 3104 b) 415	 a) 3104 b) 415	 100% 100%
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	 a) 3047 b) 396	 a) 3047 b) 396	 100% 100%
DH ACQI: Outcome from acute STEMI a) Thrombolysis delivered within 60 minutes of call b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered	 a) 6 b) 938 c) 2010	 a) 6 b) 938 c) 2010	 100% 100% 100%
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call b) Care bundle delivered	 a) 3980 b) 9269	 a) 3980 b) 9269	 100% 100%
National CPI: STEMI – auditing delivery of aspirin, GTN and analgesia and recording of two pain scores and oxygen saturation level.	600	600	100%
National CPI: Stroke – auditing assessment of Face, Arm, Speech Test (FAST), blood glucose levels, blood pressure and time of onset of stroke symptoms.	600	600	100%
National CPI: Hypoglycaemia – auditing recording of blood glucose levels before and after treatment, delivery of treatment for hypoglycaemia and if a direct referral was made to an appropriate health professional.	600	600	100%
National CPI: Asthma – auditing assessment of respiratory rate, peak flow (before treatment), oxygen saturation levels (before treatment), delivery of oxygen and beta-2 agonist.	600	600	100%
ASCQI: improve delivery of the care bundle to STEMI patients	3025	3025	100%
ASCQI: improve delivery of the care bundle to Stroke patients	3025	2375	79%
NANA: a snapshot audit of ambulance non-conveyance practice for 999 calls attended on the 24th October 2011 for a 24 hour period examining: a) Patient demographics b) Highest level of clinician at scene c) Patient Assessment d) Intervention e) Reason for non-conveyance f) Safety netting g) Re-attendance within the subsequent 24 hour period	605	605	100%

The report of three national clinical audits were reviewed by the provider in 2011-2012 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Raise awareness of the STEMI care bundle through initiatives such as posters, newsletters and further education.
- Increase the proportion of patients presenting with a STEMI who receive pain-relieving medicine by developing a pain management training session.
- Increase the number of patients presenting with a STEMI for whom two pain assessments are undertaken by creating a pain assessment tool to help patients who struggle to understand the concept of pain scoring.

- Raise awareness of the stroke care bundle with posters, newsletters and further education.
- Increase the number of referrals to GPs and diabetes teams for diabetic patients in London through the implementation of a new call back and referral process for non conveyed patients suffering from hypoglycaemic emergencies.
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by exploring the introduction of portable oxygen saturation probes and paediatric probes.
- Increase the number of data that is downloaded from defibrillators through feedback to staff on the findings from downloads.

The report of four local clinical audits was reviewed by the provider in 2011-2012 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Clinical audit of the care provided to elderly patients with a hip injury by the London Ambulance Service

- Highlight the importance of assessing the patient's pain and administering analgesia where appropriate through developing a pain training session
- Reduce the number of vehicle cancellations when a response is allocated to a patient through the introduction of CommandPoint.

Clinical audit of the Clinical Telephone Advice given to patients triaged by the Medical Priority Dispatch System as '24B1' Labour (delivery not imminent, ≥5months/20 weeks) by the London Ambulance Service

- Review, shorten, and clarify the way Clinical Telephone Advice (CTA) staff should be using the maternity pathway questioning tool
- Develop an initial screening tool that can be used by senior CTA staff members prior to the maternity pathway questioning tool
- Develop a quality assurance process for calls where CTA staff use the maternity pathway questioning tool
- Feedback the results of this clinical audit to the Medical Priority Dispatch System Working Group and to the Emergency Operations Centre
- Send CTA staff a questionnaire asking for their views on the usability of the maternity pathway questioning tool.

A clinical audit examining End of Life Care in the London Ambulance Service

- Increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness through an end of life care training package to all crews and an advanced education package for Clinical Support Desk staff
- Increase number of palliative care/end of life care handover forms registered on the patient special needs locality database
- Introduce "Co-ordinate My Care" so Clinical Support Desk staff are able to access all palliative care patient plans to ensure correct management as per patient wishes
- Publish guidance to instruct crews to call the Clinical Support Desk for further support and advise crews to contact the patient's palliative care team, particularly out-of-hours when deciding on a course of action
- Remind staff about the correct use of Patient Report Form (PRF) illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint.

A baseline clinical audit examining the measurement of end tidal carbon dioxide ($ETCO_2$) during advanced airway management of cardiac arrest patients by the London Ambulance Service

- Increase the number of $ETCO_2$ waveforms that are included in the electronic clinical record for this patient group by ensuring the corresponding computer aided dispatch number is documented when an $ETCO_2$ reading is

taken and remind station administrators that waveforms should be sent to Management Information with the associated PRF

- Remind staff the preferential use of a supraglottic airway devices, emphasising that it is a safe and effective way of maintaining a patient's airway by writing an article for the Clinical Update
- Review advanced life support in the Core Skills Refresher 1 training to include particular emphasis on the preferential use of supraglottic airway devices and including waveform print outs in the patient's clinical record.

The results of seven local clinical audits were presented to the Trust Board in 2011-2012.

- April 11 – National CPI Cycle 5, Summary of Findings
- June 11 – Stroke Care Project Summary Report
- August 11 – LAS Cardiac Arrest Annual Report 10/11
- November 11 – Clinical Audit of CTA given to patients triaged by MPDS as 24B1 labour
- December 11 – National CPI Cycle 6, Summary of Findings
- January 12 – Clinical Audit and Research Summary Report on ASCQI
- March 12 – Clinical Audit of End of Life Care in LAS

In addition, the London Ambulance Service NHS Trust conducts a programme of Clinical Performance Indicators and four ongoing clinical quality audits which monitor the care provided to patients who have had a cardiac arrest, STEMI or stroke, or have been involved in a major trauma incident. Monthly reports outlining performance in these areas are produced to enable quality improvements in clinical care.

Information: Clinical Performance Indicators (CPIs) are a tool designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. They focus on clinical areas where there is strong evidence that following the correct practice leads to the best outcome for patients, or where there is a clinical risk associated with the patient group. The delivery of care in these areas is fed back to crew members on a one-on-one basis so they can make personalised recommendations on how they can improve performance. This process has led to clear improvements in care over time. For example, as a direct result of the CPI process the London Ambulance Service NHS Trust has improved reporting of second set of observations for all patient groups, but in particular for those patients not conveyed to hospital where there has been a seven per cent service wide improvement since the beginning of the financial year.

Statement Area 4 Research

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2011-2012 that were recruited during that period to participate in research approved by a research ethics committee was 1,028. This represents a significant increase in recruitment from 2010-2011, when we recruited 164 patients into research approved by a research ethics committee.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care and contributing to wider healthcare improvement. Our clinical staff stay abreast of the latest possible treatment options and actively participate in research that leads to successful patient outcomes.

The London Ambulance Service NHS Trust was involved in three clinical research studies in pre-hospital care during 2011-2012. There were 417 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2011-

2012. These staff participated in research covering two medical specialties. These were:

- DANCE (high risk acute coronary syndrome): Pilot randomised controlled trial (RCT) comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management
- Paramedic SVT: RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management
- SAFER 2: Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.

It is important to note that as well as recruiting patients we also conducted research involving staff and student paramedics as participants. These recruitment numbers have not been included in the 1,028 figure above, which only includes patient numbers. The total number of LAS staff and student paramedics participating in research as participants in 2011-2012 was 915.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2011-2012 are displayed in the table below.

Study name	**Participants recruited in 2011/12**	**LAS clinical staff involved**
NHS REC approved studies involving patients		
Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER2)	930	87
High Risk Acute Coronary Syndrome (ACS) (*formerly known as 'DANCE'*)	60	250
Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT)	38	80
NHS REC approved studies involving LAS staff and student paramedics as participants		
Engaging Ambulance Clinicians in Quality Improvement: Questionnaire Study (ASCQI)	308	1
Quality and Safety in the NHS: Evaluating Progress, Problems and Promise (QSN)	59	-
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	390 (in follow-up)	-
How do emergency service workers cope with the traumatic events they are exposed to?	10	-
The student experience of university paramedic education/training – from classroom learning to situational understanding	1	-
Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review)*		
Quantitative Assessment of simulated infant chest compressions on a novel infant CPR manikin as delivered by trained healthcare personnel	9	-
Is 'Practice Placement Education' (PPEd) appropriate for student paramedics?	25	1
Does solo emergency responding have an impact on psychological health and levels of work-related stress in ambulance workers	113	1

- From 1st September 2011, research involving NHS staff no longer requires NHS REC review unless there is a legal requirement for review as specified in 'Governance arrangements for research ethics committees: a harmonised edition'

In addition, during the last three years, eleven publications have resulted from our involvement in research, which shows our commitment to disseminating practice and desire to improve patient outcomes and experience across the NHS. The publications include, in 2009: *'Out of Hospital Cardiac Arrest in South Asian and White Populations in London'* published in the Heart journal and *'Complexity of the decision making process of ambulance staff for assessment and referral of older people who have fallen: a qualitative study*' in the Emergency Medical Journal; in 2010: *'CPR with chest compression alone or with rescue breath'* in the New England Journal of Medicine and *'Out of hospital cardiac arrest in patients aged 35 years and under: A four year study of incidence and survival in London'* in the Resuscitation journal, and in 2012: *'Decision-making by ambulance clinicians in London when managing patients with epilepsy: a qualitative study'* published in the Emergency Medicine Journal. Our engagement with clinical research also demonstrates the London Ambulance Service NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

In addition to research, the LAS also facilitates a number of descriptive, feasibility and evaluation projects aimed at improving patient experiences and the quality of care delivered.

Our commitment to research as a driver for improving the quality of care and the patient experience is further demonstrated by our Annual Research Conference, journal clubs and research advice surgeries. Our Annual Conference 'Research to Clinical Practice: How Research in the LAS Influences Patient Care' was held on 4 May 2011 and was attended by 86 members of staff. Topics included, 'Ventricular Fibrillation - A Tale of Two Cities' which presented the findings of an international project, the preliminary results of a large-scale prospective study in post-traumatic stress disorder, and a presentation of the 'Improving stroke recognition by ambulance services' study which was led by the LAS. During 2011-2012, we held three Journal Clubs, attended by 54 staff, through which staff reviewed and critically appraised scientific publications; topics covered include trauma in London, the quality of chest compressions in cardiac arrests, Chronic Obstructive Pulmonary Disease and care of mental health patients. Additionally, we held Research Advice Surgeries for staff interested in undertaking research to help guide and develop new research. The contents pages of medical journals are circulated to all staff on a monthly basis to enable them to keep updated with the latest scientific evidence; copies of the full articles can then be accessed through our library.

We have an extensive collaborative research portfolio for the forthcoming 2012-2013 period, which includes the following studies:

- High Risk ACS (*formerly known as 'DANCE'*): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management
- Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT): RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management
- Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER 2): Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice
- Identifying emergency personnel at risk of post traumatic stress disorder (PTSD): Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics
- Assessment of call handling speed and equity of calls from non-English speaking callers to a large metropolitan Ambulance Service: An investigation into whether call handling speed and allocated response differs between English and non-English speaking callers
- The student experience of university paramedic education/training – from classroom learning to situational

understanding: Observational study exploring acculturation within the ambulance service and how this may influence student paramedics

- Informing delivery of care through research evidence: An investigation of randomised control trial implementation in pre-hospital emergency care: An investigation into the factors affecting implementation of RCTs in pre-hospital emergency care
- The use of section 136 of the UK mental health act in SW London: Investigation into healthcare professionals' experiences of using Section 136 of the UK Mental Health Act
- A Critical Discourse Analysis of Paramedics' talk about their administration of analgesia to patients who are cognitively impaired: Qualitative study exploring how paramedics decide to administer analgesia to cognitively impaired patients

Statement Area 5 CQUINs

A proportion of the London Ambulance Service NHS Trust's income in 2011-2012 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the commissioning for Quality and Innovation payment framework.

The details of the agreed goals for 2011-2012 are as follows:

1a. Reducing conveyance rate to A&E services (£996,765 maximum and £747,574 achieved).
1b. Hear & treat resolution (no convey) via clinical telephone advice & NHS Direct (£746,640 maximum and £746,640 achieved).
1c. Implementation of NHS pathways in clinical telephone advice (£746,640 maximum and £447,984 achieved.
1d Clinical performance indicator non conveyed (£248,631 maximum and £0 achieved).

2a Falls and older people referrals to GPs (£248,631 maximum and £248,631 achieved).

3a End of life care patients held on our system (£90,129 maximum and £52,834 achieved).
3b End of life care usage of register by our staff to affect outcome (£124,316 maximum and £71,482 achieved).

4a Mental health service improvement plan, including outcome of wider mental health review (£124,362 maximum and £99,476 achieved).
4b Development of mental health protocols for direct access to mental health crisis teams (£127,271 maximum and £62,138 achieved).

5a Whole system clinical group established & effective including joint review of referral, treatment & discharge protocols, including specific review of protocol frequent callers, metropolitan police & high referring/call locations (£111,837 maximum and 99,404 achieved.
5b Whole system clinical incident reporting & resolution 124,372 maximum and 105,714 achieved).

The details of the agreed goals for 2012-2013 are as follows

1a. Increase in See & Treat and See & Refer (£372,000)
1b. Increase in Appropriate/Alternative Care Pathways (£310,000)
1c. Overall reduction in conveyance to Emergency Department (£372,000)

2 Increase in hear & treat (£496,000)

3a. Diabetes Management (hypoglycaemia) (£248,000)
3b. Diabetes Management (Hyperglycaemia) (£248,000)

4a. Evaluation of Alcohol Recovery Service (£558,000)
4b. Alcohol health promotion (£372,000)

5a. GP information sharing of patient level data (£496,000)
5b. GP Information sharing of NHS Number (£496,000)
5c Information regarding frequent callers (£248,000)

6a. Patient experience audit (£186,000)
6b. Use of Urgent Care Toolkit (£186,000)
6c. Core Skills Training for staff (£186,000)
6d. Monitoring long delays (£186,000)

7a. Introduction of allocated rest breaks (£496,000)

7b. Change the annual leave arrangement (£496,000)
7c. Review of the staff roster (£248,000)

Statement Area 6 Care Quality Commission

The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is "registered". The London Ambulance Service NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The London Ambulance Service NHS Trust during 2011-2012.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2011-2012.

Statement Area 7 Data Quality

The London Ambulance Service NHS Trust will be taking the following actions to improve data quality:

Data features within our CQUINs in 2012-2013 particularly our compliance with the capture of patients NHS number. Specific targets and measures for this will be agreed with our commissioners.

Statement Area 8 NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2011-2012 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The London Ambulance Service NHS Trust was not required to submit records during 2011-2012 using patients' valid General Medical Practice Code

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score overall score for 2011-2012 was 79% and was graded at level 2.

Statement area 10 Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2011-2012 by the Audit Commission.

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Part 4: Looking Back

Section A. National Quality Indicators

Review of quality performance 2011-2012

2011/2012 saw the introduction of the national ambulance quality indicators. These are a set of measures that allow individual Ambulance Trusts to look where they lie in comparison with other NHS ambulance providers. It is not always possible to draw direct comparisons as services differ slightly across the country but it allows Ambulance Trusts to use the information analytically.

The following graphs illustrate the London Ambulance Service NHS Trust year end position in all 12 quality measures. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking therefore the data for those includes data from April to December 2011.

Measure 1. Outcome from acute ST-elevation myocardial infarction (STEMI)

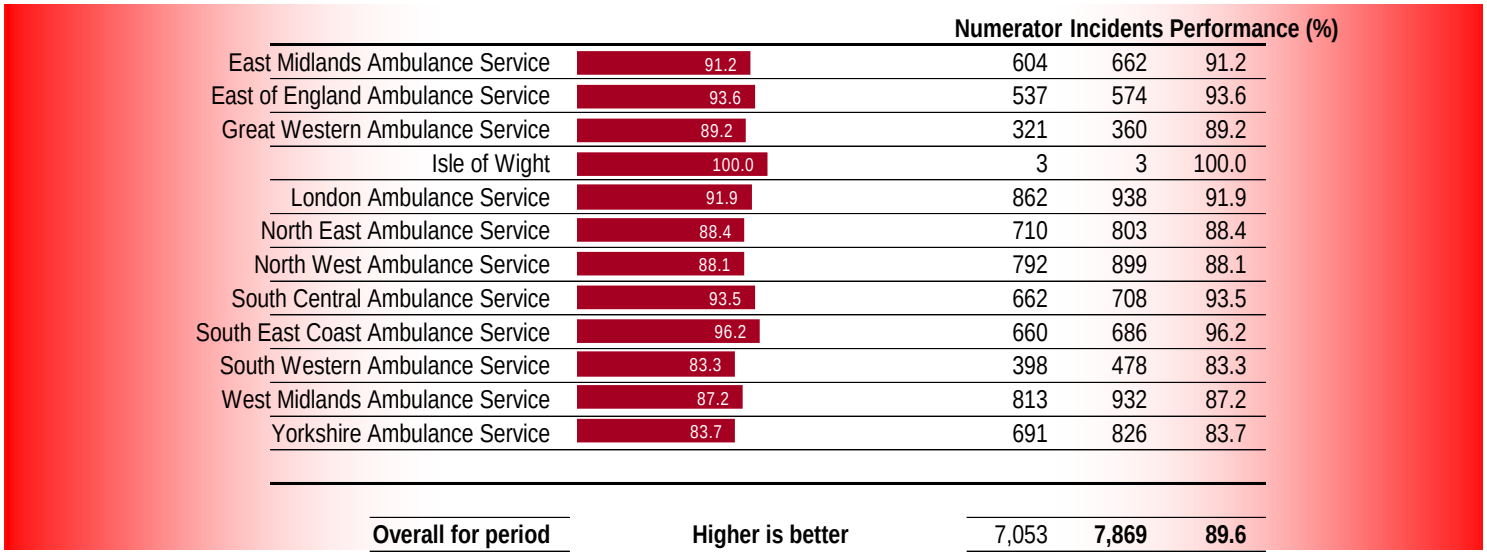
STEMI is an acronym meaning 'ST (a particular segment) Elevation Myocardial Infarction', which is a type of heart attack. Early access to cardiac intervention is considered an important element in reducing the mortality and morbidity associated with a STEMI.

There are three elements to this quality measure the first two of which measure speed or time. The final element measures the care undertaken by the clinical staff employed in the ambulance service and asks Trusts to record when aspirin is given, when Glyceryl Trinitrate (GTN) is given, when 2 pain scores are recorded and when a patient has received analgesia of either Morphine or Entenox.

Element 1; Percentage of patients suffering a ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call (Year end position)

The London Ambulance Service NHS Trust does not participate in this measure as the service does not administer thrombolysis. Instead we access the alternative intervention of primary angioplasty through direct admission to one of the 8 heart attack centres within London. This is different in other areas in the country where Accident & Emergency departments are some distance away so ambulance clinical staff are trained to deliver the intervention.

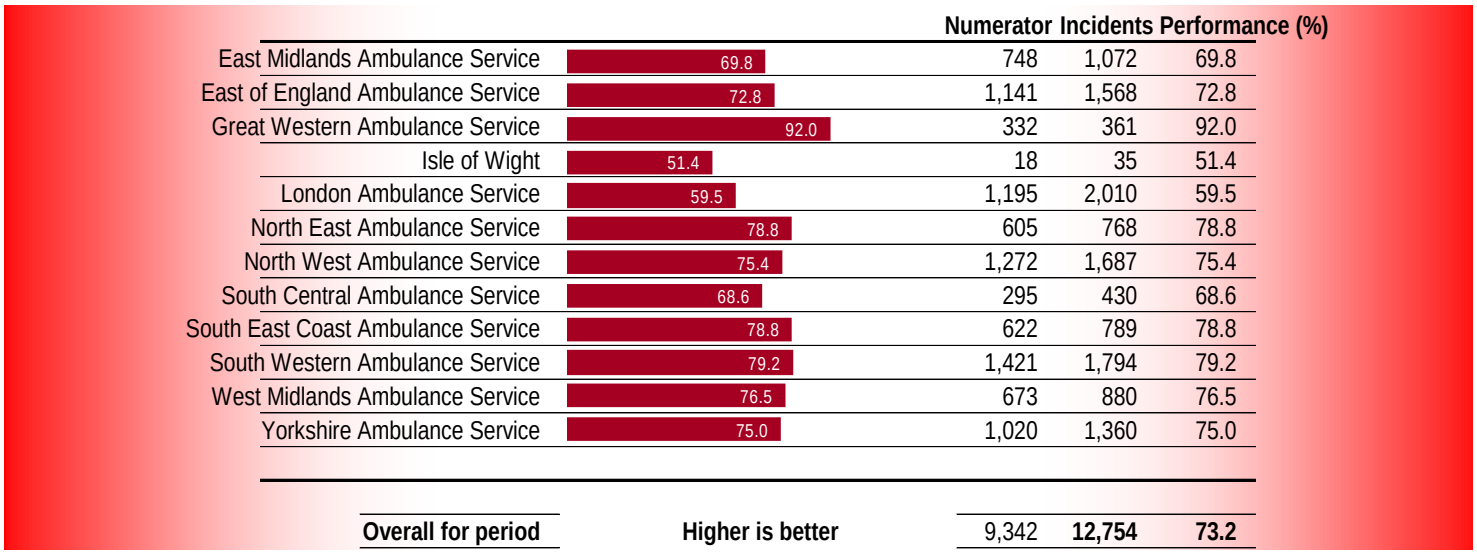
Element 2; Graph 1:Percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	91.2	604	662	91.2
East of England Ambulance Service	93.6	537	574	93.6
Great Western Ambulance Service	89.2	321	360	89.2
Isle of Wight	100.0	3	3	100.0
London Ambulance Service	91.9	862	938	91.9
North East Ambulance Service	88.4	710	803	88.4
North West Ambulance Service	88.1	792	899	88.1
South Central Ambulance Service	93.5	662	708	93.5
South East Coast Ambulance Service	96.2	660	686	96.2
South Western Ambulance Service	83.3	398	478	83.3
West Midlands Ambulance Service	87.2	813	932	87.2
Yorkshire Ambulance Service	83.7	691	826	83.7
Overall for period	**Higher is better**	7,053	**7,869**	**89.6**

The majority of ambulance services are performing at a level where over 90% of patients are receiving the intervention within 150 minutes of the call. The London Ambulance Service NHS Trust achieved a rate of 91.9% from April 2011-December 2011.

Element 3; Graph 2: Percentage of patients suffering a STEMI who receive an appropriate care bundle (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	69.8	748	1,072	69.8
East of England Ambulance Service	72.8	1,141	1,568	72.8
Great Western Ambulance Service	92.0	332	361	92.0
Isle of Wight	51.4	18	35	51.4
London Ambulance Service	59.5	1,195	2,010	59.5
North East Ambulance Service	78.8	605	768	78.8
North West Ambulance Service	75.4	1,272	1,687	75.4
South Central Ambulance Service	68.6	295	430	68.6
South East Coast Ambulance Service	78.8	622	789	78.8
South Western Ambulance Service	79.2	1,421	1,794	79.2
West Midlands Ambulance Service	76.5	673	880	76.5
Yorkshire Ambulance Service	75.0	1,020	1,360	75.0
Overall for period	**Higher is better**	9,342	**12,754**	**73.2**

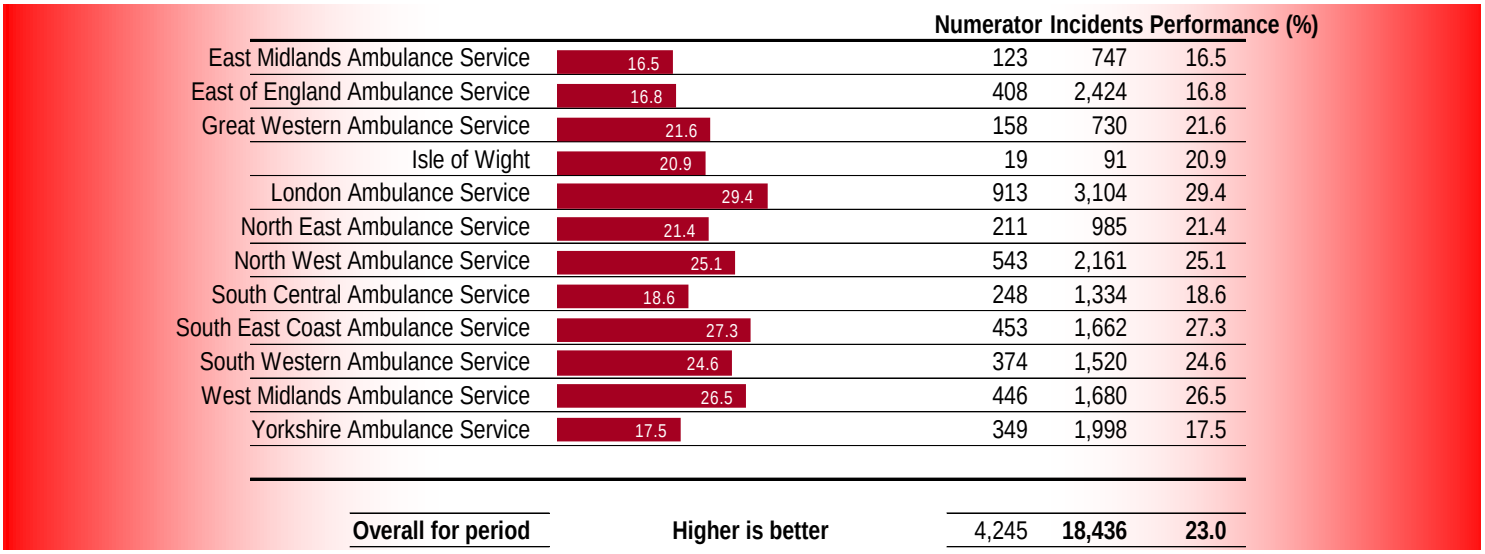
The London Ambulance Service appears to be under performing when compared to other Ambulance Trusts with 59.5% of patients receiving an appropriate care bundle. However, this is not strictly accurate as the data submission only permits the counting of patients who receive Morphine or Entenox for pain relief. As a service the London Ambulance Service NHS Trust offers alternative pain relief therapy, such as positioning, for patients who declare their pain is relatively minor.

Measure 2. Outcome from cardiac arrest - return of spontaneous circulation.

The aim of this indicator is to reduce the mortality associated with a cardiac arrest. The indicator measures the overall effectiveness of the urgent and emergency care services by considering how many patients have a pulse or heartbeat on arrival to hospital following a cardiac arrest. However, it is known that those patients who have their cardiac arrest witnessed are more likely to survive the episode than those who have a cardiac arrest while unobserved. This significantly shortens the length of time that it takes the emergency services to respond.

Therefore, the measure is broken into two indicators. The first counts all of the cardiac arrests whilst the second counts only those that are witnessed.

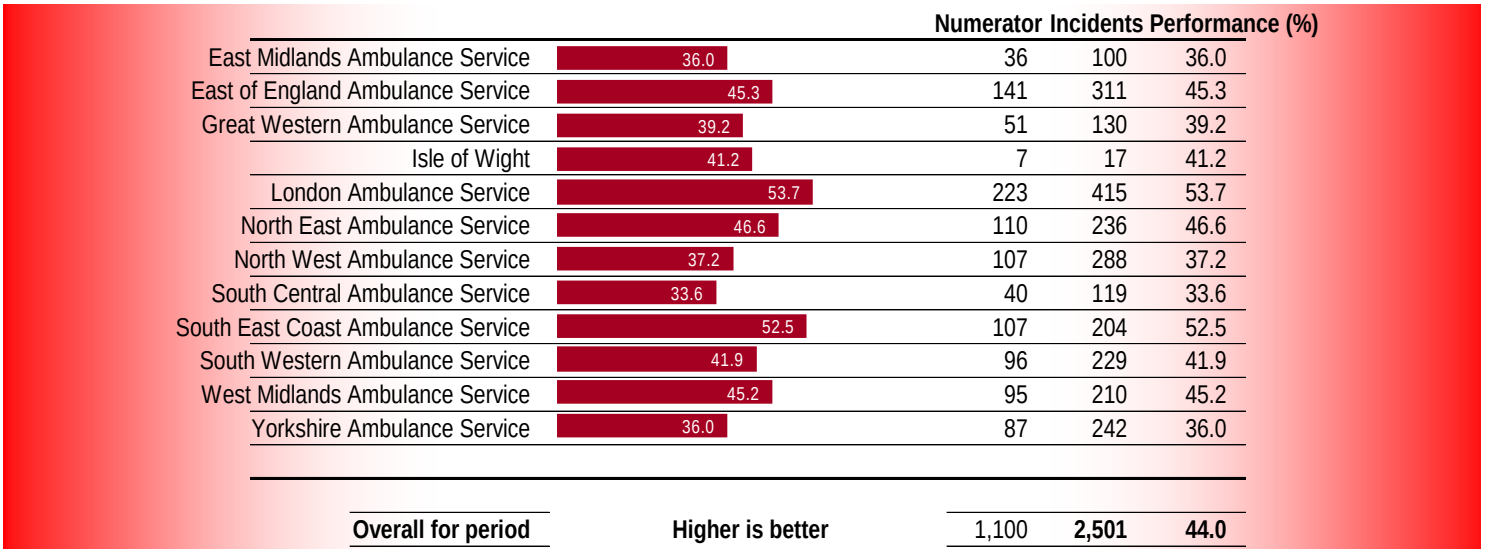
Element 1; Graph 4 Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall) (Year end position)



	Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	123	747	16.5
East of England Ambulance Service	408	2,424	16.8
Great Western Ambulance Service	158	730	21.6
Isle of Wight	19	91	20.9
London Ambulance Service	913	3,104	29.4
North East Ambulance Service	211	985	21.4
North West Ambulance Service	543	2,161	25.1
South Central Ambulance Service	248	1,334	18.6
South East Coast Ambulance Service	453	1,662	27.3
South Western Ambulance Service	374	1,520	24.6
West Midlands Ambulance Service	446	1,680	26.5
Yorkshire Ambulance Service	349	1,998	17.5
Overall for period **Higher is better**	4,245	**18,436**	**23.0**

Residents and visitors to London appear to have a good outcome with 29.4% of all cardiac arrests having a pulse, or heartbeat, on arrival at hospital.

Element 2; Graph 5Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein) (Year end position)



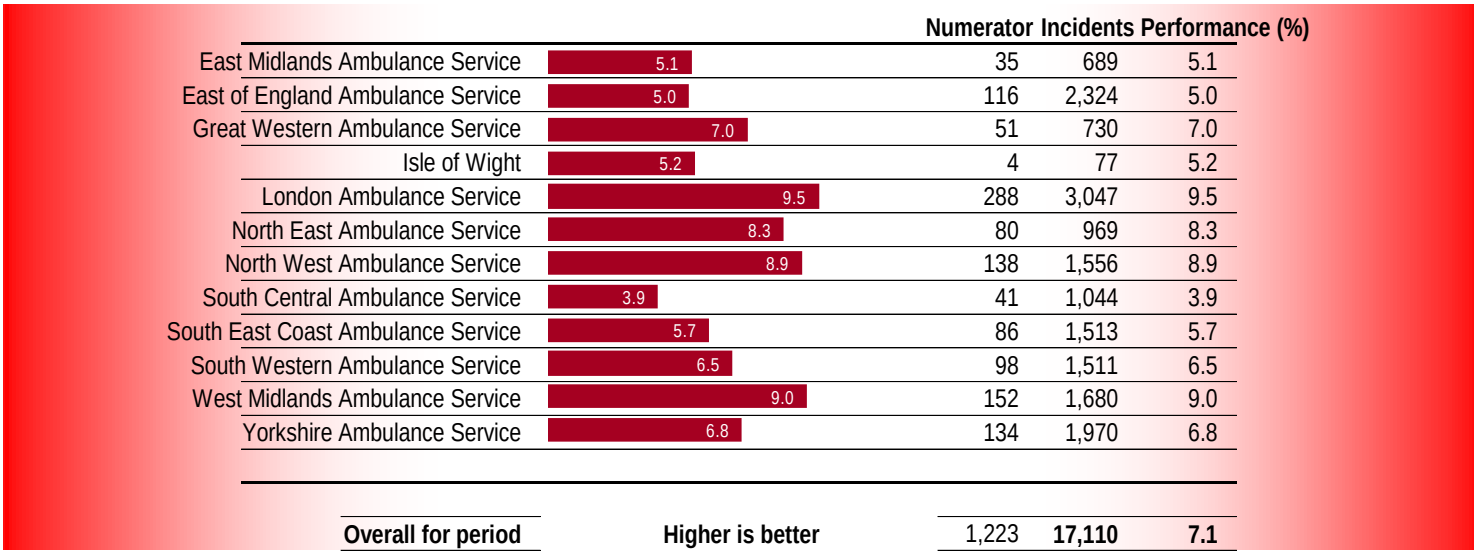
	Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	36	100	36.0
East of England Ambulance Service	141	311	45.3
Great Western Ambulance Service	51	130	39.2
Isle of Wight	7	17	41.2
London Ambulance Service	223	415	53.7
North East Ambulance Service	110	236	46.6
North West Ambulance Service	107	288	37.2
South Central Ambulance Service	40	119	33.6
South East Coast Ambulance Service	107	204	52.5
South Western Ambulance Service	96	229	41.9
West Midlands Ambulance Service	95	210	45.2
Yorkshire Ambulance Service	87	242	36.0
Overall for period **Higher is better**	1,100	**2,501**	**44.0**

London has the highest number of witnessed arrests and again the table shows a good outcome with 53.7% of witnessed cardiac arrests having a pulse or heartbeat on arrival at hospital.

Measure 3. Outcome from cardiac arrest - survival to discharge

Following on from the second indicator, this one measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital. Again this is broken into the all cardiac arrest group and the witnessed cardiac arrest group.

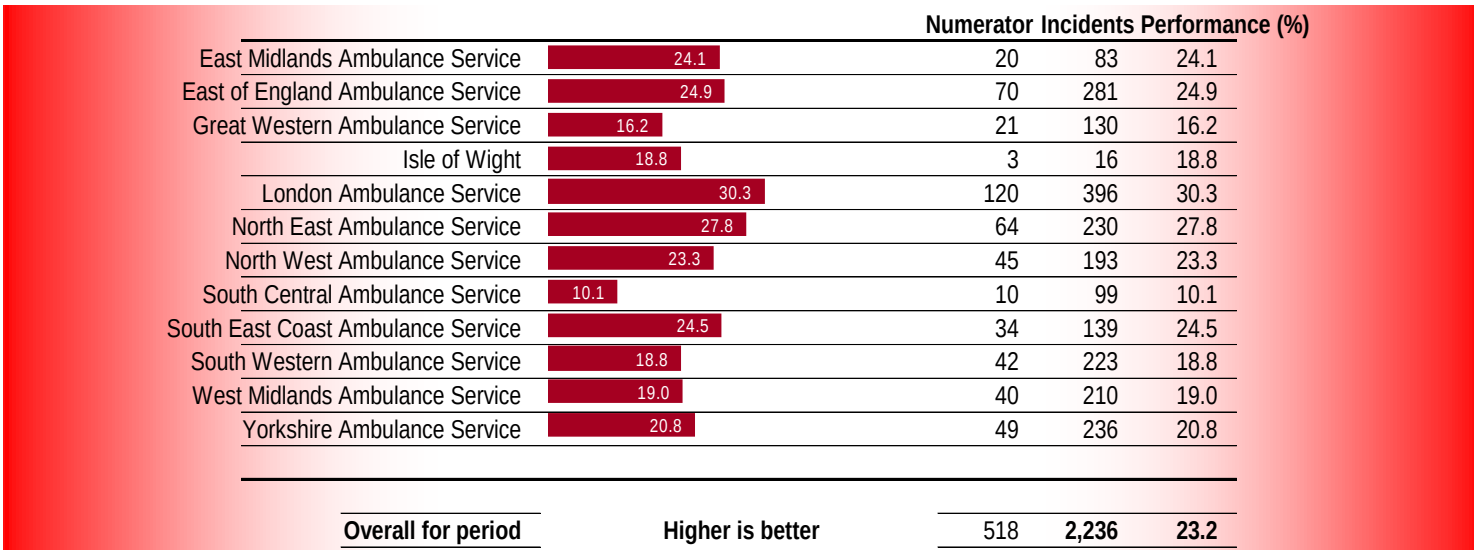
Element 1; Graph 6 Survival to discharge – Overall survival rate (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		35	689	5.1
East of England Ambulance Service		116	2,324	5.0
Great Western Ambulance Service		51	730	7.0
Isle of Wight		4	77	5.2
London Ambulance Service		288	3,047	9.5
North East Ambulance Service		80	969	8.3
North West Ambulance Service		138	1,556	8.9
South Central Ambulance Service		41	1,044	3.9
South East Coast Ambulance Service		86	1,513	5.7
South Western Ambulance Service		98	1,511	6.5
West Midlands Ambulance Service		152	1,680	9.0
Yorkshire Ambulance Service		134	1,970	6.8
Overall for period	**Higher is better**	1,223	**17,110**	**7.1**

This shows that 9.5% of all patients who had a cardiac arrest in the London region survived to be discharged from hospital. This is the best rate in the country.

Element 2; Graph 7: Survival to discharge – Utstein comparator group survival rate (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		20	83	24.1
East of England Ambulance Service		70	281	24.9
Great Western Ambulance Service		21	130	16.2
Isle of Wight		3	16	18.8
London Ambulance Service		120	396	30.3
North East Ambulance Service		64	230	27.8
North West Ambulance Service		45	193	23.3
South Central Ambulance Service		10	99	10.1
South East Coast Ambulance Service		34	139	24.5
South Western Ambulance Service		42	223	18.8
West Midlands Ambulance Service		40	210	19.0
Yorkshire Ambulance Service		49	236	20.8
Overall for period	**Higher is better**	518	**2,236**	**23.2**

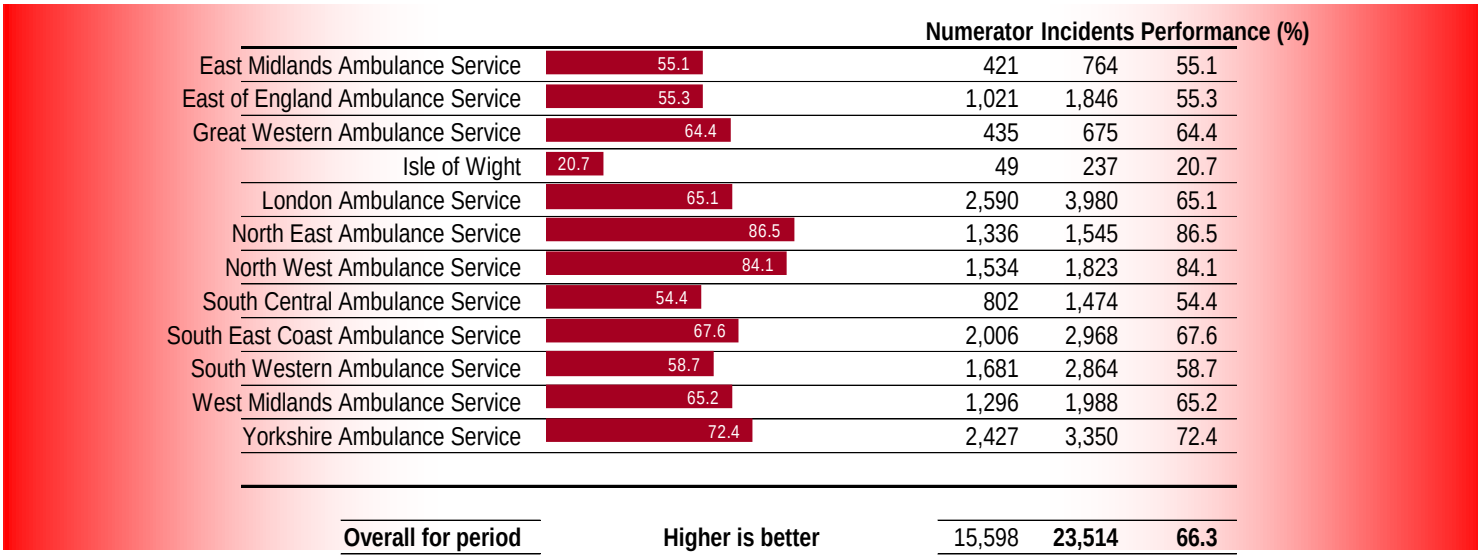
This graph really demonstrates the benefits to outcome when a cardiac arrest is witnessed as this shows that 30.3% of all patients who had a cardiac arrest witnessed in the London region survived to be discharged from hospital. This is also the best rate in the country.

Measure 4. Outcome following stroke for ambulance patients

Patients should be arriving at an appropriate place as soon as possible following the onset of a stroke. Time to confirmed diagnosis and treatment is key to reducing mortality associated with a stroke. This indicator requires ambulance services to measure the time it takes from the 999 call to the time it takes those positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for thrombolysis treatment.

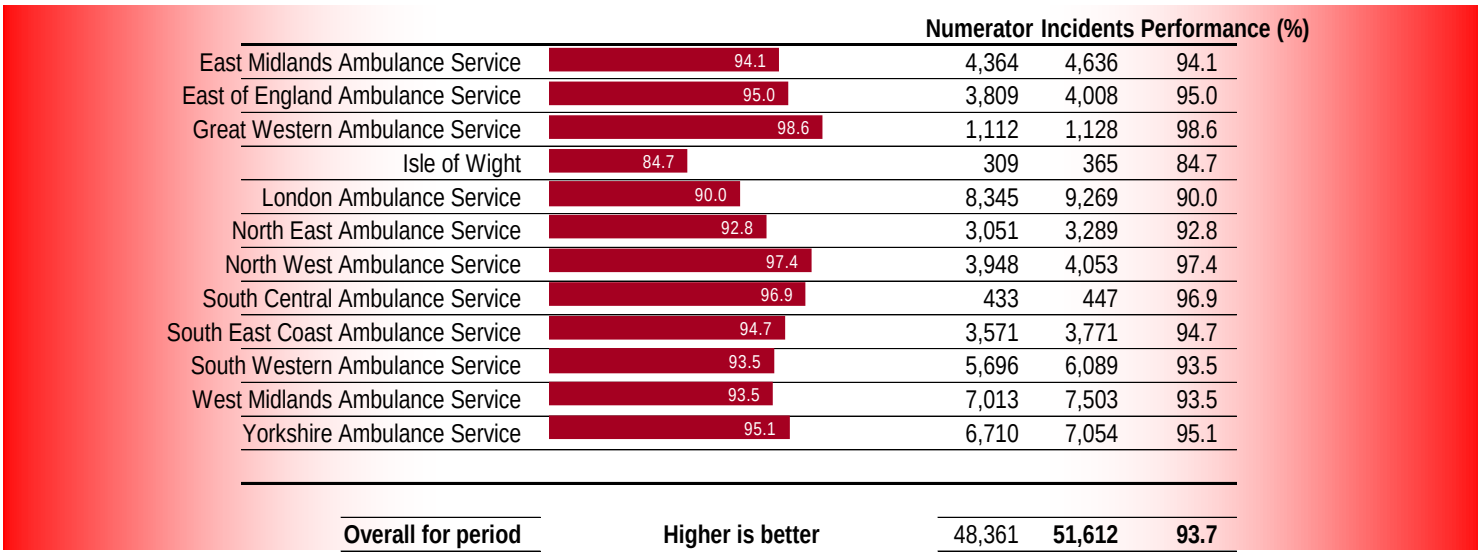
There are two indicators to this measure. The first records the time and the second considers the care given by ambulance clinical staff. The care should include the completion of a stroke diagnostic test (called a FAST test), the checking of a patient's blood glucose and a complete blood pressure taken.

Element 1; Graph 8: Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call (Year end position)



This graph reveals that some other ambulance services are managing to convey stroke patients to a hyperacute unit faster than the London Ambulance Service. The Trust needs to understand this further and will undertake work in 2012-2013 to improve this position.

Element 2; Graph 9: Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle (Year end position)



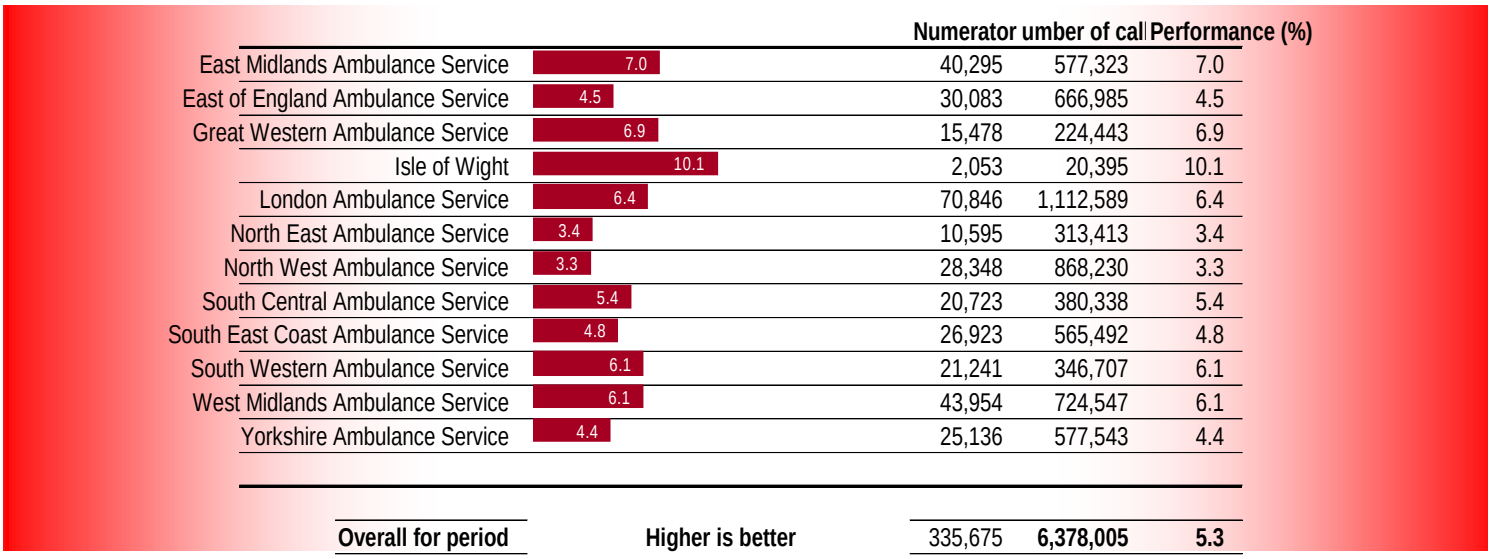
This graph suggests other ambulance services perform better than the London Ambulance Service. However, the Trust is reasonably confident that this is a data collection issue in that the clinical staff are not recording FAST test performed in the correct area of the form and therefore compliance is not recorded by the automated scanning of documentation. This will also be reviewed in 2012-2013.

Measure 5. Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

This indicator reflects how the whole urgent care system is working, rather than simply the ambulance service or Accident & Emergency, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

This is a single indicator that is simply made up of the number of calls where the London Ambulance Service provided an intervention where an ambulance was not required.

Graph 10: Percentage of 999 calls that have been resolved by providing telephone advice (Year end position)



		Numerator	umber of cal	Performance (%)
East Midlands Ambulance Service	7.0	40,295	577,323	7.0
East of England Ambulance Service	4.5	30,083	666,985	4.5
Great Western Ambulance Service	6.9	15,478	224,443	6.9
Isle of Wight	10.1	2,053	20,395	10.1
London Ambulance Service	6.4	70,846	1,112,589	6.4
North East Ambulance Service	3.4	10,595	313,413	3.4
North West Ambulance Service	3.3	28,348	868,230	3.3
South Central Ambulance Service	5.4	20,723	380,338	5.4
South East Coast Ambulance Service	4.8	26,923	565,492	4.8
South Western Ambulance Service	6.1	21,241	346,707	6.1
West Midlands Ambulance Service	6.1	43,954	724,547	6.1
Yorkshire Ambulance Service	4.4	25,136	577,543	4.4
Overall for period	**Higher is better**	335,675	**6,378,005**	**5.3**

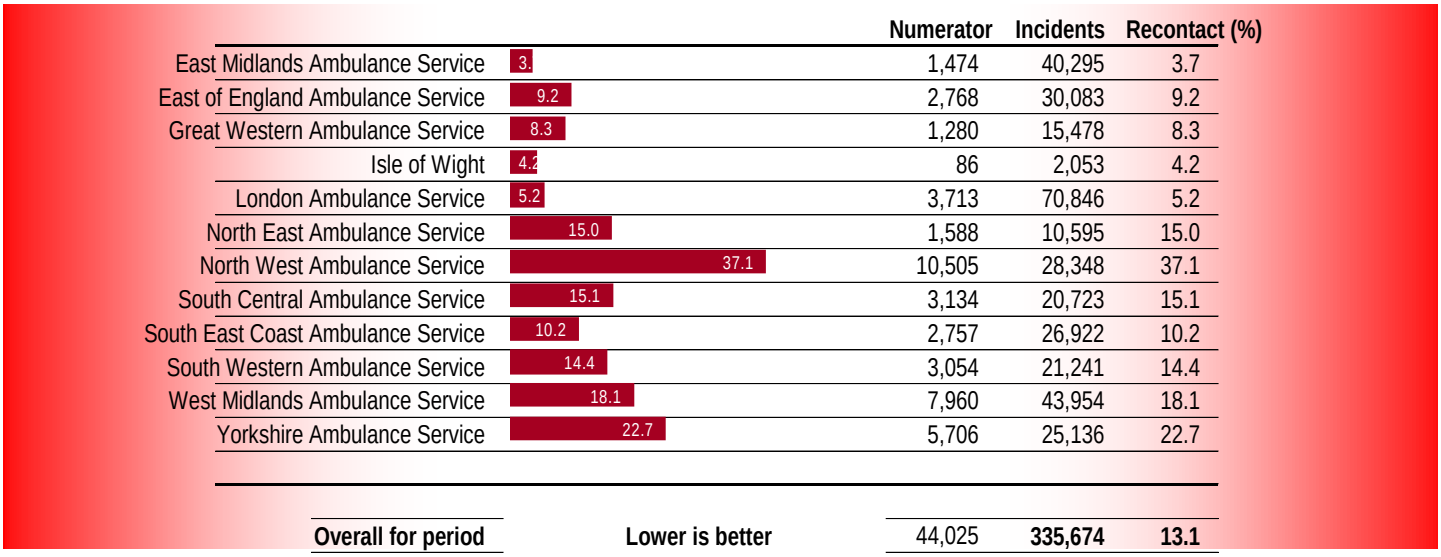
The graph reveals that the London Ambulance Service has the highest number of calls and the highest number of calls that receive a telephone intervention. As a rate the Trust scores as the second highest ambulance service in the country. This means that many patients were not inconvenienced by being taken to Accident & Emergency when a more immediate solution was possible.

Measure 6. Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time this indicator will measure how many callers or patients call the Ambulance Trust back within 24 hours of the initial call being made.

The measure is broken down into 2 indicators. The first is the number of patients that call back following clinical advice over the telephone and the second is the number of patients that call back after being given an intervention at home and discharged (not taken to Accident & Emergency).

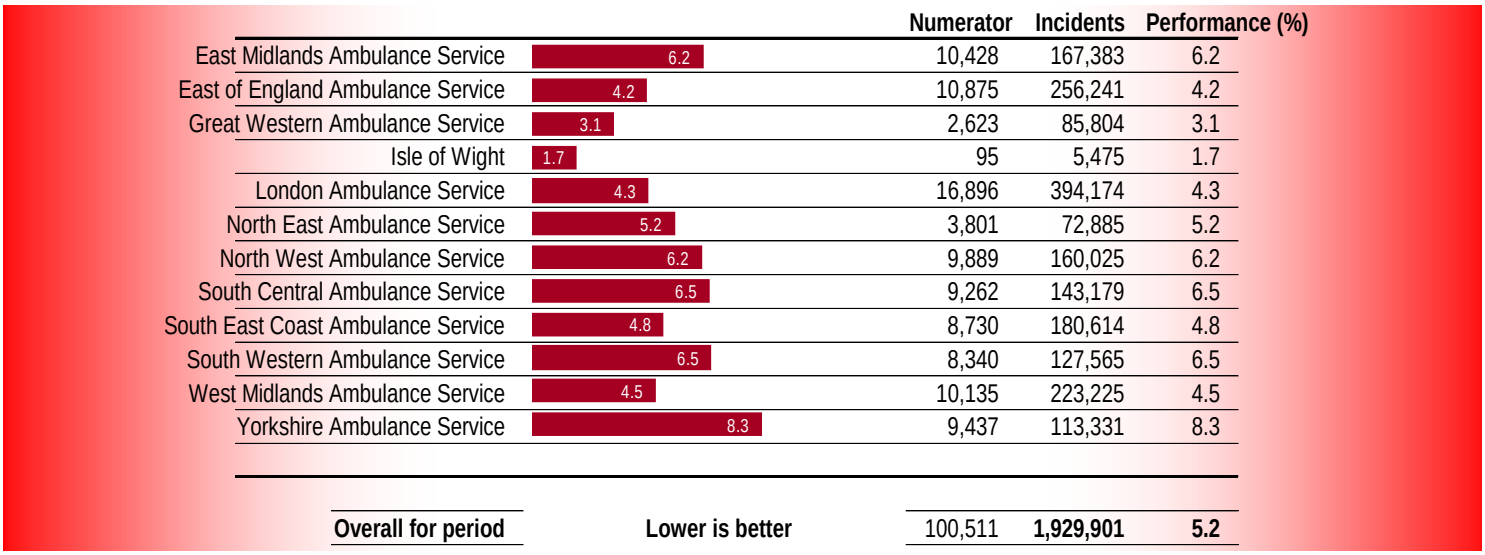
Element 1. Graph 11:Percentage re-contact following discharge of care by telephone (Year end position)



	Numerator	Incidents	Recontact (%)
East Midlands Ambulance Service	1,474	40,295	3.7
East of England Ambulance Service	2,768	30,083	9.2
Great Western Ambulance Service	1,280	15,478	8.3
Isle of Wight	86	2,053	4.2
London Ambulance Service	3,713	70,846	5.2
North East Ambulance Service	1,588	10,595	15.0
North West Ambulance Service	10,505	28,348	37.1
South Central Ambulance Service	3,134	20,723	15.1
South East Coast Ambulance Service	2,757	26,922	10.2
South Western Ambulance Service	3,054	21,241	14.4
West Midlands Ambulance Service	7,960	43,954	18.1
Yorkshire Ambulance Service	5,706	25,136	22.7
Overall for period	44,025	**335,674**	**13.1**

The graph demonstrates that the London Ambulance Service has the second lowest re-contact rate following telephone advice.

Element 2. Graph 12: Percentage re-contact rate following discharge of care on scene (Year end position)



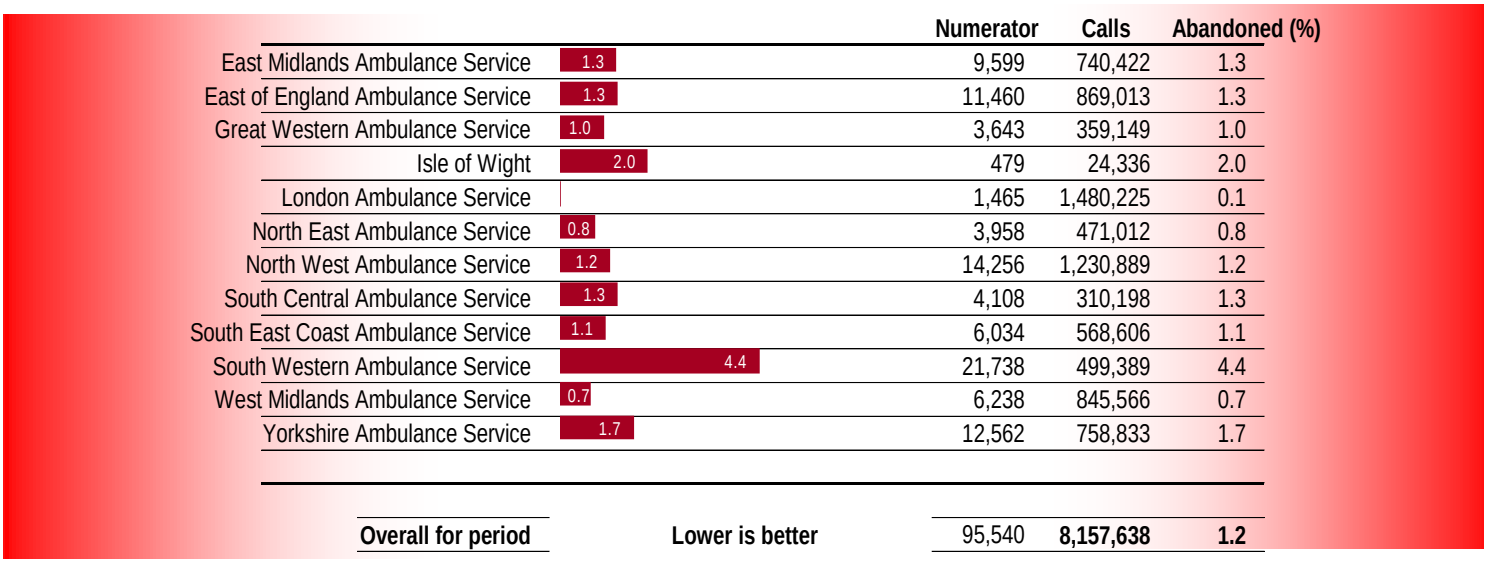
	Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	10,428	167,383	6.2
East of England Ambulance Service	10,875	256,241	4.2
Great Western Ambulance Service	2,623	85,804	3.1
Isle of Wight	95	5,475	1.7
London Ambulance Service	16,896	394,174	4.3
North East Ambulance Service	3,801	72,885	5.2
North West Ambulance Service	9,889	160,025	6.2
South Central Ambulance Service	9,262	143,179	6.5
South East Coast Ambulance Service	8,730	180,614	4.8
South Western Ambulance Service	8,340	127,565	6.5
West Midlands Ambulance Service	10,135	223,225	4.5
Yorkshire Ambulance Service	9,437	113,331	8.3
Overall for period	100,511	**1,929,901**	**5.2**

The graph demonstrates that the London Ambulance Service has the third lowest re-contact rate following telephone advice.

Measure 7. Call abandonment rate

This indicator measures if patients phoning 999 and not being able to get through and are hanging up before being answered.

Graph 13: Percentage of calls abandoned before being answered (Year end position)



		Numerator	Calls	Abandoned (%)
East Midlands Ambulance Service	1.3	9,599	740,422	1.3
East of England Ambulance Service	1.3	11,460	869,013	1.3
Great Western Ambulance Service	1.0	3,643	359,149	1.0
Isle of Wight	2.0	479	24,336	2.0
London Ambulance Service		1,465	1,480,225	0.1
North East Ambulance Service	0.8	3,958	471,012	0.8
North West Ambulance Service	1.2	14,256	1,230,889	1.2
South Central Ambulance Service	1.3	4,108	310,198	1.3
South East Coast Ambulance Service	1.1	6,034	568,606	1.1
South Western Ambulance Service	4.4	21,738	499,389	4.4
West Midlands Ambulance Service	0.7	6,238	845,566	0.7
Yorkshire Ambulance Service	1.7	12,562	758,833	1.7
Overall for period	**Lower is better**	95,540	**8,157,638**	**1.2**

Time to answer calls

It equally important that if patients dial 999 that they get their call answered quickly. This indicator measures how quickly all 999 calls that are received are answered.

No Graph Percentage of calls abandoned before being answered (Year end position)

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 0.0 seconds 2) 95th percentile where we achieve a rate of 0.09 seconds and 3) the 99th percentile where we achieve a rate of 0.58 seconds.

Our results demonstrate that at the 50th and 95th percentile we are the best in the country.

Measure 8. Service experience

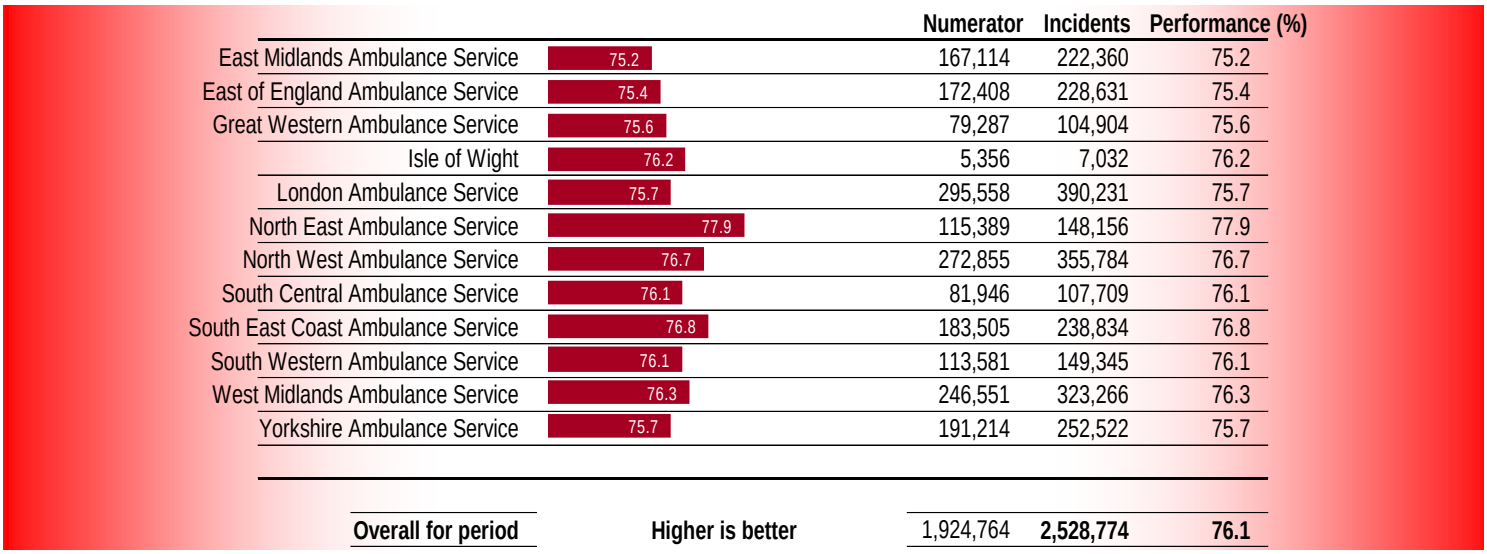
All ambulance services need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how they are acting on that information to continuously improve patient care.

There is no mandatory element and each individual Trust is able to decide how they meet the expectations of this measure. The London Ambulance Service NHS Trust has introduced a service experience action plan that is formulated from any lessons arising out of patient complaints, incidents, serious incidents, and legal claims. The London Ambulance Service believes it satisfies the expectations of this indicator.

Measure 9. Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and records only those who are most in need of an emergency ambulance. It is divided into two measures. The first is the length of time taken to respond within an eight minute window and the send measure is the time taken to respond in a 19 minute window.

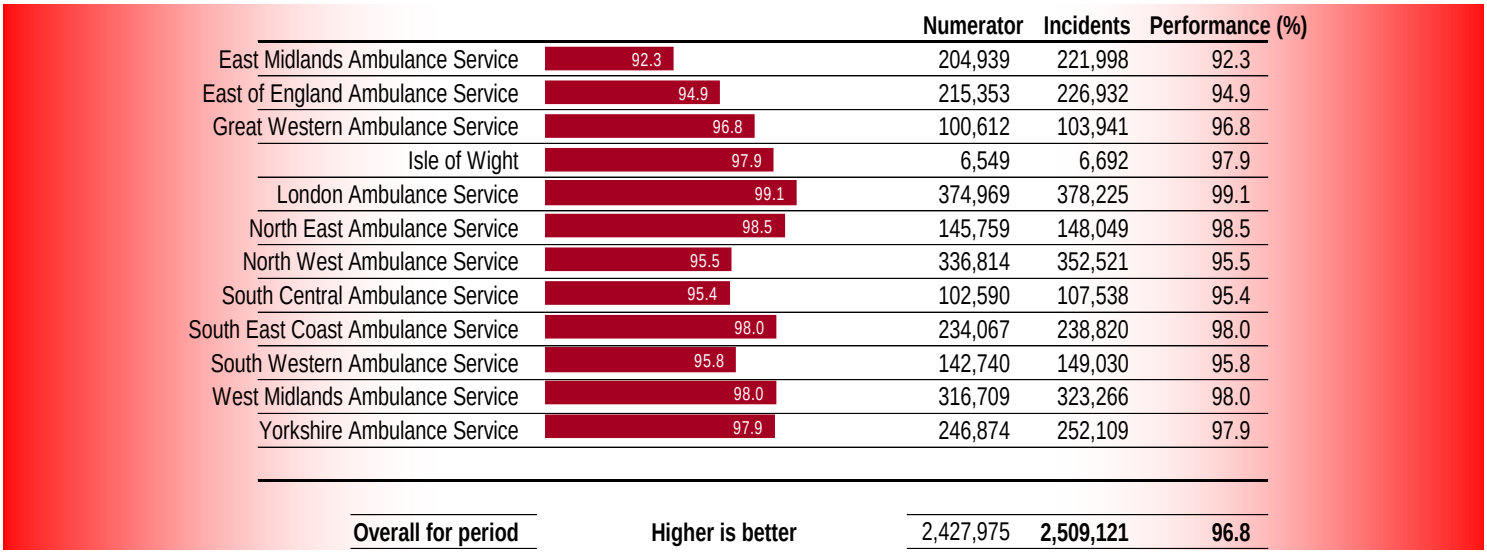
Element 1. Graph 14: Category A 8 Minute Response Time (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		167,114	222,360	75.2
East of England Ambulance Service		172,408	228,631	75.4
Great Western Ambulance Service		79,287	104,904	75.6
Isle of Wight		5,356	7,032	76.2
London Ambulance Service		295,558	390,231	75.7
North East Ambulance Service		115,389	148,156	77.9
North West Ambulance Service		272,855	355,784	76.7
South Central Ambulance Service		81,946	107,709	76.1
South East Coast Ambulance Service		183,505	238,834	76.8
South Western Ambulance Service		113,581	149,345	76.1
West Midlands Ambulance Service		246,551	323,266	76.3
Yorkshire Ambulance Service		191,214	252,522	75.7
Overall for period	**Higher is better**	1,924,764	**2,528,774**	**76.1**

The graph reveals that the London Ambulance Service achieved the requirement to complete 75% of all calls within eight minutes.

Element 2. Graph 15: Category A 19 Minute Response Time (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		204,939	221,998	92.3
East of England Ambulance Service		215,353	226,932	94.9
Great Western Ambulance Service		100,612	103,941	96.8
Isle of Wight		6,549	6,692	97.9
London Ambulance Service		374,969	378,225	99.1
North East Ambulance Service		145,759	148,049	98.5
North West Ambulance Service		336,814	352,521	95.5
South Central Ambulance Service		102,590	107,538	95.4
South East Coast Ambulance Service		234,067	238,820	98.0
South Western Ambulance Service		142,740	149,030	95.8
West Midlands Ambulance Service		316,709	323,266	98.0
Yorkshire Ambulance Service		246,874	252,109	97.9
Overall for period	**Higher is better**	2,427,975	**2,509,121**	**96.8**

The graph reveals that the London Ambulance Service achieved the requirement to complete 95% of all calls within 19 minutes.

Measure 10. Time to treatment by an ambulance-dispatched health professional

It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

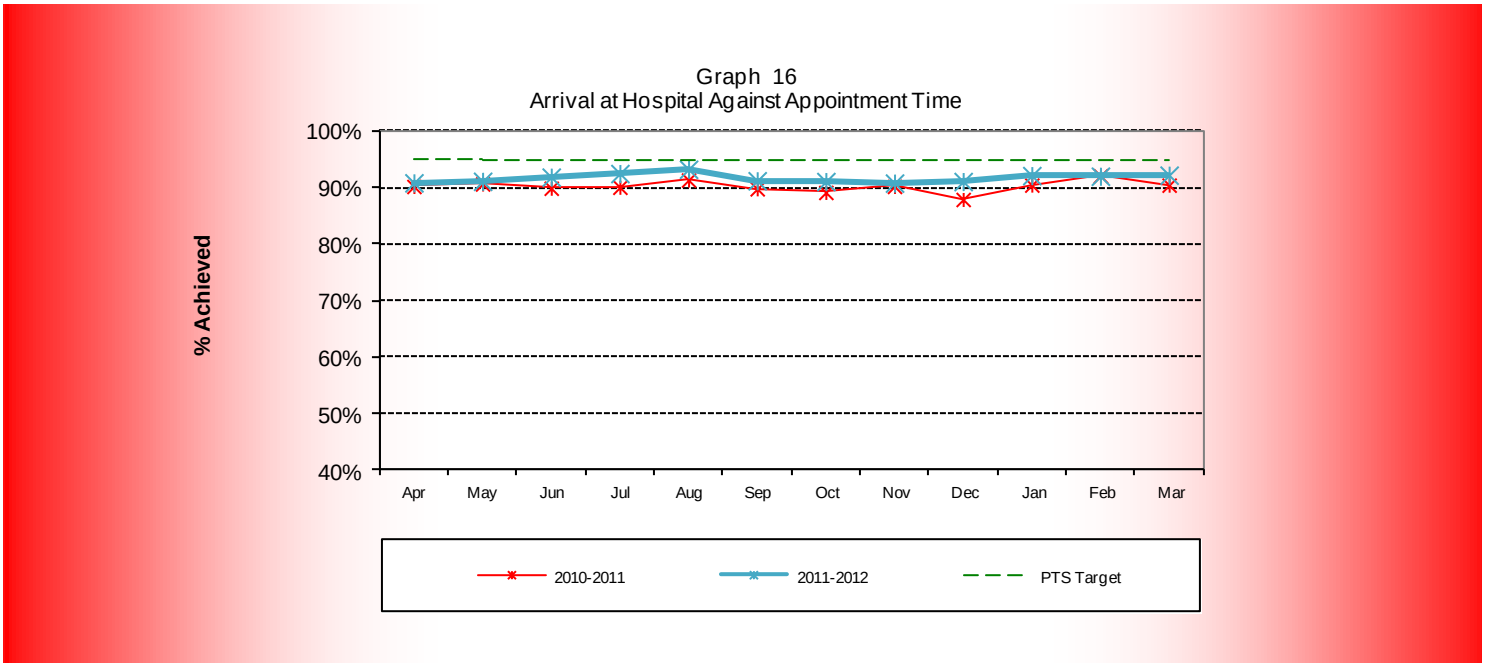
Category A 19 Minute Response Time (Year end position)

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 5.37 seconds 2) 95th percentile where we achieve a rate of 12.18 seconds and 3) the 99th percentile where we achieve a rate of 19.03 seconds. These figures are consistent with other ambulance services.

Patient Transport Services

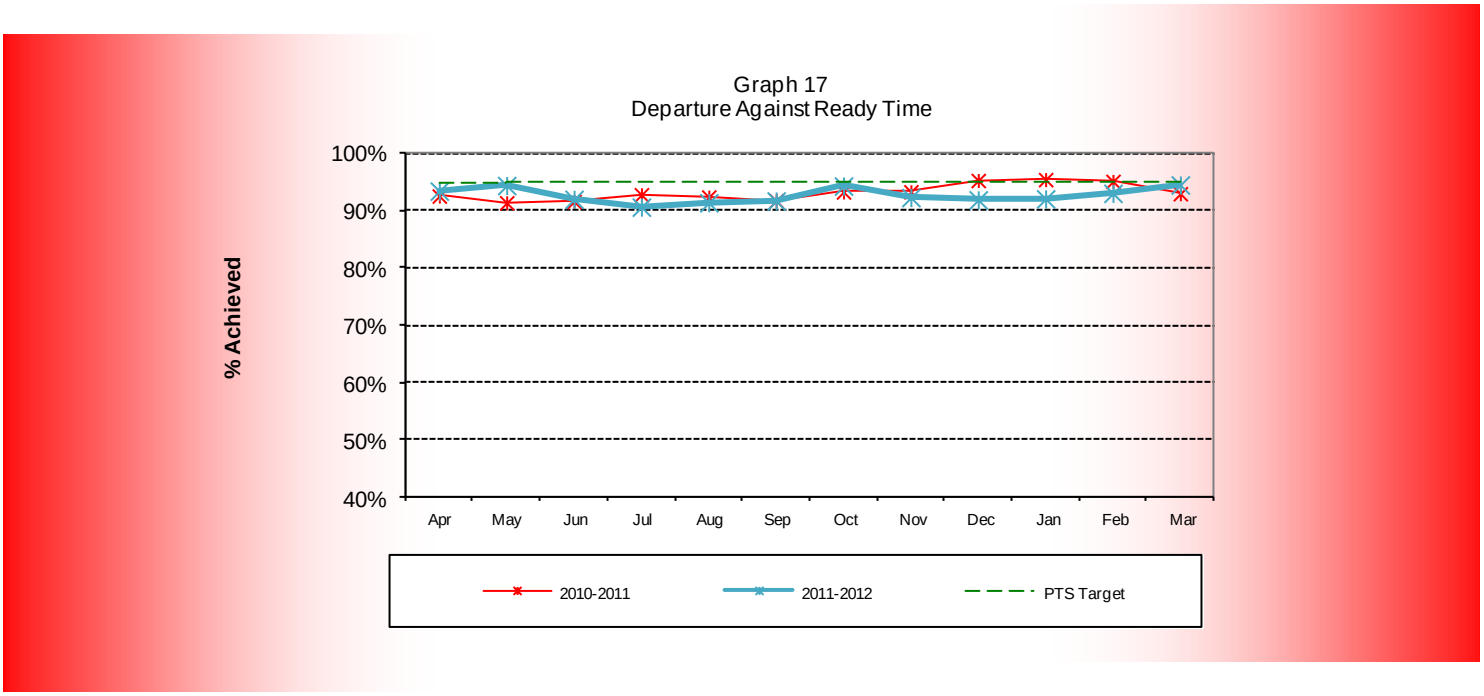
We are commissioned by a number of London NHS trusts and PCTs to provide non-emergency patient transport for patients attending hospital or clinic appointments carried out by, or on behalf of, the contracting trust/PCT. Each contract is specific to the requirements of the individual organisation and therefore the scope of each contract is different. For example, hours of operations, areas covered, types of patients conveyed. However we have a number of quality standards that we strive to achieve across our Patient Transport Service.

Graph 16: The percentage of patients who arrive within an agreed time frame of their appointment



The graph illustrates that our patient transport service has continued to improve the timeliness of arrival for appointment times. We are however, slightly below the trajectory that we have set ourselves.

Graph 17: Departure against ready time



The graph illustrates that our patient transport service has maintained a similar year end position for the timeliness of collection times and we are slightly below the trajectory that we have set ourselves.

Section B. Last year's priorities

Last year's Quality Account, despite only identifying four main quality priorities, actually highlighted 51 individual action points for 2011-2012.

This section provides a progress update on all of the 51 points identified.

Improvements to our quality processes

1. We need to embed the quality dashboard
   The quality dashboard has been refined through the year and now features as part of the Senior Management Group meetings, Quality Committee, Trust Board and Area Governance/Quality Meetings. The dashboard has also been presented at a number of internal conferences during the year and is also presented to the Clinical Quality Group; our meeting with commissioners.

2. We need to improve the way we structure and use feedback from patients
   The Integrated Report has significantly strengthened the way we learn from patient feedback. In addition in 2011-2012 the Trust saw the introduction of the "Patient Story" at the Trust Board. This means a patient is now invited to Trust Board to give a personal account of their experience.

3. We need to improve the way we learn and share the learning from serious incidents
   We have made significant improvements in the way we manage Serious Incidents. Investigations are completed more quickly and to a higher standard of finishing and each investigation is presented at the Senior Management Group and an outline given at Trust Board. The Associate Directors' Group monitors the implementation of the learning from serious incidents.

Improving mental health care

4. Improve the skill and competence of our clinical staff
   We now have an e-learning package available for staff and have now developed face to face training as part of our clinical skills refresher training which we plan to deliver to each member of clinical staff every three years.

5. Participate in whole system transformation work with partner organisations
   The Trust is now well represented in a number of pan London mental health forums, including the Mental Health Programme Board at the Metropolitan Police and the Pan London Overview Scrutiny of Section Patients Board.

6. Improve the advice and support available to our clinical staff
   We have now established the post of Mental Health Clinical Advisor and have successfully recruited into this post. We believe we are the only Ambulance Trust to employ a registered mental health professional in this capacity.

7. Improve the actual clinical intervention we provide to mental health patients
   This is dependent upon the delivery of action point 4 which is due to commence in April 2012.

8. Improve our governance and safeguarding arrangements with mental health patients
   The mental health work stream is now part of our safeguarding structure. We

are currently considering the issues of safeguarding and mental health and taking a view about referrals for mental health patients.

9. Improve the care of patients with dementia

There was little progress in this area as we were unable to identify any specific improvements that needed to be made from the published reports. We will continue to observe for improvements that can be made with this group and it remains on the agenda for the mental health committee.

10. Consider how we can use health promotion work with mental health patients

We have considered mental health promotion and in 2012-2013 we will focus on alcohol related health promotion. However, we also recognised our role in physical health care for those affected by mental illness and undertook an audit in 2011 to ensure we were maximising the opportunity of face to face contact by also assessing patients physical health.

The audit results demonstrated that good practice was identified in this clinical audit with ambulance crews obtaining the history of the patient's presenting complaint for almost all patients. Past psychiatric and general medical history were also obtained for the large majority of patients (93% and 94% respectively).

Allergies and medications were also documented for the majority of patients (80% and 78% respectively), although there was room for improvement. Whether the patient had a current psychiatric/ community psychiatric nurse or approved social worker was considered for just over half of patients.

11. Improve the management of alcohol related harm

This work was started in 2011-2012 and will be developed further in 2012-2013. During the year we opened an alcohol recovery service at times of high demand for alcohol related calls which proved successful at preventing admissions to Accident & Emergency for such patients.

Improving end of life care

12. Improve the skill and competence of our clinical staff

The Trust has developed a bespoke end of life care course for all front line clinical staff. The course is four hours duration and is being delivered as part of our mandatory training programme in 2012/2013.

13. Hold and share the information about a patient's current care preferences

At the end of the year we held 2,500 individual care plans on our system. These plans help guide our clinical staff in their decision making and reduce the need to convey patients to accident & emergency.

14. Clarify how we obtain clinical support from local providers

We have worked closely with the Royal Marsden NHS Foundation Trust and have worked with a number of clinicians. Each care plan has as a minimum the contact details of clinicians that we can contact for support and advice.

15. Improve the confidence in the systems so we can handover care

This has not been so successful. We found a number of the care plans on the system were not specific to end of life care and we have worked hard to improve the way that care plans are flagged to the Trusts. This work has not yet been completed.

16. Have the knowledge to take appropriate action if the agreed care provision breaks down

We now have a Senior Clinical Advisor who takes the lead on end of life care. He acts as a specialist for those occasions when our clinical staff our our clinical support desk staff are unable to resolve particular issues.

17. Improve the knowledge in the dying process,

    and

18. Improve the ability of clinical staff to make an examination and assessment,

    and

19. Improve the knowledge of drug use in and out of hospital end of life care,

    and

20. Understand the challenges associated with end of life care for people with dementia

    The training package that we have developed will address the following objectives;

    - Understanding palliative diagnosis and illness trajectories
    - Understanding prognostication when attending to the palliative patient and how this impacts on the management plan
    - Recognise the dying phase
    - Assessment and management of palliative care emergencies and common symptoms at the end of life
    - Knowledge of the pharmacology of commonly used drugs in end of life care
    - Reflect on the needs of the carer and families of the dying patients
    - Knowledge of contracts to support the care of the palliative patient.

Improving the care for patients who have fallen

21. We will further develop the tool to assist our clinicians in decision making and make this more widely available to staff

    and

22. We will implement training so that staff are familiar with the developed tool

    The initial development work focused on the need to design a training package and decision-support tool to enable staff to better assess and manage elderly patients who had fallen. The aim of the training package was to provide supporting education and knowledge around general issues affecting older people as well as specific falls information taken from national guidelines. The training package rollout was commenced in the late autumn of 2010, and continued throughout the following 12 months, with most of the training sessions being delivered on complex/area-based training days. All operational staff were included in the group identified for training, with additional engagement offered to team leaders and staff on the Clinical Support Desk to enable them to provide additional support to staff who may have specific queries.

    During the initial discussions regarding the process of onward referral, scoping work was undertaken to map local falls community care providers across London. It became clear that the services provided varied widely in type and capacity of the team, as well as ability to accept referrals from different sources. A decision was taken that the route of referrals for elderly fallers within the LAS would be to their own GP, and it would then be the doctor's decision regarding any further onward referral.

23. We will improve our monthly referral rates following agreed falls protocol (back to GP) for uninjured people who have fallen.

    At the start of the 'go-live' for the Referral Support Team', approximately 270 referrals were made to GPs across London, and through continued communications with staff via a variety of media (including posters, LAS News and clinical update articles, and a podcast), this number increase to a little under 1100 by March 2012. Across the year, a total of 9940 referrals were made from crew staff to London GPs specifically for elderly patients who had fallen.

Implementing a quality dashboard

24. Implement the use of the dashboard through our quality governance structure

    The quality dashboard is now implemented through the organisation.

25. The implementation of the additional quality measures identified within our quality strategy

All the quality measures have been included on the dashboard although we were unable to collect any evidence or audit data for controlling body temperature and have therefore decided to remove this indictor from the dashboard for 2012-2013.

26. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success

The integrated report is considered alongside the quality dashboard and indicators are added and removed as evidence suggests. Last year we added "missing documentation" due to feedback obtained during the year.

Improving cardiac care

27. Due to the abundance of data indicating the benefits of therapeutic hypothermia, and the fact that it is recommended in the 2010 Resuscitation Council UK guidelines, this treatment will be rolled out pan London as soon as the most feasible means of instigating hypothermia is determined

We were unable to consider rolling this out during the year as the training programme was fully committed. However, we will continue to monitor and consider as part of our clinical strategy.

28. Enable the downloading of information from defibrillators to be made as accessible as possible

We have made little progress on this priority during the year. The clinical directors will champion this during the coming year.

Improving trauma care

29. In conjunction with the London trauma office work is ongoing to develop a triage tool suitable for paediatric patients

Currently Trust staff are encouraged to convey any child with serious injuries to one of the four Major Trauma Centres, as an interim position and pending the possible designation of paediatric major trauma centres. The adult triage tool advises staff to discuss the management of injured children with the Clinical Coordination Desk. A specific paediatric triage tool will strengthen the decision making process for this group of patients. The London Trauma Office established a paediatric subgroup, chaired by Dr Tina Sajjanhar, Consultant in Paediatric Emergency Medicine. One of the objectives of the group was to develop a paediatric triage tool, based on the adult tool which was introduced in March 2010. The paediatric version was signed off by the group in September 2011, and presented for information at the London Trauma Office Triage Tool workshop on 26th March 2012. Next steps are to reflect any relevant changes made to the adult triage tool (see below), arrange for the printing, lamination and distribution of the paediatric triage tool to LAS staff.

30. Evidence suggests that the major trauma field decision tree is currently over sensitive and may be taking more patients than necessary to major trauma centres. This needs reviewing in 2011/12

The London Trauma Office held a Triage Tool Development workshop on 26th March 2012, where the data linking the use of the triage tool with TARN outcome data, collected within the past two years, was reviewed. The data suggests that the tool has proved a safe and effective means of identifying seriously injured patients, with an average of 11 patients a day being transported to one of the four Major Trauma Centres. A third of these patients are subsequently shown to have an injury severity score of above 15 (major trauma). The positive predictive value of the tool is 31% and the negative predictive value 99%, the sensitivity is 77% and specificity 99.5%. The number of inter hospital transfers for seriously injured patients has fallen by 50%.
The workshop was attended by representatives from the Major Trauma Centres, Trauma Units, LAS and other ambulance services, Surrey and Sussex Air Ambulance, and other experts from relevant hospital specialities. There was agreement that the fundamental principles of the triage tool were robust. A number of minor modifications, including the triage of burns, open lower limbs fractures and the inclusion of 'crew

concerns' as an additional trigger were suggested. The output of the workshop will be finalised and presented to the London Trauma Board, prior to reprinting the triage tool and ensuring the dissemination of the changes to LAS staff and relevant stakeholders.

Progressing alternative & appropriate care pathways

31. There are further opportunities to develop the care pathways and this has been identified as a specific priority for 2011/12

    and

32. We will continue to explore opportunities within urgent care centres

    Over the 12 months from 1st April 2011, there has been strategic drive to improve the use of all types of ACP by operational staff – this has been encouraged by the Trust's commissioning team who has in-turn been liaising with commissioning cluster leads to understand local priorities relating to the management of urgent care cases in particular.

    In April 2011 a total of 2706 patients were conveyed or referred to alternative care pathways (with 904 to Acute Departments, 570 to urgent units and 1232 were not-conveyed and referred to community services), by March 2012 these numbers had increased to 6931 in total, (1519 acute, 2555 urgent, 2857 referred).

33. We will look for ways to obtain patient feedback on how the pathways benefit patients

    Whilst we did undertake a mental health survey this did not directly address the action point. This has been rolled into a specific CQUIN for 2012-2013 and we will undertake a piece of evaluation work on those patients who are left at home.

Improving stroke care

34. Support the final Hyper Acute Stroke Unit to open

    During the year, the HASU at the Princess Royal University Hospital in Farnborough opened, which saw a reduction in journey times for patients in the south east of London. The slight adverse impact of this was the planned closure of the Temporary HASU at St Thomas' in October, which has lead to a loss of central resilience. However, we now convey over 700 patients per month to a Hyperacute Stroke Unit, and have demonstrated that we consistently triage over 97% of stroke patients to a clinically appropriate destination

35. The bed capacity had initially appeared to be more than needed. However the final months of the year saw units reporting zero bed status. This has meant ambulance crews being sent to more distant hyper acute stroke units. We will support the network in reviewing the arrangements

    Bed capacity is constantly monitored. There is generally a good capacity in the north west and south west. Capacity appears lowest in the north east. We were able to support the network through outbreaks of norovirus in two HASUs.

Ambulance Availability

36. We will continue to drive down times when vehicles are off the road for avoidable circumstances

    The Vehicle Resource Centre has developed overnight planning systems to reduce avoidable vehicle off road time. The centre conduct triage of vehicle faults over the phone to direct an appropriate resource to the fault, rather than send every vehicle to a workshop location. Increasingly, third party fleet suppliers are held to robust service level agreements but there is more work to do.

    The vehicle resource centre is asked to meet a target of sourcing vehicles within 30 minutes of shift start (85%). Steady progress has been made in achieving this target in 2011/12, rising from 45% to 82% by the end of the reporting period.

    The vehicle preparation (Make Ready) contract has been awarded to a new supplier. Demanding key performance indicators, in terms of vehicle cleanliness and equipment, are being implemented aimed at ensuring that 100% of available vehicles are made ready - reducing the burden on operational staff and

managers, and in turn the downtime associated with vehicles in a poor state of readiness.

Also, 500 new Lifepak defibrillators have been brought into use. The availability of new equipment has improved reliability and contributed to a 50% reduction in unequipped vehicles. Vehicle packs ("red bags") are now in place across the entire fleet following strong partnership working with Operations. Critical equipment that is known to contribute to vehicle downtime is provided within these packs including key portable diagnostic equipment.

The new mobile communications provider, Telent, started work during 2011-2012. Fault diagnosis and repairs are now carried out by mobile technicians travelling to the vehicle, eliminating protracted and unproductive journeys to a single, central location under the previous contract.

37. We will look at the times that mechanical or equipment repair result in lost vehicle availability

Average vehicle availability remained on target for 2011-2012 at 88%. The percentage of lost hours against plan for fleet related issues fell below 2% at the end of the reporting year – a reduction of nearly 1% from the previous year. The number of vehicles with insufficient equipment to operate on a daily basis has reduced on average by 50%. Targets are set for these areas and monitored on a daily and monthly basis. A daily conference call has been introduced in the Fleet and Logistics Department aimed at assessing and improving the percentage of ambulances available to Operations by taking immediate corrective actions when necessary. The call considers resources available against planned shifts, workshop manning and loading, percentage of vehicles made ready overnight, and maintenance of the daily supply chain to station complexes.

Mobile vehicle technicians have been introduced to work overnight to reduce lost vehicle time impacting on early shift starts. It is estimated that mobile resources can resolve up to 75% of reported faults. Early results from this initiative have been encouraging. There is significant further work planned in 2012-2013 to shift the burden of running repairs out of workshops and onto mobile workshops provided internally (lessening the reliance on third parties).

38. We will continue to drive down the length of unnecessary delay during the transfer of care between ourselves and other Trusts

We have made considerable reduction in the elements of handover that lie wholly within our responsibility. However, the time that hospitals contribute to this delay has lengthened. We are continuing to work with commissioners to drive down unnecessary waiting at Accident & Emergency departments.

Emergency Operations Centre

39. Implement and embed the new computer system

The new computer system went live on 28th March 2012 and whilst we are still early in the implementation we are seeing some encouraging improvements with performance better than expected.

40. Embed new ways of working in dispatch

New dispatch model version 2 implemented in the autumn of 2011.

41. Understand impact of the new Department of Health code changes

These have been implemented as required.

42. Focus on developing our hear and treat activities to optimise response to certain categories of calls

This has been achieved with LAS exceeding the new 6,300 monthly target consistently from August.

43. Introduce a new system for supporting our clinical telephone advice

Not yet implemented.

44. Move to dual control rooms
Second control room planned and prepared. The operational move is scheduled for October 2012

45. Support the re-launch of our clinical response model
Not yet delivered.

46. Continue to plan for the Olympics and Paralympic Games
Olympic Board continue to plan for the Olympic event.

Patient transport services

47. Continuing to lower the age of the fleet to a projected 1.2 years old by the end of 2011
The average age of the PTS fleet by the end of 2011 was 2.9 years. This has been reduced from 4.1 years at the start of 2011. The difference between what has been achieved and what was projected has been as a result of variation in the portfolio of contracts held by PTS. The subsequent addition of a new contract in August 2011 has resulted in the necessity to retain some of our older vehicles whilst plans are put in place to procure additional new vehicles as part of our rolling replacement programme.

48. We will see enhancements to the equipment carried on our bariatric vehicles as well as the introduction of a bariatric support vehicle. This will provide additional specialist equipment such as a hoist, lifting cushions and a variety of ramps for the most challenging situations
As this new service has developed over the last year, we have reviewed the requirement to implement a support vehicle with additional equipment. Our experience to date has been that there was no requirement for us to carry a hoist, lifting cushions etc. What we have found is that there have been difficulties on occasion with more primary equipment in stretcher and chair to cater for larger patients. Consequently, we have used funding to purchase more specialised stretchers and have been trialling a number of different carry chairs.
We will continue to monitor the bariatric service we provide and consequently the equipment we require to undertake this work safely and efficiently. If there becomes a growing demand for a support vehicle we will develop this solution in a timely manner.

Emergency bed services

49. Roll out the incident reporting and critical care pilot work
The Incident Reporting Pilot was implemented in early 2011. The interim evaluation has been positive. This will be developed further into 2012-2013 alongside the introduction of a pilot for Safeguarding Telephone Referrals. Now all London adult and PICU bed data is stored on our Clinical Manager System with other parts of the country joining the process later this year.

50. Introduce a falls referrals support service
This has been implemented. An interim evaluative survey asking GPs if they valued the service was overwhelmingly positive.

51. Implement call voice recording for safeguarding referrals
After extensive analysis this option has been discounted on the grounds that the added value is minimal for the associated costs. However, a safeguarding telephone referral pilot will commence shortly which will strengthen the referral process.

Part 5 Stakeholder Comments

Stakeholder comments

As part of the governance process for writing the Quality Account we are required to engage with stakeholders and seek comments on a draft of the account. Any feedback received needs to then be incorporated within the Final Quality Account.

This section contains the received feedback. The feedback has not been edited in any way.

We wanted to be extensive in our engagement and made the decision to ask all of the London LINK groups and a number of non NHS stakeholders. Hillingdon's Scrutiny Committee asked us to present our Quality Account to a committee meeting.

Not all others have taken up the invitation but the opportunity was extended to the following organisations or stakeholders.

Organisations receiving a draft report

Commissioners
Director of London Ambulance Commissioning

LINKS
Barking & Dagenham
Barnet
Bexley
Brent
Bromley
Camden
City of London
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith & Fulham
Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington & Chelsea
Kingston Upon Thames
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond Upon Thames
Southwark
Sutton
Tower Hamlets
Waltham Forrest
Wandsworth
Westminster

Partner Organisations
City Police
NHS Direct

Other Organisations
London Ambulance Patient Forum
Hillingdon Overview and Scrutiny Committee

Feedback Received from NHS North West London (Commissioners)

NHS North West London Cluster statement in response to the London Ambulance Service (LAS) NHS Trust Quality Accounts 2011/12

NHS North West London (the Cluster), a cluster of 8 PCTs, and lead commissioner of the London Ambulance Service (LAS) NHS Trust's has reviewed LAS' Quality Accounts (QA) for the year 2011/12. The Trust presented a draft for formal comments on 11th May 2012 and a further draft on 22nd May 2012. These were reviewed by the relevant commissioning team, the cluster quality team, the Clinical Quality Group (CQG) and the cluster Quality & Clinical Risk Committee. This statement has been signed off by the Non Executive Chair of the cluster's Quality & Clinical Risk Committee on behalf of the Cluster Board and approved by the CQG chair. In our view, the QA in general complies with guidance as set out by the Department of Health (DH).

Review of Quality Priorities & Performance 2011/12

We welcome the Trust's significant progress in establishing systems and processes for measuring and assuring the quality of service it provides. The implementation of a quality dashboard has been very beneficial, and provided a useful structure for discussions at the Clinical Quality Group.

2011/12 was the first year of the new national ambulance quality indicators, and in general the Trust is commendably performing above average or better than its counterparts across the country for the majority of indicators, notably cardiac arrest survival. This is enabling a focus on quality outcomes, rather than just achieving time targets. We do expect to see further improvement across all measures in subsequent years when it will be possible to compare and document year on year improvement.

The commissioners have seen significant improvement in the investigation and review of serious incidents (SIs), with a more timely response and demonstration that there is more rigour in learning from these incidents and preventing a reoccurrence, for example the use of the high risk register. We expect the Trust to continue to build on this in 2012/13.

The commissioners have seen that the focus on Mental Health Care in 2011/12 has delivered a significant improvement in training, assessment skills/tool, crisis protocols and overall focus for the Trust. The recruitment of a dedicated Mental Health professional is welcome, and will support this 2012/13 priority.

The End of Life Care initiative has increased the number of care plans held by the LAS, and the audit work has shown the value of developing and using shared patient care plans. Further work, such as the roll out of the 'Coordinate by Care' system in 2012/13 will help to progress this.

The Trust had a number of reviews and visits during the year, such as the Command Point review, Foundation Trust gateway review, 30th November industrial action and the Care Quality Commission (CQC) visit. As commissioners we have been involved in many of these reviews and it is encouraging to see the learning and recommendations followed through, for example the successful implementation of CommandPoint at the end of March 2012. A brief summary of the key learning and improvements made from these reviews would have been a useful inclusion within the QA given the major media coverage on these areas during the year.

For data routinely measured as part of the contract, and presented in the draft received for comments, we can confirm that these are consistent with what is reported on performance scorecards and reviewed at contract meetings.

Areas for improvement:

We reviewed all other actions reported as part of the Trust's priorities for 2011/12 and have noted some have not been fully delivered or implemented or carried over to 2012/13. The rationale for 'retiring' these actions or information on how they will continue to be measured, improved, monitored and reported has not been fully

provided. While we acknowledge that priorities do change, it is important to provide stakeholders with assurance that 'retired' priorities are still being reviewed and developed and that progress will be maintained.

We recognise some improvements have been made in the 2011/12 NHS staff survey results, however, concrete plans to further improving staff engagement and satisfaction are not covered in the QA. It is recommended that the Trust considers making this one of its quality priorities in the future.

Examples of measures being taken to address the top three issues emerging from the review of incident, complaints and claims should have been included.

Priorities for improvement 2012/13

We fully support the four priorities for improvement for 2012/13, presented by the Trust.

1. Improving mental health care – this builds on the work in 2011/12, which was one of our CQUIN priorities. We are encouraged that this will continue with training, clinical support, care pathway development and improving patient experience.

2. Reducing alcohol related harm – we will work collaboratively with the Trust and partners, such as the London Mayor and the London Health Improvement Board, on health promotion, as well as implementing the best models of care for this increasing group of patients.

3. Providing a quality service during the Olympics – we are pleased to have secured additional DH funding for the Trust for the Olympics and Paralympics. We will be working with the Trust to ensure safe and effective services for Londoners can be maintained throughout, without a compromise on quality.

4. Improving diabetic care – this work directly relates to commissioner priorities (and the 2012/13 CQUIN). We welcome the focus on long term conditions, as this is a significant group of patients who use the ambulance service, and can be supported more effectively to manage their care. This initiative will help encourage collaborative and integrated care with primary care (GPs).

Whilst each of these priorities is supported by commissioners, specific detail in the QA on how success will be measured, monitored and reported would have been helpful (as per DH QA guidance).

Concluding Statement

The CQG has developed during the year with increasing clinical commissioner engagement and has played an important role in monitoring quality and providing support to the Trust. We hope the Trust finds these comments helpful and we pledge our continuing support as we look forward to continuous improvements in 2012/13.

Feedback Received from Haringey Link

We received an email on 22nd May regarding the LAS Quality Account 2011-12 asking for our comments, but we will have to decline to comment at this time as we feel we do not have the information to challenge or ratify the account.

Feedback Received from LINk Southwark

"LINk Southwark would like to provide the following commentary to the report which is well laid out and mostly very clear.

We welcome the principle "that the account should reflect the views of patients" and are glad that "kindness" was amongst the qualities valued.

- There is the occasional phrase that needed more explanation e.g. "dashboard"; and what that is in order for the public to understand this.

- Staff relations seem to have deteriorated, but no observation is made as to the causes of this, or how it might be improved.

- It is commendable that continuing efforts are being made to improve the service for mental health patients, by staff training, patient consultation and liaison with mental health providers.

- The alcohol recovery project sounds useful and its future evaluation is welcomed.

- Diabetes care: "automatic referral to GP", sounds like a good idea, but is the patient's consent or at least knowledge required. In fact are all ambulance attendances notified to the GP, and how easily do ambulance staff discover the name of the GP?

- The research topics all appear very useful.

- It has been noted that LAS was not required to submit data using the NHS number and General Medical Practice Code.
    - How can people be better prepared for emergencies? Such as having their details at hand, as with the Bottle in the Fridge scheme? Could LINks/local HealthWatch help on this?

- Adding to LAS' challenges would be the large number of unregistered foreign visitors/immigrants in London - this topic does not appear to be examined. Perhaps the Olympics are an opportunity to consider this.

Many thanks

LINk Southwark"

Feedback Received from Patients' Forum Ambulance Services (London)

1) Public Involvement

a) The LAS has a strong commitment to public involvement and the Forum plays an active part in the following LAS committees: Patient and Public Involvement, Equality and Diversity, Mental Health, Clinical Quality, Safety and Effectiveness Committee, Infection Prevention & Control Committee Meeting, Clinical Audit and Research Committee, and the Learning from Experience Committee.

b) Questions put the LAS by the Forum are usually responded to quickly and fully.

c) The LAS supports the Forum by providing, information, meeting rooms, refreshments, photocopying and presentations to meetings.

d) The Forum has been unable to obtain a response to the issues it submitted to the LAS for the 2011-2012.

e) Evidence of patient experience having real influence on policy and practise in the LAS is weak.

Recommendation: The LAS should develop a greater focus on collecting detailed qualitative data from service users especially where they have criticised or complemented the service. They should develop methodologies to demonstrate how qualitative data collected from patient groups, individual patients and the public has influenced LAS services. Evidenced based public involvement work in which public influence on the LAS can be demonstrated should be a priority.

2) Corporate Objectives CO2 and CO5 – Equality and Diversity

CO2. To improve the experience and provide more appropriate care for patients with less serious illness and injuries.

CO5. To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population.

a) The Forum was pleased with the decision of the LAS to hold a meeting for the public on the Equality Delivery System (EDS) and felt this was an important way of including the public in the developing EDS.

b) We have concerns about the care of patients with sickle cell disease. We have met with the Sickle Cell Society which is committed to working with the LAS and the Forum to improve the care of people in a sickle cell crisis. We do not believe that the LAS gives sufficient priority to the health needs of black and ethnic minority communities and strongly recommend that a focus on the care of people with sickle cell disease. This would enable the LAS to demonstrate how they are prioritising the needs of protected groups.

c) The priority given to diabetic care by the LAS could expanded to ensure that front line staff are trained to appreciate that some ethnic groups have higher levels of diabetes.

d) The LAS has been unable to attract significant numbers of staff from black and ethnic minority communities, despite this matter having been raised by the Forum continuously since 2003. We understand that 94% of front line clinical staff are white. We recommend the LAS seeks expert advice to address this problem and initiate a programme of work to transform the ethnic composition of staff and Board members.

3) Quality Domain 5: Clinical Outcomes

a) The Forum welcomes progress made by the LAS in examining clinical outcomes of LAS interventions for patients with cardiac arrest, STEMI and stroke.

b) We would like to see this approach to quality developed by mainstreaming a system that enables frontline LAS clinical staff to review the outcomes of clinical care they have provided to acutely ill patients who are admitted through A&E. This could be done on a cohort basis, or through the selection of patients that LAS clinical staff have particular concerns about. The development of joint clinical meetings between LAS frontline staff and A&E staff would be an important step in meeting this important quality objective and supporting reflective practice and annual appraisal for paramedics, technicians and medical staff.

4) Mental Health and Dementia Care

a) The Forum is very pleased with the progress made by the LAS with the development of their mental health strategy, the prioritisation of this work over the past year and the employment of a mental health specialist.

b) The Forum would like to see this work developed though targeted qualitative research with patients who have been taken by the LAS to A&E departments and Places of Safety, with a diagnosis of a severe mental illness, e.g. sectioned under s4, s135 or s136 of the Mental Health Act.

c) The Forum would like to see prioritisation of rapid admission to appropriate mental health services – waits of several hours to handover patients to appropriate mental health practitioners are appalling. Urgent negotiations are needed with commissioners and the acute and mental health sector in London to resolve this problem.

d) Progress with providing appropriate care for people with dementia should be a priority. The Forum has recently met with Alzheimer's UK, who would like to work the LAS to ensure that people with Alzheimer's disease receive appropriate assessments, referral to memory clinics and mitigation of long waits in A&E.

5) Bariatric Care

a) The QA identifies appropriate care for heavy patients as a cause of concern. The Forum is concerned about the distress caused to these patients and their families, when staff do not have the right equipment, and training to provide appropriate care and support.

b) We recommend the LAS ensures staff have access to appropriate equipment and vehicles 24/7, and fully trained staff are available to ensure heavy patients do not suffer delay in their care or treatment.

6) Learning from Serious Incidents and Complaints Patients Safety and Patients Complaints

a) We compliment the LAS on significant progress made through the Learning from Experience Committee.

b) We recommend the LAS formally adopts the Health Service Commissioner's statement 'Driving improvement and learning from NHS complaints information', which provides a bridge for learning from incidents, accidents and complaints.

c) We would like to see details of all recommendations made following complaints investigations placed in the public arena with evidence of enduring improvement to LAS services.

7.0 Being Open

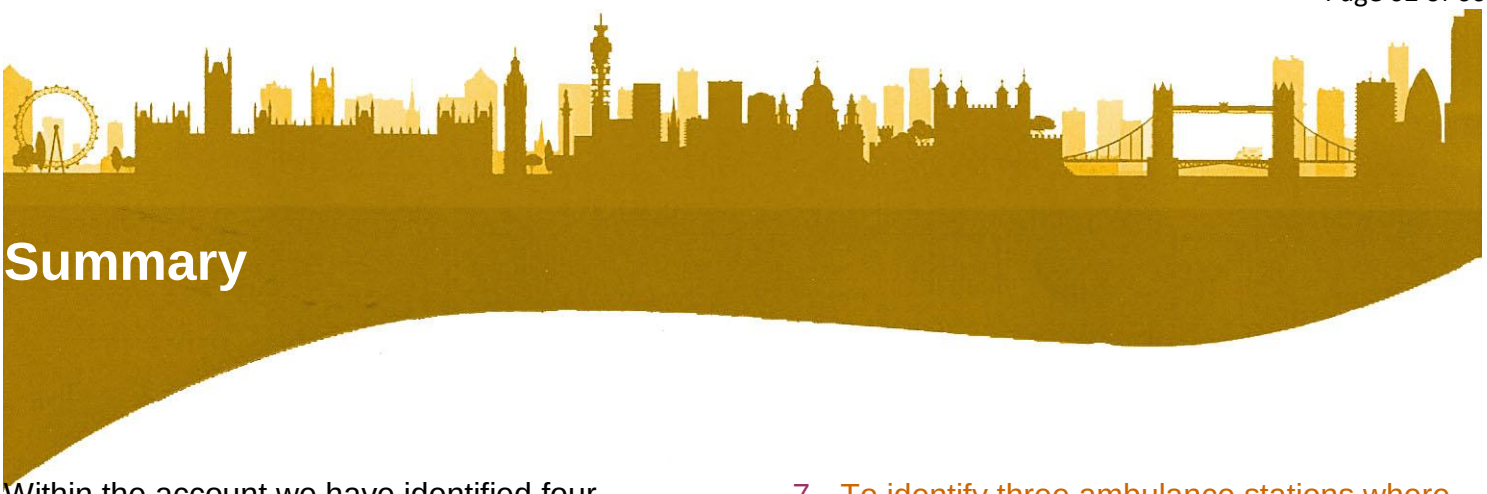
a) We would like to initiate a joint project with the LAS to gather evidence that people are informed when something has gone wrong with the treatment or care provided to them by the LAS.

"Open and **honest** communication with patients is at the heart of health care. Research has shown that being open when things go wrong can help patients and staff to cope better with the after effects of a patient safety incident.

Healthcare staff may be fearful of upsetting the patient, saying the wrong or admitting liability. This guidance and the associated actions outlined in the Alert, provide reassurance that *Being open* is the right thing to do, and encourage NHS boards to make a public commitment to openness, honesty and transparency".

National Patients Safety Agency (NPSA) 2009

Part 6 Summary



Summary

Within the account we have identified four priority areas for the coming year. In addition, we have also identified a number of other quality improvements that we have said we will make. This section summarises all the main quality improvements cited within this account.

Improving Mental Health Care

1. To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face to face element of training in the coming year (page 19).

2. To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health (page 19).

3. To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction (page 19).

4. To role out the agreed care pathways across the whole Trust (page 19).

Reducing Alcohol Related Harm

5. To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy (page 20).

6. To make recommendations, to our commissioners, on the future delivery model for alcohol (page 20).

7. To identify three ambulance stations where we can introduce an alcohol assessment protocol (page 20).

8. To identify what course of action can be taken when a patient triggers the assessment (page 20).

Quality during the Olympics

9. We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the games (page 21).

10. We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed (page 21).

11. These messages will be communicated as required and need to be reinforced by robust local messages (page 22).

12. Identify the quality indicators to monitor in real time during the period of the Olympic Games (page 22).

Improving diabetic care

13. Develop a protocol and training for our clinical staff that supports patients with a reading of 8mmol/L to be referred, when appropriate, to their GP (page 23).

Other quality improvements

14. During the course of the year we will make further clarifications and make contact with other ambulance services in other countries to start comparing, where possible, outcome data(page 9).

15. We have the aspiration to be upper quartile in all of the Ambulance Clinical Quality Indicators and this year expect to move up a quartile in those areas where we are not currently in the upper quartile (page 9).

16. We also intend to drive the quality dashboard through the organisation which will require stronger communication links with clinical staff (page 12).

17. We need to roll some of these systems into our less serious incidents so that we have a single robust process (page 12).

18. We will undertake further analysis of staff feedback in early 2012-2013 (page 13).

19. We have further work to do in recording and quality assuring our safeguarding training (page 14).

20. This coming year will see the development of a clinical strategy for the Trust (page 18).

National Clinical Audit

21. Raise awareness of the STEMI care bundle through initiatives such as posters, newsletters and further education (page 27).

22. Increase the proportion of patients presenting with a STEMI who receive pain-relieving medicine by developing an LAS pain management training session (page 27).

23. Increase the number of patients presenting with a STEMI for whom two pain assessments are undertaken by creating a pain assessment tool to help patients who struggle to understand the concept of pain scoring (page 27).

24. Raise awareness of the stroke care bundle with posters, newsletters and further education (page 28).

25. Increase the number of referrals to GP's and diabetes teams for diabetic patients in London through the implementation of a new call back and referral process for non conveyed patients suffering from hypoglycaemic emergencies (page 28, but this will be addressed through our diabetic work).

26. Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by exploring the introduction of portable oxygen saturation probes and paediatric probes (page 28).

27. Increase the number of data downloads from defibrillators through feedback to staff on the findings from downloads (page 28).

Clinical audit of the care provided to elderly patients with a hip injury by the London Ambulance Service

28. Highlight the importance of assessing the patient's pain and administering analgesia where appropriate through developing an LAS pain training session (page 28).

29. Reduce the number of vehicle cancellations when a response is allocated to a patient through the introduction of CommandPoint (page 28).

Clinical audit of the Clinical Telephone Advice given to patients triaged by the Medical Priority Dispatch System as '24B1' Labour (delivery not imminent, ≥5months/20 weeks) by the London Ambulance Service

30. Review, shorten, and clarify the way Clinical Telephone Advice (CTA) staff should be using the Maternity Pathway Questioning Tool (page 28).

31. Develop an initial screening tool that can be used by senior CTA staff members prior to the Maternity Pathway Questioning Tool (page 28).

32. Develop a quality assurance process for calls where CTA staff use the Maternity Pathway Questioning Tool (page 28).

33. Feedback the results of this clinical audit to the Medical Priority Dispatch System Working Group and to the Emergency Operations Centre (page 28).

34. Send CTA staff a questionnaire asking for their views on the usability of the Maternity Pathway Questioning Tool (page 28).

A clinical audit examining End of Life Care in the London Ambulance Service

35. Increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness through an End of Life Care training package to all crews and an advanced education package for Clinical Support Desk staff (page 28).

36. Increased number of Palliative Care/End of Life Care Handover forms registered on the Patient Special Needs Locality database (page 28)

37. Introduce Co-ordinate My Care so Clinical Support Desk staff are able to access all palliative care patient plans to ensure correct management as per patient wishes (page 28).

38. Publish guidance to instruct crews to call the Clinical Support Desk for further support and advise crews to contact the patients' palliative care team, particularly out-of-hours when deciding on a course of action (page 28).

39. Remind staff about the correct use of Patient Report Form (PRF) illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint (page 28).

A baseline clinical audit examining the measurement of end tidal carbon dioxide ($ETCO_2$) during advanced airway management of cardiac arrest patients by the London Ambulance Service

39. Increase the number of $ETCO_2$ waveforms that are included in the electronic clinical record for this patient group by ensuring the corresponding Computer Aided Dispatch (CAD) number is documented when an $ETCO_2$ reading is taken and remind Station Administrators that waveforms should be sent to Management Information with the associated PRF (page 28).

40. Remind staff about the preferential use of a supraglottic airway devices, emphasising that it is a safe and effective way of maintaining a patient's airway by writing an article for the Clinical Update (page 29).

41. Review Advanced Life Support in the Core Skills Refresher 1 training to include particular emphasis on the preferential use of supraglottic airway devices and including waveform print outs in the patient's clinical record (page 29).

Improving trauma care

42. Reflect any changes to the adult triage tool in the paediatric care, arrange for the printing, lamination and distribution of the paediatric triage tool to LAS staff (page 49).

43. The output of the workshop will be finalised and presented to the London Trauma Board (page 50).

Patient Transport Services

44. We will continue to monitor the bariatric service we provide and consequently the equipment we require to undertake this work safely and efficiently. If there becomes a growing demand for a support vehicle we will develop this solution in a timely manner (page 52).

Emergency Bed Services

45. Implement the telephone referral pilot to strengthen the safeguarding referral process (page 52).

Appendix I: Vision & Values

Our **vision** remains the same for 2012-2013 as it was for 2011-2012;

To be a world class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.

In 2011-2012 this vision was underpinned by three strategic goals which were considered essential for the delivery of our vision. Each strategic goal had a number of corporate objectives which supported the delivery of the strategic goals.

During 2011-2012 we reviewed our corporate objectives and made the importance we give to quality more explicit within three of the objectives.

The three changed objectives for 2011-2012 were as follows;

Corporate Objective 1.	**To improve outcomes for patients who are critically ill or injured.**
Corporate Objective 2.	**To provide more appropriate care for patients with less serious illness or injury.**
Corporate Objective 4.	**To meet all other regulatory and performance targets**

The three objectives for 2012-2013 are as follows;

Corporate Objective 1.	**To improve the experience and outcomes for patients who are critically ill or injured.**
Corporate Objective 2.	**To improve the experience and provide more appropriate care for patients with less serious illness or injury**
Corporate Objective 4.	**To meet all other quality, regulatory and performance targets**

In addition we also made changes to the corporate objective supporting us to improve the diversity of the workforce. In 2011-2012 we were awarded top 100 employer status by Stonewall, whilst we recognise there are always improvements that can be made in the number of staff recruited from different groups, we took the decision to change the emphasis to quality by focussing on the diversity needs within our patient group.

The changed objectives for 2011-2012 were as follows;

Corporate Objective 5.	**To develop staff so they have the skills and confidence they need to do their job.**
Corporate Objective 6.	**To improve the diversity of the workforce.**

The change saw us combine the objectives and reword the objective for 2012-2013 as follows;

Corporate Objective 5.	**To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population.**