



London Ambulance Service



NHS Trust

The London Ambulance Service NHS Trust

2013/14

The annual quality account





The London Ambulance Service NHS Trust **Annual Quality Account 2013/14**

An account on the quality of service provided by the Trust and the identification of improvement priorities for 2014/15

Incorporating an end of year review of the DH Ambulance Quality Indicators



Acknowledgements
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Introduction

Statement on quality from the Chief Executive

This is the fifth Quality Account published by the London Ambulance NHS Trust. It acts as a written review for the public of our Quality during 2013-14.

Like all years, 2013-14 was to be a challenging year and we saw significant change and achievement within the service. But unlike other years it was not simply due to the on-going challenges of balancing resources with demand. In 2013-14 we saw a culmination of events that possibly brought about the biggest challenges ever seen in 65 years of the NHS.

The year saw the introduction of the health reforms designed by the previous Secretary of State Andrew Lansley. The vision of local clinical commissioning with the requirements to become more locally focused and locally responsive have given us real opportunities to work differently with local clinicians on the issues for their groups of patients. However, as a pan-London provider it is significantly challenging to respond to 32 commissioners and deliver a consistent pan-London service.

We are doing a number of things to respond to these propositions but they all produce their own challenges. We are responding to this by restructuring our operational teams to mirror local Clinical Commissioning Clusters; by developing links locally with commissioners; by thinking about how we engage with patients differently; and by ensuring our data becomes more locally focused.



The year also saw the publication of the Francis Report. This heralded the biggest criticisms of quality ever of the NHS and in turn led to a number of subsequent reviews on quality. All these together asked any NHS trust to reflect hard on how they run the organisation and relate to staff and patients. We are now implementing the necessary changes from these reviews. These include, a review of organisational culture, introduction of Duty of Candour (being open), and we are reviewing how we engage with our patients and with our staff. During the year we launched a programme of staff engagement called Listening in Action; we held a number of events with our staff that allowed us to listen to their concerns and identify a range of improvement measures that would make a difference to them.

We also launched our own two-year Transformation Programme which would see some of the biggest changes in the way we deliver our services for many years.

All of this culminated to become a year of significant change. We have risen to these challenges and have demonstrated a real resilience. We delivered, for the eleventh consecutive year, the target to reach 75% of our most urgent patients within 8 minutes. Whilst we now believe it is time to reflect and ask if this is the best measure of quality it is still the benchmark on which others judge us and we are proud of this achievement. Inevitably we have lost some of our staff either directly through these changes or through frustration regarding some of the problems we are now trying to change. This has revealed a new issue regarding a shortage of registered clinicians across

the country and we are focusing on recruiting more talented and skilled clinicians to the service during 2014-15.

We have maintained good cardiac care and London is now one of the world's leading cities in which to survive a cardiac arrest. We also have one of the fastest call answering services in the world and external scrutiny of this continues to rate it highly with an excellent satisfaction rate with this aspect of our service. In addition, London saw a major incident with the collapse of seating in a large West End theatre venue. We were able to demonstrate our emergency preparedness for Londoners.

This year also saw our services grow into a new area of care as we took on responsibility for NHS 111 services in South East London. We report on this in our Quality Account as we believe this service has been well received by patients and commissioners.

This Quality Account details some of our other achievements during 2013-14. We have tried to present a balanced view. Not all of our aspirations have delivered the results we wished but I hope you agree that this has been a challenging but successful year for the service.



Ann Radmore
Chief Executive



What is a Quality Account?

The purpose of the Quality Account

Since the introduction of the Quality Account in 2009 all NHS Trusts are required to publish quality accounts in accordance with the annual reporting guidance from NHS England. By publishing data, supported by explanation, the aim is to improve transparency for patients and service users on what is working well and what needs further improvement. The key is to provide a balanced report.

Monitor, the regulator of NHS Foundation Trusts, state four main aims of Quality Accounts:

A focus on quality improvements in each organisation: the reports provide an opportunity to set out how the Trust intends to improve its own quality.

Board ownership: this can lead to ambitious board-driven quality improvement priorities, measures and programmes of work.

Engagement with clinicians and patients: the priorities and metrics included in the Quality Account must be relevant and credible to clinicians within the organisation and help form a narrative that is credible to patients and the local public. Broad engagement in the development of quality reports is needed to meet these requirements.

A wider quality debate: Quality Accounts should provide an opportunity for providers to describe their performance and their improvement goals.

The Quality Account is required to follow a template and report on a set of mandatory items. We have divided our Quality Account into four distinct sections.

Section 1 contains a statement on quality from the Chief Executive and this introductory explanation.

Section 2 looks back at the previous year and reports against a set of mandatory measures. The section also reports progress made against the priorities we identified for improvement in the 2012/13 Quality Account.

Section 3 looks forward to the year ahead and identifies new priority improvements.

Section 4 is where we share the written feedback we have received on the 2013/14 Quality Account.

In order to give a more comprehensive view on quality we have made the decision to report beyond the minimum requirements. In addition, where possible we have also reported comparative data from other Ambulance Trusts in England.

Involving patients, staff, commissioners, and stakeholders in the creation of our Quality Account.

Section 4 contains the formal feedback we have received from stakeholders on the finished Quality Account. In particular, we have actively sought the opinion of others in identifying what improvements we need to make in 2014/15.

This journey started with our staff. Our clinical staff have been telling us that they often feel unable to deliver a satisfactory service to patients requiring mental health care and have asked us for more training. In addition, the Patient Forum suggested mental health care as a potential area for improvement.

During the course of the year we considered the suggestion to have mental health care as an improvement priority for 2014/15 to other groups.

As an aspirant Foundation Trust we have a membership which has over 8,000 representatives. In February

2014 we invited them to a dedicated event where we discussed mental health care. At the event we shared a number of suggestions on how we could improve mental health care and these were widely supported by those who attended the event.

This proposal was also discussed with the management of "Healthwatch Southwark" who were supportive of the initiative as Mental Health services was also one of their priority areas

In April 2014 we also presented the main themes within this Quality Account to the London Borough of Hillingdon External Services Scrutiny Committee.

During the course of the year we have been working with the Metropolitan Police in identifying specific improvement actions for mental health in 2014.

Finally, the Trust formally meets with commissioners monthly. This has representation from across London commissioning and at every meeting we discuss quality. These discussions continuously shape our improvement plans and they have supported mental health as being our primary improvement priority.



Vision and Values

Our Strategic direction and our values

Our vision for 2013/14 was the same as the previous year; 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.

During 2013/14 we recognised the need to undertake a comprehensive review of our strategy, our vision, and our values. Consequently we streamlined our three strategic goals to help bring some immediate clarity to our strategic priorities. These are:

To improve the quality of care we provide our patients

To deliver care with a highly skilled and representative workforce

To provide value for money

This was supported by identifying four clear service priorities which were designed to provide focus during the year. These are:

The Trust's Modernisation Programme

Communication and engagement

Sustain performance to ensure safe services to patients

Building a sustainable financial position for 2014 and beyond

Progress on the Transformation Programme is reported on within this

Quality Account as it was identified as a specific Quality Improvement for 2013/14. Progress against other strategic and service priorities is outlined in our 2013/14 Annual Report.

Our values

Our values in 2013/14 were the same as the previous year. These are:

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.

We will be consulting with our staff and stakeholders during 2014 on our new strategy and values provisionally called **Right Response, Right Care.**





Prioritising Quality

How we prioritise and monitor quality

As an NHS Trust we are required to spend time on a number of different priorities. However, we are continually seeking opportunities to strengthen the priority we place on quality and we use a number of sources and influencers to shape our quality focus.

The Experience of other NHS Providers

In 2013/14 the NHS saw a number of high profile and increasingly critical publications regarding quality within the NHS.

These have formed the backbone on how we are reviewing and prioritising quality. The following highlights what we consider to be the main areas of learning for the Trust,

The second [Francis Report](#) into the Mid Staffordshire NHS Trust was published in February 2013. The report calls for a fundamental change in culture whereby patients are put first and goes on to make 290 recommendations covering a broad range of issues relating to patient care and safety in the NHS.

Sir Robert Francis called for "patients to be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and must be protected from avoidable harm and any deprivation of their basic rights".

On the publication of the Francis Report, the Prime Minister David Cameron commissioned Professor Don Berwick, an expert in patient safety, to consider what needs to be done "to make zero harm a reality in our NHS". The [Berwick Report](#) was published in August 2013.

Berwick called for a culture of learning and a clear message that goals and incentives are clear and in patients' best interests



Key recommendations from the Francis Report include the following;

The introduction of a new statutory 'Duty of Candour. This requires all NHS staff and directors to be open and honest when mistakes happen.

Only registered people should care for patients. A registration system should be created under which no unregistered person should be permitted to provide direct physical care to patients.

Hospitals (and possibly other providers) should review whether to reinstate the practice of identifying a senior clinician. This asks to clearly identify who is in charge of a patient's case.

Directors should be subject to a new fit and proper person test. Such a test should include a requirement to comply with a prescribed code of conduct for directors.

The complaints systems within Trusts need to be strengthened The Health Service Ombudsman will increase the number of complaints that she considers for review.

GPs need to undertake a monitoring role. GPs, on behalf of their patients who receive acute hospital and other specialist services will monitor their care. From April 2014 there will also be a named accountable clinician for all vulnerable older people in out of hospital care.

He suggested that connecting with patients and the frontline was fundamental. Leaders need first-hand knowledge of the reality of the system and the patient voice must be heard and heeded at all times

He reinforced Francis' view that the complaints system need to be continuously reviewed and improved.

Transparency must be complete, timely and unequivocal

The third key review of the year was the [Keogh Review](#) of 14 NHS Trusts.

The review team led by Professor Keogh acknowledged that in the 14 Trusts there were a set of common themes that were leading to challenges in delivering a high quality service right across the Trusts.

These themes included a lack of awareness of the power of listening to the experience of patients, carers and staff to understand and improve services.

On the whole it was felt that not enough value is placed on the input of frontline clinicians who have constant interaction with patients and who are regarded as having natural innovative tendencies.

We have undertaken a thorough review of these publications and whilst they were primarily written from the hospital perspective we believe there are direct transferrable lessons to the London Ambulance Service.

We have developed three key themes that arise from these reports. The first theme is to *“develop a culture of learning”*. This is being taken forward within our new Quality Strategy which we will publish in 2014/15. This will clearly set out how we plan to transform into an organisation that learns through experience and strives for continuous improvement.

The second theme is the need to *“value and listen to our staff”*. Prior to the publication of these reports we had already acknowledged the need to enhance the engagement with our staff and we are now planning how we can develop this further within our organisational development plan.

The final third theme is *“Valuing and including the patient voice”*. This is a challenging theme as we do not have a dedicated patient group living in a catchment area and, whilst we do have a number of patients who depend upon us to assist in the management of their life long condition, the majority of patients will use us just once or twice in their lifetime. Nevertheless, we recognise the importance of engaging patients and are developing an engagement strategy. The patient voice will also feature highly within our new engagement strategy

Commissioners

The relationship with our commissioners has evolved during the year. As both commissioners and the Trust have become more familiar with the new process the challenge and associated accountability has also strengthened.

Consequently we have implemented a temporary operational structure that mirrors the way commissioning is organised. We have divided into seven functional areas. This has allowed us to develop stronger relationships with local commissioners and to become more responsive to local needs. We still have some distance to travel before we are able to truly call ourselves integrated into local services but we have every intention of becoming more responsive to local need. This means in the future we will be better placed to undertake local quality improvement work.

In addition, each year we work with our commissioners to identify commissioning intentions. These act as advance notice as to what areas our commissioners are expecting us to address in the coming year. These then influence the final contract, the key performance indicators and the final projects identified within the Commissioning for Quality and Innovation Framework (CQUIN).

The Trust Board

The Trust Board is accountable for ensuring the Trust consistently provides a safe and high quality service and this is demonstrated by the following

Nominating the Director of Nursing and Quality as being responsible for bringing quality issues to the attention of the Trust Board and acting as the custodian to quality issues.

Prioritising quality on the agenda by ensuring there are, wherever possible, placed at the top of the agenda.

Inviting a patient, or member of staff, to every Trust Board to meet the Trust Board and present a patient or staff experience of the London Ambulance Service NHS Trust.

Having a Board level committee nominated to focus on quality that has the same status as the audit and finance committees.

Monitoring the quality of care provided across all our services and routinely measuring and benchmarking services internally and externally where this information is available.

Proactively looking at any risks to quality and taking prompt mitigating action.

Challenging poor performance or variation in quality and recognising quality improvement.

Building a quality culture across the organisation.

Working to ensure our workforce is valued and motivated and able to deliver high quality care.

Government Policy

For the fourth year the government has published an NHS Outcomes Framework. This gives guidance to the wider NHS on what Quality outcomes have been identified as critical to achieving the national priorities for health improvement.

The NHS Outcomes Framework states that measuring and publishing information on health outcomes helps drive improvements to the quality of care people receive. The White Paper: Liberating the NHS outlined the Coalition Government's intention to shift the NHS from a focus on process targets to a focus on measuring health outcomes.

The national objectives and outcomes for 2014/15 are the same as 2013/14. Therefore they remain within the five domains presented in our 2013/14 Quality Account:

Domain 1. Preventing people from dying prematurely

Domain 2. Enhancing quality of life for people with long term conditions

Domain 3. Helping people to recover from episodes of ill health or following injury.

Domain 4. Ensuring that people have a positive experience of care

Domain 5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Our Quality Strategy will embrace the shift in emphasis from having defined targets with associated Red, Amber, Green colour ratings, and will look for continuous improvement.

The Expectations of our Regulators

Our quality regulator is the Care Quality Commission (CQC). They are responsible for setting the minimum standards for quality and safety that people have the right to expect whenever they receive NHS funded care.

The CQC then monitor the provision of healthcare and stipulate a range of minimum standards which are observed through their monitoring programme.

We regularly benchmark ourselves and ensure we are meeting these fundamental standards.

The NHS Trust Development Authority

The NHS Trust Development Authority is the body who oversees the transition of NHS Trusts to NHS Foundation Trust status. As a NHS Trust the London Ambulance Service has a relationship with this body. We are required to undertake monthly meetings to assure that our quality governance meets the expectations of the NHS Trust Development Authority and is fit for purpose as we progress through the Foundation Trust pathway.



Monitoring Quality in 2014//15

We are currently reviewing our quality governance arrangements and the sub committee structure that sits under the relevant Board Committee.

As part of this review we plan to strengthen the governance and monitoring and improve the degree of challenge and scrutiny that is applied

to the various functions that sit under the umbrella of quality.

We will also redesign our internal quality dashboard with the aim of promoting continuous improvement.





Review of the Year 2013/14

Measuring quality in 2013/14

We use a wide range of indicators to give us a measure of the level of quality we are providing and these are specifically reported later in this publication. However, we also use a number of other indicators to help us triangulate the information. Some of these measures are reported within this section.

Complaints and Patient Advice & Liaison (PALS)

Patient experience and feedback is a rich source of information that allows us to understand whether our services meet the expectations of the patient. We take all patient feedback very seriously and do our best to undertake a fair and thorough investigation so that we can clearly identify the lessons and use these to improve our service, where necessary.

During 2013/14, concerns raised through the PALS and complaints process was reported to every Trust Board meeting. During the course of 2014/15 we will be adopting the recommendation made by Francis and will be publishing more detail from complaints on the Trust's website.

We work to the Health Service Ombudsman's *Principles of Remedy* and our complaints policy and procedure complies with the NHS complaints regulations.

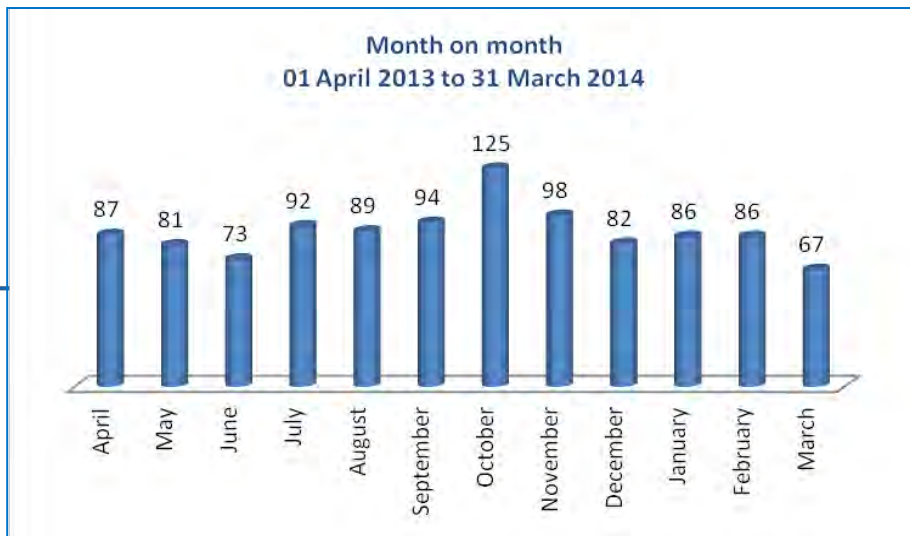
For each complaint we receive, we appoint a case officer to identify the key themes. This can involve arranging an evaluation of the 999 call management, liaison with local managers, and comprehensive clinical reviews of the care provided.



Once our investigation is complete, we provide a full explanation and, where appropriate, an apology together with details about recourse to the Health Service Ombudsman and the independent advocacy assistance available.

All our responses are approved by the Director of Nursing & Quality and the Chief Executive.

The following table demonstrates complaint volumes in 2013/14 when we received 1060 complaints and over 6000 PALS enquiries.



The main issues arising from complaints are similar to previous years and are broadly within five categories: **delayed response, staff attitude, driving and road handling, treatment & care, non-conveyance to hospital.**

Complaint themes are reviewed by the Trust's Learning from Experiences Group which comprises multi-disciplinary membership.

Throughout the year we have identified a small number of themes regarding our management of 999 calls. These are:

1. We use a tape recorded exit message at the end of some calls which explains what the caller needs to do next. Some patients do not like this aspect of our service and it can cause some callers to call us back.

2. Some calls appear to be unnecessarily referred to our clinicians in our call taking area. For example calls where the Emergency Medical Dispatcher already knows that a resource will be sent because the patient is situated in an outside location.

3. Patients have told us that they don't like not being kept up to date with the progress of their call.

We will work on improving these issues for our patients in 2014/15.

Based on feedback from the previous year we have made some improvements to the service we provide. These improvements include:

1. The way we manage calls from patients who have harmed themselves through overdose.

2. Upgrading calls that are made by elderly patients who have fallen.

We have also implemented a number of initiatives in 2013/14 to improve the way that we manage complaints: These include:

1. Cases are now graded by a Patient Experiences Manager by using a tool to assist in the prioritisation. This allows a more rapid identification of serious issues that need raising with the Trust's executive management team.

2. We now routinely distribute a weekly update on all current concerns to individual Area Assistant Directors of Operations. This ensures that they are aware of outstanding issues and matters awaiting resolution.

As a result of the Francis Report the Ombudsman is now investigating an increasing number of cases across the NHS. This reflects a small increase in the number of cases the Ombudsman has looked into; with 22 cases being considered in this way.

Serious Incidents

In total across the year 32 incidents were deemed to meet the criteria to be declared as serious to NHS England (London). Each of these 32 has been investigated thoroughly, with a root cause of the incident identified, and recommendations to mitigate any future occurrences of the same situation.

19 out of 32 serious incidents related to incidents where the patient had died and the investigation looked at the root cause to determine whether this was as a result of patient harm and/or a preventable outcome.

Whilst the numbers declared is an increase on those for 2012/13 (17 was the declared total), it is felt that this reflects both an improved understanding on the need for reporting incidents internally, as well as the impact of increasing demand on the Trust.

It is this increased demand on the service which has been a recurrent theme across a number of serious incidents during 2013/14. This has resulted in an inability to provide some patients with a response within the target assigned on triage of the call.

The Trust is undergoing a significant two-year transformation programme to ensure we are able to meet this increased demand and progress is reported later in this Quality Account.

Towards the end of 2013/14, a review of the internal process for the management of serious incidents was undertaken. From this, steps to improve the decision-making structure and reporting format have been implemented – both of these will contribute to improved investigation and report writing.

Patient Engagement

During 2013/14 we participated in 717 community events.

These events included school and college visits, cub and scout groups, Junior Citizen Schemes, career and job fairs, first aid training, gang and youth violence events, and health and safety days. We have taken part in health events, including some for deaf people, and given talks to “over 50s” and “over 60s” groups.

We also ran a patient involvement event to find out about the experiences and views of lesbian, gay and bisexual service users in support of our Stonewall application.

In June 2013 we invited our Trust membership to learn more about our plans for the future. We have also held member events on first aid technique, cardiac care, trauma care, and mental health care. The mental health event included presentations from the Croydon charity Hear Us. They told the 40-strong audience about how they were diagnosed with different illnesses, including schizophrenia and depression, as well as their experiences of calling for help from the ambulance service.

The findings of last year’s non-conveyed patient and staff survey were presented to the Patient Forum and to the Trust’s Learning from Experience Group and this has fed into this year’s quality improvement work which is reported later in the Quality Account.

A Safeguarding conference was held in June 2013, and included two patients talking about their personal experiences.

The National Ambulance Service Patient Experience Group worked with the CQC and Picker to develop a national Hear & Treat survey. The

telephone surveys were carried out during the winter months, and the results will be available in May 2014. This should provide some comparison between patients’ experiences of hear and treat services across the country.



The Staff Voice

In 2013/14 we commenced a programme of staff engagement. We ran a number of events and workshops that gave our staff the opportunity to work with the management team to identify a range of issues that needed addressing.

These workshops were well received by the staff and a number of short “quick win” projects were adopted as a result of the programme.

We also launched the staff Facebook page. This is an electronic platform that allows our staff to raise issues and participate in discussion.

In addition we commenced a series of sessions using a web-based teleconference facility that allows a number of staff working across London to participate in the event.

The Student Voice

Our students are a significant part of our workforce and we recognised the need to strengthen their voice. This work is continuing but we have appointed a Director of Paramedic Education and Development who will strengthen the way students are represented in decision making and in our quality monitoring.

The 2013/14 Quality Indicators

This was the third year of the national Ambulance Service Quality Indicators. They are designed to consider the speed of response and the quality of care offered to patients.

The indicators are specific to the ambulance service but are designed to be read alongside the indicators for Acute Trusts that have Accident & Emergency departments. They measure elements of patient safety and patient outcomes.

We monitor these indicators monthly as part of our quality dashboard and a fuller report is contained within this Quality Account.

Patient Feedback (Stonewall)

As one of the first national Stonewall Health Champions, the Trust takes part in the annual Stonewall Healthcare Equality Index. Part of the assessment criteria includes feedback from our patients.

The Stonewall Healthcare Equality Index shows how individual organisations are improving the health and expectations of Lesbian, Gay, and Bisexual patients.

A total of forty-four health care organisations across England entered in 2013/14. Submissions to the Healthcare Equality Index are assessed against specific criteria. The criteria includes: policy and practice, staff training, engagement, communication, data collection, and patient feedback.

The patient feedback is provided through a confidential web link giving access to the Stonewall Patient Feedback Survey. This survey

enables patients and service users of health care organisations entering the Index to comment on their experience of using that service.

Responses to the survey enable Stonewall to gain further information which can help inform organisations of key areas they may wish to work on.

Questions include whether patients feel comfortable disclosing their sexual orientation to the respective healthcare organisation, questions about organisational policy around sexuality and non-discrimination, and also whether patients and service users felt they were treated with dignity and respect while using that service, and whether they would recommend the service to friends and family.

For two years running the Trust has been recognized as a Stonewall Healthcare Equality Index Top 10 Performer.





Our 2013/14 Quality Priorities

Progress against our Improvement Priorities

In 2013/14 we identified that, in order to meet the challenge of a rise in over 100,000 calls in the previous year, we would need to embark on an extensive transformation programme (which we called Modernisation in last year's Quality Account). This was to be our main Quality Improvement Priority for 2013/14.

Modernisation/Transformation Programme

The London Ambulance Service Modernisation Programme was launched on 24 April 2013. The programme consisted of 9 projects which will be delivered over a period of 2 years.

Year one has seen the following projects start to deliver their benefits to both patients and staff:

Increasing Vehicle Availability

By having more vehicles available we are able to offer a better service to patients. This project went live in June 2013.

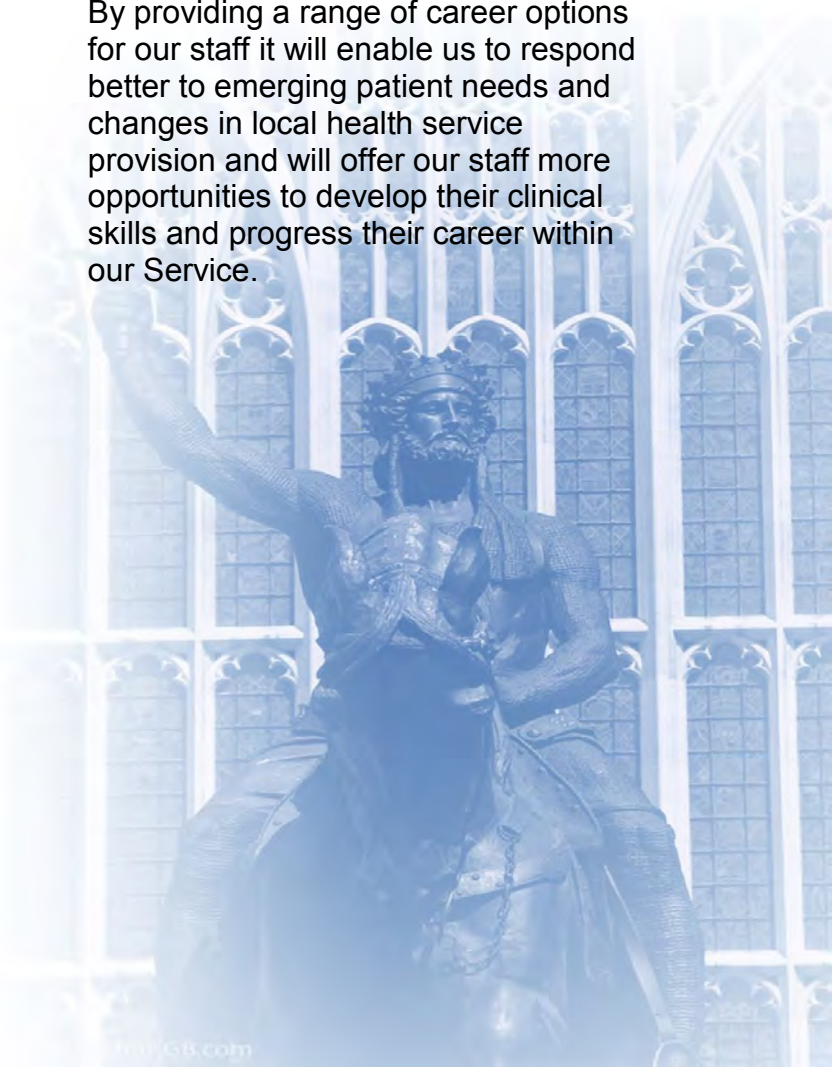
Clinical Hub (Hear and Treat)

Many of the 999 calls which the Trust receives are from patients who do not have life threatening injuries and illnesses, and who do not need an ambulance crew to attend. Instead they can be given a full clinical

assessment over the phone and safely be offered advice, or redirected to other healthcare providers. In 2013/14 we increased the number of paramedics who worked within the clinical hub. These registered healthcare professionals provide an enhanced clinical triage service over the telephone for those patients who are categorised with less serious conditions.

Clinical Career Structure

By providing a range of career options for our staff it will enable us to respond better to emerging patient needs and changes in local health service provision and will offer our staff more opportunities to develop their clinical skills and progress their career within our Service.



In 2013/14 we introduced the new role of Advance Paramedic Practitioner. These now respond to the most serious 2% of life-threatening incidents involving patients with complex medical conditions. Twelve of these posts have been recruited in year and a further 24 are planned for over the next 2 years.

We have revised the job description for our clinical team leaders and have finalised arrangements for a new skill mix on our ambulances from Spring 2014. This will see a new role being introduced into the service which will be able work alongside our paramedics and will mean that all of our front line staff will be able to respond to a full range of calls which has not been the case to date. This will increase the flexibility of our workforce to respond to patients across the full spectrum of urgent and emergency care.

Other Priority Areas

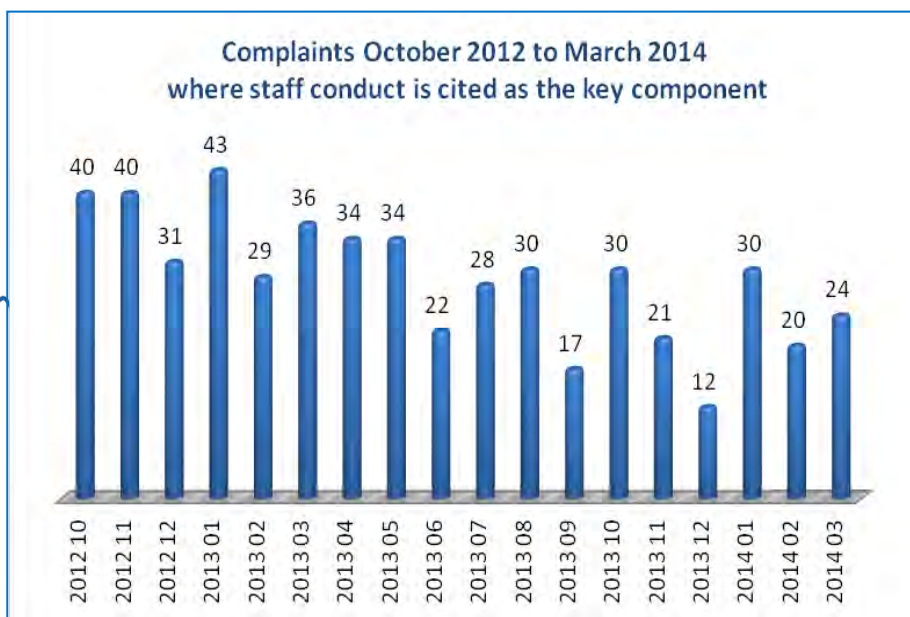
In addition to the transformation agenda we identified four additional priority areas where we aimed to make improvements:

- Reducing the number of complaints regarding attitude & behaviour
- Improving the experience of patients subjected to a delay.
- Improving the experience of patients referred to Alternative Care Pathways
- Reduce the incidence of Missing Equipment

Reducing the number of complaints regarding attitude & behaviour

We have had mixed success with this improvement measure. Our ratio of dissatisfaction due to poor attitude compared to the number of patients calling us is extremely low. Nevertheless we wanted to try and make further improvements.

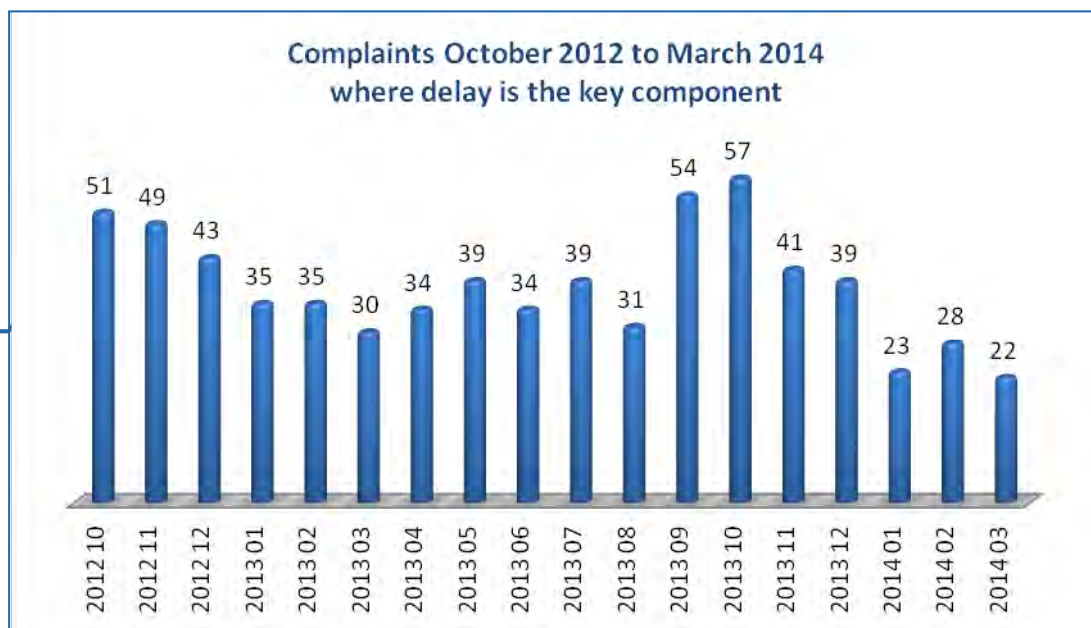
The Assistant Directors of Operations developed an action plan; although this was not fully implemented during the year its development helped raise awareness across the Trust. There was a drop in the number of complaints.



Improving the experience of patients subjected to a delay.

We are very successful in providing a quick response to patients who are seriously ill. But this does mean that less urgent patients wait longer than we would like. Our Transformation programme will help us release more capacity into the system and improve this in the future.

Patients who do wait often tell us that it is not the actual wait that is the issue but the poor communication between us and the waiting patient. Therefore, during the year we implemented an improved system for ringing patients back and undertaking a welfare check. We believe this has reduced the sense of abandonment and this has started to impact on the number of complaints we receive regarding a delay.



Improving the experience of patients referred to Alternative Care Pathways (ACP)

Emerging from our complaints analysis in 2012/13, and from our patient survey, was a theme where patients were appearing less satisfied when they were not conveyed to hospital. So we developed an action plan to see if we could understand this in more detail. The action plan included:

- Carrying out an audit of current ACP usage: find out which of the agreed ACPs are being used.
- Involving staff in work to identify and understand the barriers to

using ACPs: we know that some staff are reluctant to use ACPs and some of the reasons for this. However there may be more to find out.

- Develop key messages for patients, the public and staff about ACPs, including:
 - 111
 - Walk-in centres etc.
 - Mental Health and other specialist pathways
 - Treatment at home

This is a challenging area for the Trust to improve as many patients have often made up their mind that they

wish to go to Accident & Emergency before they call 999.

Reduce the incidence of Missing Equipment

During 2011/12 we identified an increasing trend in the number of vehicles that were not equipped beyond the basic minimum and embarked upon a programme to reduce this trend in 2012/13.

One work-stream was to move from a pooled source of equipment and introduce equipment that was issued personally to our clinical staff.

Personal issue kits that record patient blood glucose were introduced six months into the year and this made a dramatic reduction. The low number of reported losses is being maintained.

Personal issue thermometers were purchased in the last quarter of 2013/14 and we are due to implement this during April 2014. This will ensure that all staff have access to basic diagnostic equipment and we should see a reduction in the number of reported shortages of these items.

During the last quarter of 2013/14 other initiatives were put in place to address the reported equipment shortages. Funding was provided to purchase additional medical equipment and during the period 3rd to 6th February 2014, 26 “shells” were equipped with the key pieces of equipment that are required for a vehicle to be available to respond.

Also operations have been working to reduce the number of “shells” reported each day by equipping vehicles from equipment sourced from ambulance stations.

The majority of the additional equipment ordered in the last three months of the financial year has now been delivered and this will be issued during the first quarter of 2014/15.

To ensure that the equipment is used to replace missing items on vehicles and equip “shells” the Logistics Department will be working in conjunction with the Vehicle Preparation contractors and Vehicle Resource Centre to ensure a structured approach is taken to make best use of the additional equipment.

Previously, stations have been expected to pay for equipment repairs and this has in some instances caused delays in the repair of equipment and its return to service. From April 2014 the cost of repairs will be funded by Logistics budgets which will improve turnaround times for equipment repairs. In addition, Equipment Support Personnel will be exchanging the majority of equipment immediately when visiting stations instead of bringing it back to the Logistics Support Unit for repair or exchange. This will also improve equipment availability, especially for defibrillator accessories.

The last quarter of 2013/14 has seen an increase in the reports of drug pack shortages from a number of ambulance stations. Whilst the number of packs in circulation should more than cover the daily requirement, additional drug packs have been ordered and will be distributed across the Trust to increase stocks held on stations and improve availability. Additional packs will be issued based on existing stock levels on stations and requirements.



Mandatory Assurance Statements **Statements mandated by NHS England**

Each year we are required to report a number of mandatory statements. These are reported in this section.

Statement Area 1: Data Review

During 2013/14 the London Ambulance Service NHS Trust provided three NHS Services and has reviewed the data available to them on the quality of care in these services.

Statement Area 2: Income

The income generated by the NHS services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2013/14.



Statement Area 3: Clinical audit

During 2013/2014, two national clinical audits and no national confidential enquiries 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 that the London Ambulance Service NHS Trust was eligible to participate in during 2013/14 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:

- Hypoglycaemia
- Asthma
- Lower leg fracture
- Febrile convulsion.

The national clinical audits that the London Ambulance Service NHS Trust participated in during 2013/14 are as follows:

Department of Health Ambulance Clinical Quality Indicators:

- Outcome from cardiac arrest –ROSC
- Outcome from cardiac arrest – Survival to discharge

- Outcome from acute STEMI
- Outcome from stroke.

National Clinical Performance Indicators (CPI) programme covering:

- Hypoglycaemia
- Asthma
- Lower leg fracture
- Febrile convulsion.

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2013/14 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.



National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a)2735 b) 393	a)2735 b) 393	100 %
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 2675 b) 369	a) 2675 b) 369	100 %
DH ACQI: Outcome from acute STEMI b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	b) 960 c) 1948	b) 960 c) 1948	100 %
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 4413 b) 7199	a) 4413 b) 7199	100
National CPI: Hypoglycaemia a) Blood glucose before treatment b) Blood glucose after treatment c) Treatment for hypoglycaemia recorded (oral carbohydrates, glucagons, IV glucose) d) Direct referral made to an appropriate health professional e) Care bundle	600	600	100
National CPI: Asthma a) Respiratory rate recorded b) PEFr recorded (before treatment) c) SpO ₂ recorded (before treatment) d) Beta-2 agonist recorded e) Oxygen administered f) Care bundle	600	600	100
National CPI: Lower leg fracture a) Two pain scores recorded b) Analgesia administered c) SpO ₂ recorded (before treatment) d) Oxygen administered e) Immobilisation of limb recorded f) Assessment of circulation distal to fracture recorded g) Care bundle	56	56	100
National CPI: Febrile convulsion a) Blood glucose recorded (before treatment) b) Temperature recorded (before treatment) c) SpO ₂ recorded (before treatment) d) Oxygen administered e) Anti convulsant administered f) Temperature management g) Appropriate discharge pathway recorded h) Care bundle	513	513	100

In addition, the London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to seven patient groups (see box below) and quality assures the documentation on 2.5% of all clinical records completed.

Information: Clinical Performance

Indicators (CPIs) are designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. The areas of care included are: acute coronary syndrome, cardiac arrest, difficulty in breathing, glycaemic emergency, stroke, mental health, patients that are treated and left at scene (non-conveyed) and general documentation. The delivery of care to these patient groups is routinely fed back to staff on a one-on-one basis by clinical supervisors so that staff are able to discuss how they can improve their performance. Through this system we have been able to ensure continuous improvement in clinical care and this has been demonstrated in the newest CPI – care for mental health patients – which has shown enhanced assessment of this patient group since the CPI was introduced last year.

We also undertake four continuous audits that monitor the care provided to every patient who suffers a cardiac arrest, STEMI or stroke, or who have been involved in a major trauma incident.

The report of two national clinical audits were reviewed by the provider in

2013/14 and the London Ambulance Service NHS Trust has taken the following actions to improve the quality of healthcare provided:

- Supplied each member of staff with their own blood glucose monitoring kit to increase the measurement of blood glucose levels for patients presenting with hypoglycaemia.
- Purchased peak flow tubes with a one way valve to increase the number of patients with asthma who have their peak flow rate measured before treatment.
- Developed an acute coronary syndrome aide memoire to highlight all elements of the STEMI care bundle as well as ECG interpretation and the correct pathways for this group of patients.
- Created a multimedia stroke training package in collaboration with other NHS Trusts.

The reports of six local clinical audits were reviewed by the provider in 2013/2014 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Adrenaline as a treatment for anaphylaxis and acute asthma

- Through training ensure staff are able to distinguish anaphylaxis from major and minor allergic reactions, and features that differentiate between acute asthma and COPD
- Reduce drug related errors by introducing a “Check and Challenge” system.

Chronic Obstructive Pulmonary Disease

- Ensure staff are able to recognise the signs of carbon dioxide retention and the associated risks by revising current training materials.

Patients who have taken Overdose

- Ensure patients who have taken an overdose do not deteriorate whilst waiting for an ambulance by introducing an enhanced clinical telephone assessment
- Determine whether pre-hospital administration of activated charcoal is feasible to enable eligible patients to receive treatment sooner.

Hydrocortisone as a treatment for acute severe and life threatening asthma

- Clarify administration guidance with national guideline publishers to remove confusion regarding time interval prior to hydrocortisone administration
- Survey staff to determine why hydrocortisone is being underused
- Consider oral prednisolone as an alternative to hydrocortisone.

Recognition of Life Extinct (ROLE)

- Improve ROLE form completion by revising the current form and providing further completion guidance to remind staff of the correct procedures when performing ROLE
- Replace the „purple +“ illness code with „obviously deceased“ to avoid confusion between terms.

Diazepam to terminate seizures

- Publish an article in the internal clinical newsletter and revise training materials to remind staff to: exclude causes of seizure activity; to monitor patients for respiratory depression and hypotension following administration, and to obtain prompt IV access for all adults presenting with seizure activity.

Statement Area 4: Research

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff

keep up to date with the latest possible treatment options and their active participation in research leads to improved patient outcomes.

The London Ambulance Service NHS Trust was involved in conducting four clinical research studies in pre-hospital care during 2013/14. There were 333 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2013/14. These staff participated in research focused upon the medical speciality of cardiac care and the care of elderly people who have fallen. These studies were:

- **DANCE** (high risk acute coronary syndrome): Pilot 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.
- **AMICABLE** Study: A prospective observational study comparing the effectiveness of prehospital airway strategies on patient outcomes following cardiac arrest.
- **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.

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 85.

It is important to note that as well as recruiting patients, we also conducted research involving staff and student paramedics as participants. The total number of LAS staff and student paramedics who were themselves recruited as research participants in 2013/14 was 98, with a further 390 staff

involved in follow up aspects of existing projects.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2013/14 are displayed in the following table.

Study name 2013/14	Participants recruited 2013/14	Total no. of Participants recruited to study	LAS clinical staff involved
<i>NHS REC approved studies involving patients</i>			
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)	- [^]	284	2
High risk acute coronary syndrome (ACS) (formerly known as 'DANCE')	8 [^]	100	250
Safety and efficacy of paramedic treatment of regular supraventricular tachycardia (ParaSVT)	14 [^]	71	80
Airway management in cardiac arrest – basic, Laryngeal Mask Airway, endotracheal intubation study (AMICABLE)	63	-	1
<i>Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review*)</i>			
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	- [^]	390	-
Do not attempt cardiopulmonary resuscitation (DNACPR) decisions	5	-	-
Antidote use and medical management of chemical incidents casualties – How much do emergency responders know?	54	-	-
Developing leadership in the UK's ambulance service: A review of the consultant paramedic role.	1	-	-
What do ambulance service personnel consider to be the „process of“ and „issues with“ inter-hospital transfers?	7	-	1
Blue light responders, evacuation and pets: An exploratory, inter-professional study into emergency responders' perspectives on Companion Animal/pet owners' reactions in an evacuation.	16	-	-
How the London Ambulance Service manages absence	13	-	-
A study of major system reconfiguration in stroke services	2	-	-

[^] Patients recruited in study during previous years were actively followed up in 2013/14.

*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 to the above mentioned research projects, the LAS also undertook a number of descriptive, feasibility and evaluation projects to provide evidence of the best ways to treat patients and to achieve the best possible outcomes.

Within the last three years 25 papers have been published in peer-reviewed journals as a direct result of the London Ambulance Service's participation in clinical research.

These papers include: *'Increases in survival from out-of-hospital cardiac arrest: A five year study'* published in Resuscitation journal; *'Survival of resuscitated cardiac arrest patients with ST-elevation myocardial infarction (STEMI) conveyed directly to a Heart Attack Centre'* also published in Resuscitation journal, and *'Does use of the Recognition Of Stroke In The Emergency Room stroke assessment tool enhance stroke recognition by ambulance clinicians'* published in Stroke journal.

These publications demonstrate our commitment to transparency and desire to improve patient outcome and experiences across the NHS. Also, through these publications we have been able to share our knowledge and contribute to evidence-based clinical practice. 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.

Other activities which demonstrate our commitment to research as a driver for improving the quality of care and the patient experience include our Evidence for Practice Sessions and Advice Surgeries. During 2013/14, we held three Evidence for Practice Sessions for ambulance clinicians where they reviewed published papers that discussed the use of therapeutic

hypothermia following cardiac arrest, appropriate care for traumatic cardiac arrests and the use of feedback to encourage improved pre-hospital resuscitation and the implications for clinical practice.

Through our monthly Advice Surgeries we provide guidance to staff interested in undertaking research and help them to develop new research protocols. In addition, all staff are kept up to date with published literature and emerging research evidence with the circulation of journal contents pages and the facilitation of access to electronic journals. Findings from our research studies are disseminated to staff via our internal clinical newsletter and advertised on our intranet. We also present our research findings at conferences to share our learning and influence clinical practices as far afield as possible.

We have an extensive collaboration portfolio for the forthcoming 2014/15 period, which includes the following studies:

- *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 versus conventional management.
- *Identifying emergency personnel at risk of post traumatic stress disorder (PTSD):* Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics.
- *rAAA:* An observational trial that investigates whether an electronic prehospital triage tool can aid identification of ruptured aortic abdominal or thoracic aortic aneurysm (rAAA).

- **Stroke mimics:** An investigation of the incidence and diagnoses of stroke mimics, and differences in responses of strokes and mimics to the ROSIER assessment tool.
- **Exercise-related sudden cardiac arrest in London:** A retrospective analysis of cases where cardiac arrest occurred during or after exercise to investigate incidence of, and factors related to survival from, exercise-related cardiac arrest.
- **An explorative assessment of London's 999 frequent callers and the effectiveness of interventional strategies employed by the London Ambulance service's patient centred action team:** A retrospective analysis aiming to i) profile this group of patients, ii) examine the impact of the LAS Patient Centred Action Team's interventional strategies on frequent caller behaviour.
- **Out-of-hospital cardiac arrest outcomes project:** Development of a national cardiac arrest registry and use of statistical modelling to understand variability in outcomes and contributory factors to survival.
- **Prehospital Assessment of the role of adrenaline: measuring the Effectiveness of drug administration in cardiac arrest (PARAMEDIC2):** A randomised control trial to investigate whether adults that have an out of hospital cardiac arrest treated with adrenaline have improved survival rates and neurological outcomes.
- **Airway management in cardiac arrest – basic, laryngeal mask airway, endotracheal intubation study (AMICABLE):** A prospective observational study to assess the effect of prehospital airway strategies on the outcome of patients who experience an out of hospital cardiac arrest and are conveyed to a Heart Attack Centre.
- **Immediate coronary angiography after ventricular fibrillation out-of-hospital cardiac arrest (ARREST):** A randomised control trial of immediate coronary angiography versus current standard of care after ventricular fibrillation out-of-hospital cardiac arrest.
- **The impact of alcohol misuse on the London Ambulance Service:** This questionnaire based study will explore clinical staff members view's on the impact of alcohol misuse in London.
- **Alternatives to face to face contact:** This study explores the impact of the introduction of hear and treat services within the ambulance service.
- **Understanding variation in rates of non-conveyance to an emergency department of emergency ambulance users:** This study will explore the variation in non-conveyance rates between the 11 ambulance services within England.
- **Activated charcoal:** A study to explore the feasibility of using activated charcoal in the prehospital setting.
- **Stroke outcomes:** A study linking prehospital data with hospital data from hyper-acute stroke unit to identify the accuracy of stroke recognition using the face, arm and speech test (FAST).
- **Risk of sudden cardiac death in epilepsy:** A retrospective analysis of data from patients in cardiac arrest with a history of epilepsy to identify whether patients with epilepsy are at higher risk of cardiac arrest.

In addition to the above, we have developed a number of research protocols for which we are awaiting external funding decisions.

Ambulance Quality Indicators Care Bundle

The percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle

The London Ambulance Service NHS Trust submitted the following information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2013/14 and 2012/13

	2013-14 *		2012-13	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	76.1	80.5 (67.4 – 89.6)	66.8	77.6 (66.8 – 94.7)
Stroke patients	94.7	96.3 (92.1 – 99.4)	93.8	95.7 (90.9 – 100)

At the point of preparation of this Quality Account, NHS England reported data for April to December 2013.

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: this data is captured by the Trust from clinical records completed by ambulance staff attending patients as part of ongoing clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The London Ambulance Service NHS Trust has taken the following actions to improve the percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle, and so the quality of its services, by:

- Continued clinical education provided to staff through materials such as clinical webinars, training updates,

updated aide memoires, and reminders in bulletins and newsletters.

- Ensuring that staff have the necessary equipment to perform patient assessments with the provision of personal issue kit where applicable.

Statement Area 5: CQUINS

A proportion of the London Ambulance Service NHS Trust's income in 2013/14 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 2013/14 are as follows:

1. To undertake the delivery of training to staff to enable a change to two-tier working: 100% of eligible A&E support staff to have commenced the conversion course to enable front-line working. (CQUIN achieved - approximate value £1.7m)
2. Development of new roster patterns for all appropriate complexes and teams: rosters to cover all relevant staffing groups within the operational and control room environment will be developed in line with modelling results. (CQUIN achieved - approximate value £2.3m)
3. Implementation of enhanced clinical triage process: completion of recruitment process and training of staff commenced for new specific roles with the Clinical Hub (CHUB) targeted at delivering Hear and Treat services for patients (CQUIN achieved - approximate value £780k)
4. Implementation of a new response model: changes to the CommandPoint™ despatch protocols to be made to enable recommendations made regarding the allocation of resource type to calls under the new workforce skill mix model. (CQUIN achieved - approximate value £800k)

5. Engagement exercise and communications strategy delivered: completion of a series of staff engagement events, including the delivery of comprehensive information pack to staff. (CQUIN achieved - approximate value £600k)

The details of the agreed goals for 2014/15 are as follows:

1. Friends and Family Test: implementation of Friends and Family Test according to the national timetable. (valued at £1,289,609)
2. Emergency Care Pathways – End of Life Care: improving the quality of care delivered to people on an end of life care pathway by supporting the plan agreed with the patient. (Valued at £967,207)
3. Emergency Care Pathways – Community Life Support and Defibrillation for Cardiac Arrest: improving return of spontaneous circulation (ROSC) rates following cardiac arrest through Community and Partnership Engagement. (Valued at £644,084)
4. Emergency Care Pathways – Enhanced falls Service: ensuring that people who are at risk of falling, or have a history of falling, have an appropriate response model from LAS (Valued at £644,084)
5. Staff awareness and education - mental health and dementia: improving the care for people with mental health needs and dementia. (Valued at £967,207)
6. Embracing technology to improve care - clinical applications and accessible information: develop a technological solution to ensure that ambulance crews have access to information sources that exist in healthcare settings (e.g. summary care record, Directory of Services, Capacity Management System, Decision Making Software). (Valued at £967,207)

7. Embracing technology to improve care: eAmbulance development. (Valued at £967,207)

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 2013/14.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2013/14.

An unannounced inspection took place in Summer 2013 and the Trust was found to be compliant in the areas inspected.

Statement Area 7 Data Quality

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

At the time of writing the Quality Account the Trust was in discussion with the internal auditors as to what aspects would feature within the audit programme. Data Quality will feature in at least one audit project.

Statement Area 8 NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics.

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score for 2013/14 was 81% 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 2012/13 by the Audit Commission





Ambulance Quality Indicators

A review of the 2013/14 Quality Indicators

2013/14 was the third year 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 graphs on the following pages illustrate the London Ambulance Service NHS Trust year end position in the quality measures that we are mandated to report on. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking, therefore the data from April to December 2013 is included in these measures.












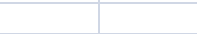


Outcome from acute ST-elevation myocardial infarction (STEMI)

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 and we are monitored on our time but we are also monitored on the care that STEMI patients receive from our staff.

There are a number of elements that are considered a “care bundle”. These are 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.

Percentage of patients suffering a STEMI who receive an appropriate care bundle (Year to date)

			Numerator	Incidents	%
	East Midlands Ambulance Service NHS Trust		862	1,127	76.5
	East of England Ambulance Service NHS Trust		1,125	1,322	85.1
	Great Western Ambulance Service NHS Trust				0.0
	Isle of Wight NHS PCT		47	62	75.8
	London Ambulance Service NHS Trust		1,677	2,204	76.1
	North East Ambulance Service NHS Trust		505	598	84.4
	North West Ambulance Service NHS Trust		1,592	1,844	86.3
	South Central Ambulance Service NHS Trust		633	939	67.4
	S. E. Coast Ambulance Service NHS Foundation Trust		725	932	77.8
	S. Western Ambulance Service NHS Foundation Trust		1,305	1,456	89.6
	West Midlands Ambulance Service NHS Trust		883	1,173	75.3
	Yorkshire Ambulance Service NHS Trust		698	830	84.1
	Overall for period	Higher is better	10,052	12,487	80.5

Our compliance for 2013/14 is 76.1 %. Last year our compliance was 66.8% and the previous year it was 61.7% suggesting we have made sustained improvements in this quality indicator.

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 and we are monitored on this element of performance.

However, similar to the STEMI care there is also a “care bundle” that we are asked to monitor.

The care bundle 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.

Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle (Year to date position)

					Numerator Incidents		%
	East Midlands Ambulance Service NHS Trust				6,903	7,084	97.4
	East of England Ambulance Service NHS Trust				5,430	5,666	95.8
	Great Western Ambulance Service NHS Trust						0.0
	Isle of Wight NHS PCT				152	156	97.4
	London Ambulance Service NHS Trust				7,781	8,219	94.7
	North East Ambulance Service NHS Trust				2,501	2,547	98.2
	North West Ambulance Service NHS Trust				9,121	9,177	99.4
	South Central Ambulance Service NHS Trust				4,666	4,742	98.4
	S. E. Coast Ambulance Service NHS Foundation Trust				5,913	6,421	92.1
	S. Western Ambulance Service NHS Foundation Trust				6,971	7,169	97.2
	West Midlands Ambulance Service NHS Trust				6,791	7,206	94.2
	Yorkshire Ambulance Service NHS Trust				5,662	5,876	96.4
	Overall for period			Higher is better	61,891	64,263	96.3

Our compliance for 2013/14 is 94.7. Last year our compliance was 93.8% and the previous year our compliance was 91.3% suggesting a slight sustained improvement.

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 second measure is the time taken to respond in a 19 minute window. The first 8 minute response is divided into two subdivisions known as Red 1 and Red 2. Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse and other severe conditions.

A Red 2 call is used for conditions which are less serious and less immediately time critical and cover conditions such as stroke and fits.

Category A 8 Minute Response Time (Year end position) for Red 1.

					Numerator Incidents		%
	East Midlands Ambulance Service NHS Trust				13,842	19,424	71.3
	East of England Ambulance Service NHS Trust				9,634	13,094	73.6
	Great Western Ambulance Service NHS Trust						0.0
	Isle of Wight NHS PCT				239	298	80.2
	London Ambulance Service NHS Trust				11,060	14,296	77.4
	North East Ambulance Service NHS Trust				2,817	3,661	76.9
	North West Ambulance Service NHS Trust				22,197	29,260	75.9
	South Central Ambulance Service NHS Trust				6,464	8,162	79.2
	S. E. Coast Ambulance Service NHS Foundation Trust				4,501	5,863	76.8
	S. Western Ambulance Service NHS Foundation Trust				10,067	13,763	73.1
	West Midlands Ambulance Service NHS Trust				6,143	7,681	80.0
	Yorkshire Ambulance Service NHS Trust				15,273	19,738	77.4
	Overall for period			Higher is better	102,237	135,240	75.6

Element 1. Graph 15: Category A 8 Minute Response Time (Year end position) for Red 2.

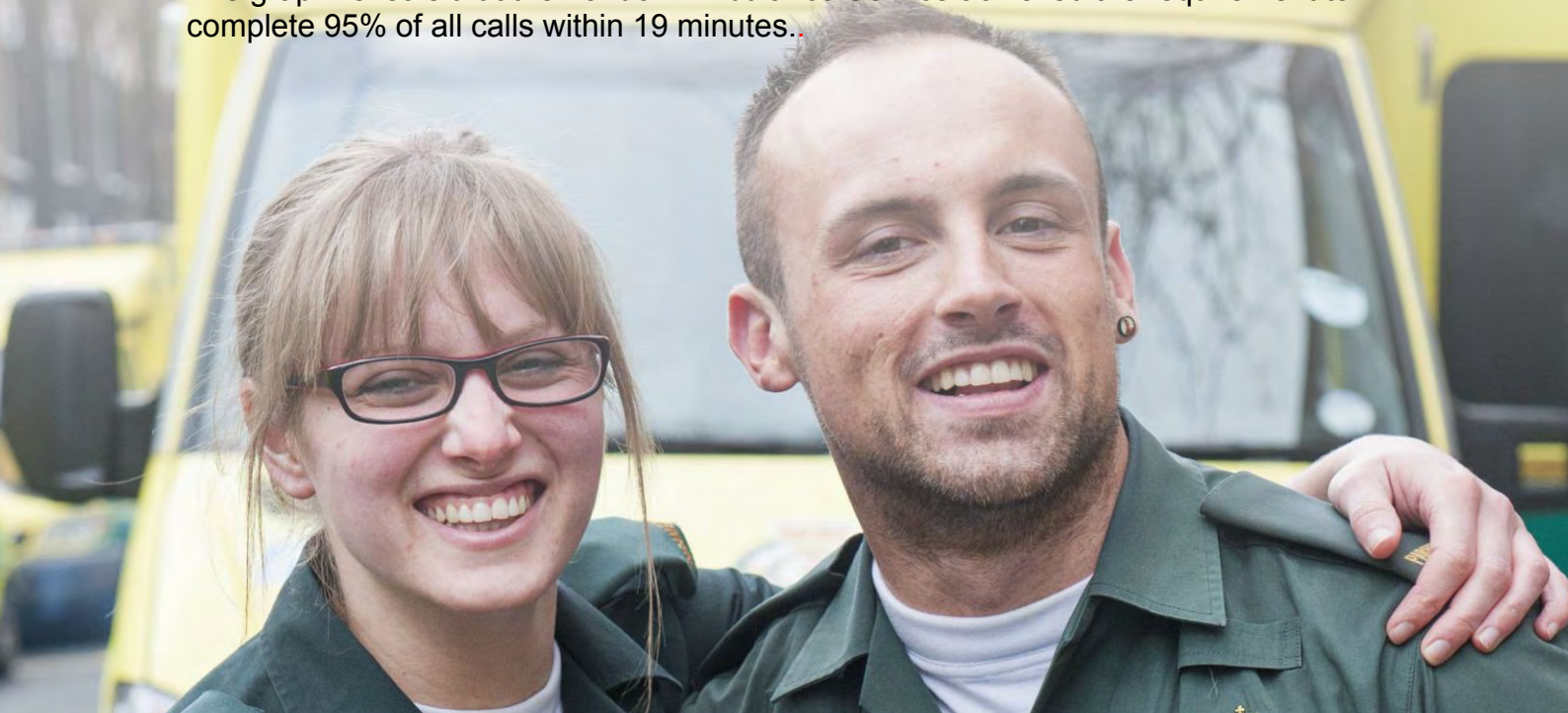
			Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust			161,493	226,126	71.4
East of England Ambulance Service NHS Trust			173,954	250,617	69.4
Great Western Ambulance Service NHS Trust					0.0
Isle of Wight NHS PCT			5,175	6,802	76.1
London Ambulance Service NHS Trust			336,090	446,319	75.3
North East Ambulance Service NHS Trust			129,553	165,274	78.4
North West Ambulance Service NHS Trust			278,026	359,079	77.4
South Central Ambulance Service NHS Trust			94,916	125,368	75.7
S. E. Coast Ambulance Service NHS Foundation Trust			189,477	256,413	73.9
S. Western Ambulance Service NHS Foundation Trust			228,226	295,515	77.2
West Midlands Ambulance Service NHS Trust			262,977	357,397	73.6
Yorkshire Ambulance Service NHS Trust			186,209	247,979	75.1
Overall for period		Higher is better	2,046,096	2,736,889	74.8

The graphs reveal that the London Ambulance Service achieved the requirement to complete 75% of all A8 calls within eight minutes.

Element 2. Graph 16: Category A 19 Minute Response Time (Year end position)

			Numerator	Incidents	%
East Midlands Ambulance Service NHS Trust			230,018	245,190	93.8
East of England Ambulance Service NHS Trust			243,622	262,192	92.9
Great Western Ambulance Service NHS Trust					0.0
Isle of Wight NHS PCT			6,861	7,100	96.6
London Ambulance Service NHS Trust			448,271	458,073	97.9
North East Ambulance Service NHS Trust			162,894	168,048	96.9
North West Ambulance Service NHS Trust			371,219	387,532	95.8
South Central Ambulance Service NHS Trust			127,285	133,426	95.4
S. E. Coast Ambulance Service NHS Foundation Trust			254,430	262,276	97.0
S. Western Ambulance Service NHS Foundation Trust			295,208	308,283	95.8
West Midlands Ambulance Service NHS Trust			354,292	365,078	97.0
Yorkshire Ambulance Service NHS Trust			259,727	266,967	97.3
Overall for period		Higher is better	2,753,827	2,864,165	96.1

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





Other Services

Our Patient Transport Services

Patient transport is an important part of our core business and whilst this service has its own dedicated management team it is fully integrated into our quality governance processes.

How do we keep our Patient Transport Staff up to date with changes?

We have continued to employ two fulltime Work Based Trainers who have been delivering new entrant and refresher training to our staff.

The Work based Trainers have been delivering refresher training on key topics such as oxygen therapy, diabetes and dynamic risk assessment as well as rolling out new core skills of pulse oximetry, and new vehicle training.

A total of 573 training sessions have been delivered to our total workforce of 149 staff.

What have we done to update our vehicles?

During 2013 we took delivery of fifteen new vehicles to a new Small Wheelchair Capable (SWC) specification. These vehicles are designed specifically for the conveyance of wheelchair and walking patients and are therefore smaller and less obtrusive than the larger ambulance sized vehicles. These

additions to our fleet, along with disposal of older stretcher vehicles have seen the average age of our fleet reduce to 5.21 years.

How have the new vehicles benefited patients?

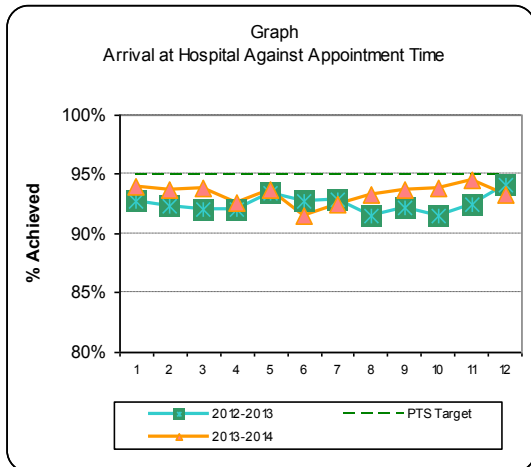
These new vehicles bring enhancements to patient and passenger safety and comfort such as all wheelchair capable vehicles having the facility to offer all wheelchair occupants a three-point seatbelt (with upper anchor point). Previously this was only available for the primary wheelchair position while the secondary wheelchair position lacked the upper anchor point.

We have made improvements to our fleet of three specialist bariatric vehicles with the addition of a revised stretcher that increases the capacity from 318kg (50st) to 450kg (70st) whilst also offering a wider patient surface area, and a new motorised tracked chair to convey seated patients up or down stairs that has a capacity of 227kg (35st).

How have we performed against our contracted quality standards?

There are three Key Performance Measures that are common across all contacts. These are as follows:

Appointment Time This is the arrival of a patient for their appointment within a time window as specified by the trust



Ready Time. This is the collection of a patient after their appointment within a time window specified by the trust

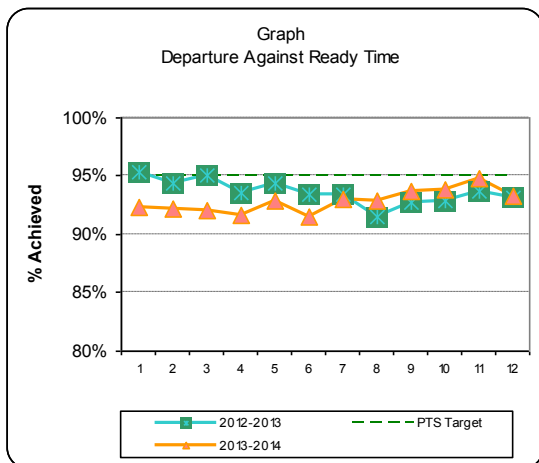
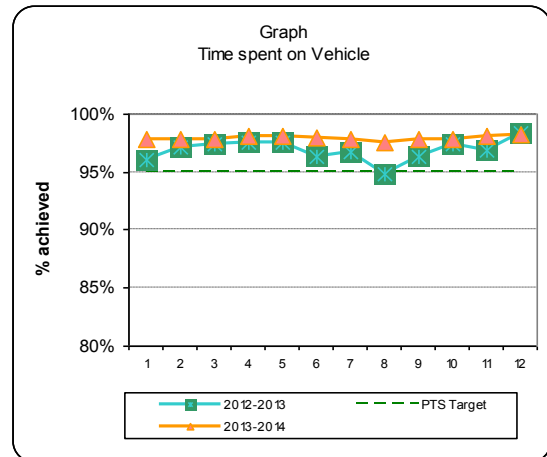


Table. To illustrate performance against the quality indicators in the contract over time.

Quality Standard	Appointment Time	Ready Time	Time on Vehicle
2009/2010	91.25%	92.81%	94.89%
2010/2011	90.22%	93.21%	95.47%
2011/2012	91.72%	92.69%	95.27%
2012/2013	92.49%	93.62%	96.89%
2013/2014	93.37%	92.85%	97.92%

Time on Vehicle. This is the amount of time a patient spends from collection to drop off against a target specified by the trust



Overall we have seen a steady rise in our performance in all three of these targets (as shown in the chart below), and our performance is currently at its highest level over the preceding five years, this is set against a backdrop of the changing nature of healthcare provision within London such as the marked increase in on the day bookings where the patients is required to be collected within one hour of the request being made.



Other Services

Our 111 Service at South East London (Beckenham)

We became responsible for the provision of 111 services to South East London (Beckenham) on 19 November 2013. Therefore, this section covers the period from 19 November 2013 to 31 March 2014.

Incidents

Incidents relate to a range of issues at LAS111. The majority since November have been relating to staff errors. The errors have been without any clear trend. However, one issue has been staff putting the wrong contact details into the computer system. This has been dealt with in terms of individual and wider learning. Other incidents have related to technical issues that have been addressed and resolved.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the ambulance crews and the GP Out of Hours (OOH) providers.

The majority of feedback was related to the perceived inappropriateness of the referral and whilst several have been upheld, many have occurred due to a poor understanding of the 111 system.

Staff Incidents

We have had very few staff incidents reported and they have all been very minor in their nature with the exception of two episodes of extremely abusive patients, both requiring Police intervention.

Authorised Confidentiality Breach

Authorised confidentiality breaches are logged when a patient has been referred to a service without their consent and /or knowledge. The breaches are used for patients where it is deemed not safe to leave them without further assistance or in the case of safeguarding, not safe to notify them i.e. domestic abuse where the assailant is still on the premises. The breaches are authorised at the time of the incident by a senior clinician within the call centre. We are currently working on a system to ensure that the clinical decision making relating to these calls is consistent across the clinicians.

Call Quality & Monitoring

Since 19th November we have exceeded the required standard for 1% percent of call audits every month with the exception of November when we had difficulty with the technology on site.

The compliance percentage has remained static and Call Handler figures have remained higher than clinicians each month. We have been working to understand the issues for the clinicians.

All staff are now logged on our new audit tool which offers increased access to data for trend analysis on individual and group development and this will be reported on in the future.

Call Audit Data	Nov -13	Dec -13	Jan -14	Feb -14	Mar -14
Calls answered at 111	7505	21,426	23,411	22,722	26,053
% Call audits % (target 1%)	0.5%	2.1%	1.74%	1.94%	1.34%
No. Call audits	41	462	409	441	349
No. Call Handler audits	5	229	204	235	157
No. Clinical Advisor audits	36	233	205	206	192
% Compliance (target >86%)	85%*	72.7%	76.3%	76.8%	80.23%

*Data reflects period following Step-in 19-30 November 2013 only.

Call Handler Data	Nov -13	Dec -13	Jan -14	Feb -14	Mar -14
No. Call Handler audits	N/A	N/A	N/A	235	157
No. achieving compliance	N/A	N/A	N/A	196	139
% Compliance (target >86%)	N/A	N/A	N/A	83.4%	88.5%

Clinical Advisor Data	Nov -13	Dec -13	Jan -14	Feb -14	Mar -14
No. Clinical Advisor audits	N/A	N/A	N/A	206	192
No. achieving compliance	N/A	N/A	N/A	143	141
% Compliance (target >86%)	N/A	N/A	N/A	69.4%	73.4%

End to End Call Audits

Monthly end to end call audits are undertaken at LAS111. The audits are attended by the clinical leads for the service. The subjects that have been reviewed thus far are:

- Non-conveyed ambulance referrals
- Calls that received an Emergency Department disposition
- 999 referrals and their appropriateness
- Calls relating to the CHIME service (see explanation) below in general governance activity

The end to end audits have all highlighted areas of good practice but also areas that require some

improvement and we have been working consistently on them. Key areas for improvement were clinicians undertaking a systematic assessment considering the „whole patient picture“ to make an appropriate decision within a timely overall call length.

Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 95 people in total to Social Services which equates to circa 0.09%. We have received three feedback reports from Social Services in total since November 2013.

Patient Experience

There is a requirement to survey 1% of patients that have called 111 for assistance. Due to technical and logistical issues, the 111 patient surveys did not start to be sent out until April 2014. We have not received any responses to date and therefore are unable to produce any data relating to patient satisfaction; however our patient concern /complaint level has remained low.

Language Line use has been low and this is in line with figures provided by the previous provider. We have taken steps to remind staff of the availability of language line and have recently added this area to the call audit information in order to ensure staff receive feedback.

Training

We have now commenced emergency life support courses for all staff at Beckenham. Staff are really keen to get involved and it will help them to understand some of the advice that they are giving as well as addressing issues that have been historically raised through incidents.

We have also had our first refresher training on Mental Health facilitated by the Trust's Mental Health Advisor. We are initially asking clinicians to attend

and will then amend the session to enable Call Handler refreshers. We are still reviewing capacity tools for telephone use to assist with clinician decision making.

All staff have undertaken two periods of mandatory training since November 2013 relating to the changes to our software; Pathways. This has all been achieved within the required timescales. Staff have also completed the mandatory training elements relating to adult and child safeguarding and Information Governance.

Quality Measures

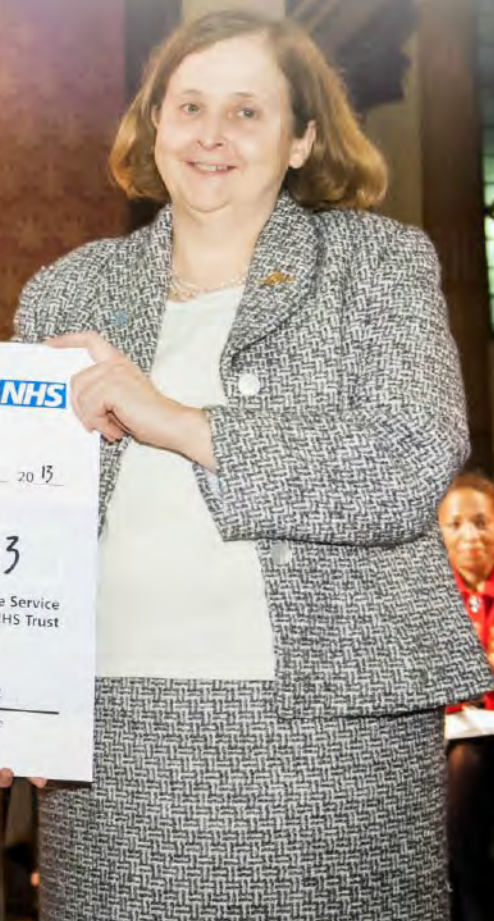
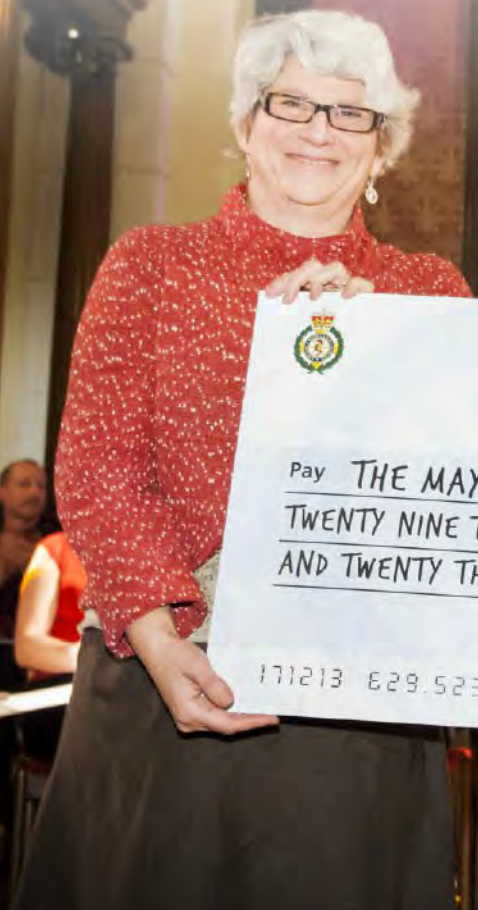
We have a number of Quality Measures that we use to monitor the service. These are as follows:

26% of calls were referred to a clinician - within acceptable parameters

2% offered a call back (no clinician available for immediate transfer) - target 98%

80% received call backs in less than 10 minutes (average 7 minutes /longest 1.18 hour) -target 100%
6 patients waited for over 1 hour for a call back -no target

9% of dispositions were ambulance dispatch and 81% of those calls were conveyed by the ambulance service - this is favourable when compared to national performance standards and is used for monitoring trends rather than aiming for an exact target



 London Ambulance Service 
NHS Trust

Pay THE MAYPOLE PROJECT
TWENTY NINE THOUSAND, FIVE HUNDRED
AND TWENTY THREE POUNDS ONLY

Date 17 DECEMBER 2015

£ 29,523

London Ambulance Service
NHS Trust

Ann Kilmore
Ann Kilmore, Chief Executive

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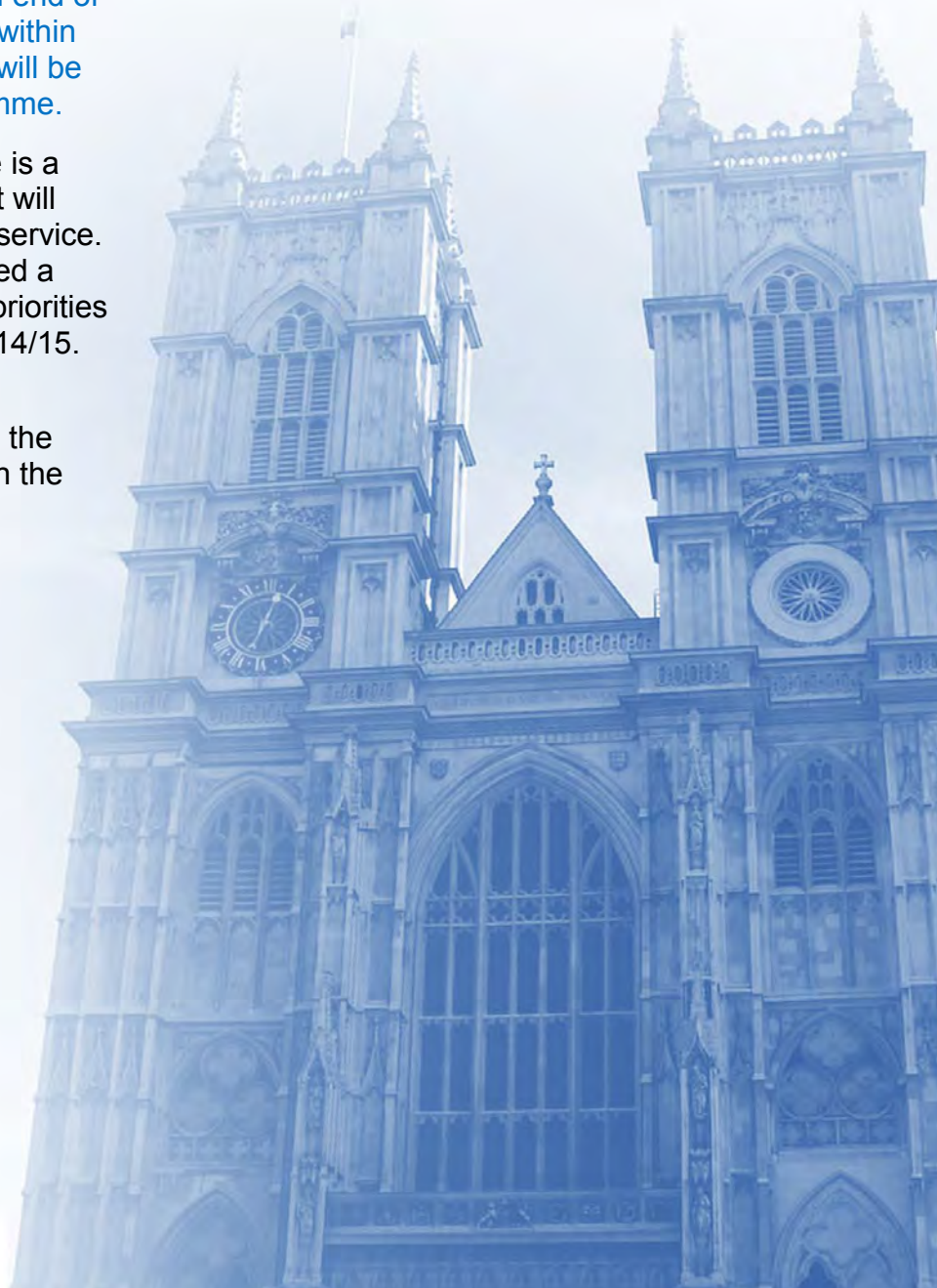
2014/15 Quality Priorities

Our improvement priorities for 2014/15

In our 2013/14 Quality Account we outlined how we were going to rise to the challenge in meeting the continuing increase in demand of over 100,000 calls a year. This was to be met through a comprehensive two-year transformation programme. An end of year report has been provided within this Quality Account. 2014/15 will be the second year of this programme.

The transformation programme is a large programme of work and it will affect everyone working in the service. However, we have also identified a number of other improvement priorities that will be taken forward in 2014/15.

The remaining actions in the transformation programme and the other priorities are described on the following pages.



Our Transformation Programme

Changing our Front Line Workforce

During 2014/15 we will be changing the way we staff our ambulances. Currently a small proportion of our ambulances can respond to only a limited number of calls because of the skill levels of the members of staff who work on the those ambulances.

To provide a better service to our patients and to allow us more flexibility we have developed a more skilled role which will enable all our ambulances to respond to a full range of calls. We expect this new role to be introduced during the summer of 2014

Changing the way we respond to patients

Historically, we have sent a single responder as well as an ambulance crew to many calls in a bid to achieve our response time targets. This is not the best way to use our resources; it does not necessarily benefit our patients and it means that staff are regularly cancelled when they are on their way to a call.

In 2014/15 we are going to reduce the number of resources we send to individual incidents. We estimate that by responding differently we can reduce the number of occasions on which we send 2 or more resources to incidents which will in turn enable us to have more capacity to treat other patients who would otherwise have to wait longer.

These changes will be introduced when our new front line workforce model has been implemented.

Aligning resources to meet demand

In 2014/15 we will be introducing new on duty rosters for all our front line staff. These rosters will ensure that we more closely match the number of ambulances and solo responders (cars and motorcycles) we have available to the peak periods of demand for our services.

We are planning to introduce the new rosters during the summer of 2014.

Recruitment and retention

There are some national challenges in recruiting registered clinicians to the ambulance service and London has some unique factors, such as accommodation and transport costs, that make this additionally challenging.

We are putting together a comprehensive plan for recruitment and retention and have made this a corporate priority.

Strengthening the Patient Voice

We recognise the need to strengthen the way we involve patients in our decision making and our service design.

During 2014/15 we will be publishing our new five year strategy and this is an ideal opportunity in involving patients and stakeholders in the strategic decisions contained within the strategy.

In addition, we will seek further opportunities to involve patients by moving towards a culture of “no decision without us”.

Our intentions will be outlined within our engagement strategy.

Strengthening the staff Voice

We recognise the need to involve our staff in the decisions we make and establish stronger processes for obtaining staff feedback.

We strengthened our staff involvement last year through our Listening into Action programme. We will reflect on this during the year and identify further opportunities.

Improving the care of Mental Health Patients

We have decided to revisit mental health care as an area for quality improvement during 2014/15. This will be our main clinical priority and will roll into 2015/16.

Mental healthcare is moving up the agenda nationally and continues to do so within the Trust. In line with the national mental health agenda, we have identified four specific areas of improvement this year.

While we continue to have mixed results this year there is evidence of improvement in the delivery of high quality responses and care when people with a mental illness urgently need help.

Training & education

Last year we undertook mental health training within our control environment and at some of our local stations. This training was unique for us in that it was undertaken by patients with mental health conditions. It was hugely successful and we wish to build upon this in 2014.

This year we are concentrating on improving the internal clinical interventions and management of a mental health crisis. As part of the main training programme for 2014/15, the Mental Health Module provides the

opportunity to review and refresh existing knowledge and to provide further information and guidance for a variety of scenarios.

A new session on dementia and a mental health risk awareness tool has been added to the programme.

We have also focused on delivering face to face training for our Clinical Team Leaders and Advanced Paramedic Practitioners with sessions including issues on the national agenda including the national section 136 protocol.

This year we also aim to improve the knowledge and skills of our staff working in the control room by introducing mental health nurses into that area.

Patient engagement and learning from patients

We have decided we need to work with patient representative groups to determine what good looks like and identify areas of improvement that are important to our patients.

The Trust has been working closely with Hear Us, a mental health charity in the previous year. We intend to continue this engagement process with the support of our Community Involvement Officers in the development of a patient experience action plan to monitor the impact of any changes.

Data recording for mental health patients

The Trust recognises that we capture and generate a tremendous amount of information which is only useful if it can be applied to create knowledge within the organisation. We would like to improve the way we capture and record mental health data to ensure that are capturing the right information

so that we can measure the impact of future changes.

We plan to review mental health coding on the patient report form to allow a more meaningful data analysis.

We want to ensure that mental health complaints and incidents are captured and readily available and to ensure that Appropriate Care Pathways are coded and captured correctly to allow for monitoring and evaluation.

This will allow the Trust to make more effective use of the mental health data we hold and use accurate information to inform decisions.

Effective partnership working

In the previous year we have rolled out mental health alternative care pathways that were agreed with all ten Mental Health Trusts across London which have allowed to reduce the number of patients inappropriately conveyed to the Emergency Department.

Whilst there has been improvements in this area we would like to further improve our relationship with Mental Health Trusts. We want to ensure representation at other key groups in cementing the role of the Trust as a mental health partner.





Feedback

Comments from our partners and stakeholders

We are obligated to give stakeholders the opportunity to comment on our Quality Account and to then publish their comments in full.

This year we invited the following organisations/groups to respond.

- Southwark Healthwatch
- Hillingdon Oversight & Scrutiny Committee
- The London Ambulance Service Patients' Forum
- The London Ambulance Service Commissioners

We would like to thank those organisations/groups for taking the time to read and respond. Their comments are published in this section.



London Ambulance Service Quality Account 2013/14

Healthwatch Southwark is pleased to provide the following comment to the London Ambulance Service (LAS) Quality Account for the second year running and are in agreement with the priorities for 2014/15. The comment contains a brief review of the performance relating to the quality priorities for 2013/14.

The account contains reference to the Modernisation Programme and the challenges relating to commissioning across 32 boroughs, the scale and challenges of which are appreciated. Any work that goes towards increasing the quality & safety of services as well as increasing excellent patient experience is welcomed.

With regards to the review of the 2013/14 priorities it is encouraging to see that the numbers of complaints regarding staff conduct has decreased. It would be useful to know whether LAS believe this is a result of the staff training.

Regarding the less urgent patients waiting longer than LAS would like we concur with patients that it would be beneficial to work out a way that patients who are waiting are kept up-to-date with progress on their call. We understand that resources are an issue however the complaint regarding poor communication could be resolved and we endorse LAS's move to improve this. Patient education and information provision is crucial for LAS to undertake as you have a reach to thousands of people each year. Each part of the health system needs to play its part in helping people to understand the range of services available such as 111 and Urgent Care Centres.

We note and applaud the improvements below and look forward to further improvements being reported:

Outcome from acute ST-elevation myocardial infarction (STEMI) the improvement in compliance from 67.3% to 76.1 % in 2013/14.

Outcome following stroke for ambulance patients the compliance for 2013/14 is 94.7 where the year it was 94.1%. Though this is a slight improvement as is written it is still to be applauded as a step in the right direction. Last year we requested an explanation for the difference in the percentage of patients suffering a STEMI who receive an appropriate care bundle i.e. in London (67.3%) as compared to the highest percentage of the Great Western Ambulance Service (94.1%) and this is still an issue we would like to discuss.

Category A8 minute response time LAS achieved the requirement to complete 75% of all A8 calls within eight minutes and achieved the requirement to complete 95% of all calls within 19 minutes.

STEMI and Stroke patients appropriate care bundle provision the improvement from 2012-13 figures to the 2013-14 data is commended however this is still below the national average. This is an area that we would like to explore with LAS to find out the reasoning behind this.

Regarding the **priorities for 2014/15** Healthwatch Southwark agrees with the LAS that these should be the focus for this year. We look forward to the new patient and public engagement arrangements that LAS will be putting into place which includes local Healthwatch and the current Patient Forum. As Mental Health service quality improvement is also one of our priority areas we look forward to joining forces with LAS on this issue.

There are a number of subject areas in the report that Healthwatch Southwark and not doubt other local Healthwatch would like to discuss with the LAS including Patient transport, patient experience and the use of the language line within the 111 service. We look forward to further improvements in the way in which we work with the London Ambulance Service.

Healthwatch Southwark



THE LONDON AMBULANCE SERVICE NHS TRUST
Consultation on the Trust's Quality Account - 2013/2014
Response on behalf of the External Services Scrutiny Committee at the London
Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2013/2014 Quality Account report and acknowledges the Trust's commitment to attend its meetings when requested. The Committee commends the Trust for the excellent service that it provides and notes that a lot of work has been undertaken by the LAS to ensure that plans and actions are being put in place to improve those areas where concerns have been identified

Although it is understood that the format and content of the Quality Report is largely predetermined, the Committee believes that it would benefit from the use of more digestible language and less "organisational speak". In addition, Members believe that the report could be strengthened by the use of better time serialised data going back five years to identify trends and show a course of direction. Nonetheless, the Committee applauds the LAS for the range of indicators that it measures which will help the Committee to monitor the organisation's progress in improving its performance over the next year.

Over the last year, the findings detailed within the Francis Report, Berwick Report and Keogh Review were primarily written from the hospital perspective. However, the Committee is pleased to note that the Trust is keen to learn from directly transferable lessons – this has led to proposed improvements such as the introduction of a Duty of Candour and the development of a patient engagement strategy. Furthermore, these publications' findings will inform the development of the Trust's new Quality Strategy which we look forward to seeing in 2014/2015.

Members are pleased to note that, for the eleventh consecutive year, the LAS has delivered on its target to reach 75% of its most urgent patients within 8 minutes. However, the Committee is concerned that other road users are frequently hindering the emergency vehicles' progress to their destination. It is suggested that consideration be given to how the Members could possibly help to raise awareness of the implications of this type of inconsiderate driving. The Committee believes that this could help reduce the number incidents where the Trust is deemed to take too long to get to an incident.

Mental healthcare is moving up the agenda nationally. As such, it is encouraging to note that mental healthcare has been identified as the main improvement priority for the Trust during 2014/2015, identifying four specific areas for improvement: training

and education; patient engagement and learning from patients; data recording for mental health patients; and effective partnership working. It is anticipated that further improvements in these areas will result in a reduction in the inappropriate use of resources.

There have been a number of recent reports in the media in relation to the number of patients being held in ambulances outside Accident and Emergency departments as, for various reasons, they are unable to be transferred into the building. Although, the Committee is aware that this is in no way the fault of the ambulance service, Members felt that it would have been useful to mention this issue within the report as it is clearly a threat to the availability of resources and therefore the quality of service provided by the LAS.

There is a continuing problem where members of the public are still presenting at Accident and Emergency departments for minor ailments that could be seen by a GP – these individuals are using the service as a first resort rather than for emergencies only. Furthermore, ambulances are also being used by some people as a convenient way to get to hospital rather than making their own arrangements. With the rapidly growing demand on the Trust's limited resources, Members feel that further consideration could be given to working in partnership to re-educate the public about a more appropriate use of the health services that are available to them. To this end, Members are pleased to note that the LAS is routinely asking those patients with minor ailments whether they are able to get to the hospital under their own steam.

Overall, the Committee is pleased with the continued progress that the Trust has made over the last year and the excellent service that it continues to provide, but notes that there are a number of areas where further improvements still need to be made. We look forward to receiving updates on the progress of the transformation programme and the work to support the priorities outlined in the report over the course of 2014/15.

Hillingdon Oversight & Scrutiny Committee

PATIENTS' FORUM

FOR THE LONDON AMBULANCE SERVICE

QUALITY ACCOUNT FOR 2013-2014

Thank you so much for inviting the Forum to contribute to your Quality Account for this year. We present below our contribution to the LAS's Quality Improvement Priorities for the Quality Account.

1) OUR RELATIONSHIP WITH THE LONDON AMBULANCE SERVICE

The Patients' Forum values continuous engagement with the LAS in relation to discussions about all aspects of LAS performance and clinical care. This engagement takes place at the seven internal LAS committees on which the Forum is represented: Patient and Public Involvement, CQSEC, Learning from Experience, Equality and Inclusion, Mental Health, Infection Prevention and Community Responder. We also actively engage with the Trust Board at their meetings and at meetings with leaders of the LAS. The Forum also values the contributions by the Chair, Chief Executive, Directors, the Head of Patient & Public Involvement and Public Education and other LAS leaders to our monthly Forum meetings held in the LAS Conference Room. Close regular contact with the commissioners for the LAS also enables the Forum to exercise influence in relation to the quality and performance of LAS services.

2) QUALITY ACCOUNT FOR 2012-2013 - REFLECTIONS FROM BERWICK

We have received no formal feedback to the Quality Account Statement we submitted for the previous period.

3) PROTECTING PATIENTS FROM AVOIDABLE HARM – THE HIGHEST PRIORITY

We welcome the LAS's commitment to take all patient feedback very seriously, and their review of the management of the investigation of serious incidents. In keeping with the priorities highlighted by the Francis and Berwick Reports, providing the safest and most effective care for patients must be the highest priority for the LAS. Reporting, investigating and learning from patients safety incidents and complaints must be fundamental to ensuring patient are safe and evidence produced that learning on incidents and accidents is constantly taking place. Patients must always be told when they have been harmed due to clinical errors. The LAS should ensure that all ambulances carry equipment that is clean and sterile; shortfalls in infection control are always taken seriously and acted upon; required clinical equipment is always available, e.g. tympanic thermometers, when needed, is intact and up to date.

WE RECOMMEND that the LAS publishes in the public arena the outcome of all incidents, complaints and accidents investigated, where there are recommendations for service improvement; with evidence demonstrating enduring improvements to service quality and safety, and

evidence of staff and organisational learning and implementation of recommendations.

4) PRE-HOSPITAL DEMENTIA CARE WILL BE TRANSFORMED

The Forum is pleased that the LAS has started to focus more specifically on the need of patients with cognitive impairment. The LAS should develop clear effective dementia pathways with the LAS commissioners (CCGs), acute hospitals and where possible community care professionals to ensure „right care first time“ for patients with dementia and cognitive impairment. LAS should continue the development of its Clinical Support Desk to ensure its capacity and expertise to advise clinical staff on meeting the needs of people with dementia, especially with regard to assessing cognitive impairment and pain.

WE RECOMMEND the LAS should produce evidence to demonstrate that front line staff have continuous education and training in this area. This should include access to Health Education England training resources. See also section on mental health (4) below. Access to appropriate care pathways for patient with cognitive impairment must become fundamental to providing right care, first time.

5. PATIENTS WHO FALL SHOULD ALWAYS RECEIVE INTEGRATED CARE

The Forum welcomes to decision of the LAS to upgrade calls from patients who have fallen, and their participation in research into the need of these patients (SAFER 2). When patients fall and do not require access to hospital acute care, paramedics should have direct access to local Falls Teams, in order to ensure expert clinical advice and care for these patients and avoid inappropriate transfers to A&E. We welcome the CQUIN for an Enhanced Falls Service for 2014/5

WE RECOMMEND that the LAS ensures care for people who have fallen is provided within appropriate time-scales, and includes agreed care pathways and integrated care plans, with clear governance mechanisms to ensure care plans are fully implemented, enable appropriate access to services and demonstrate clear outcomes for the patient.

6. CARE FOR PEOPLE IN A MENTAL HEALTH CRISIS MUST BE TRANSFORMED

We commend the LAS for the considerable progress that has been made in the prioritization of care for people with mental health problems. However, we are concerned that E-learning approaches have been adopted as the main vehicle for training of staff. We are very pleased that work is developing with mental health Trusts to create effective mental health pathways which should help to divert patients away from A&E departments, to more appropriate community care – however, this approach needs to gather pace and speed to ensure implementation in the short term. We are very pleased that the Chief

Executive is providing leadership by chairing the LAS Mental Health Committee to ensure implementation of this improvement priority.

WE RECOMMEND that the LAS develops a specialist front-line team of paramedics and nurses who are expert in the care of patients with a mental health diagnosis. All paramedics and A&E support workers should be continuously and dynamically trained in the care of people with mental health problems, bearing in mind the special needs of people with learning difficulties and the need focus on cultural, language and age related issues. A significant proportion of this training should be live rather than via e-learning, as interpersonal skills and attitudes appropriate to this group of patients need to be practiced, evaluated and demonstrated.

7. EXCELLENT END OF LIFE CARE MUST ALWAYS BE PROVIDED

The LAS should continue to develop its excellent work with Advance Care Plans (ACP), End of Life Care (EoLC) and CoOrdinate My Care (CmC). Protocols should be developed between the LAS and London's CCGs and GPs to ensure that CoOrdinate My Care (CmC) is fully developed to meet the needs of people who have an Advance Care Plan. We welcome the CQUIN for End of Life Care for 2014/5.

We RECOMMEND that the LAS enables far greater number of people to access appropriate care through CoOrdinate My Care (CmC). The LAS should publish examples of good practice in 'end of life care' for front line staff, together with evidence of outcomes showing the effectiveness of appropriate and compassionate care for these patients.

8. DELAYS IN PROVIDING URGENT AND EMERGENCY CARE ARE NOT ACCEPTABLE

We congratulate the LAS on the achievement of its Category A targets. Vulnerable patients who have requested emergency care must never be left waiting for LAS care.

Patients requiring a slightly lower level of care, who are vulnerable, who are in pain, who have fallen, or taken an overdose, should not have to make repeated calls to the LAS to get help. Such delays suggest a significant breakdown in care provision and are the cause of many complaints to the LAS. This particularly concerns patients categorised as needing care classified as C1 and C2. We understand the limitations caused by a shortage of staff and resources.

WE RECOMMEND that urgent action is taken to promote recruitment to the LAS front line from schools, universities, job centres and religious/cultural centres in London. The work-force must be enlarged to ensure that the Category C targets which follow are always met:

Category C1 – 90% within 20 minutes, 99% in 45 minutes (from Clock Start)
Category C2 – 90% within 30 minutes, 99% in 60 minutes (from Clock Start)

Achievement of targets in 2013/4 were as follows:

Category C1 – reached in 20 minutes – 72.88% (target 90%)

Category C2 – reached in 30 minutes – 66.88% (target 90%)

9. STAFF SHIFT PATTERNS SHOULD BE FULLY EVALUATED

There is considerable national and international research pointing to the deleterious effects of shift work, including shift work patterns on both short and long term physical and mental health. Some staff members are not suited to shift work and able to remain healthy as well, but are excellent front line clinicians.

WE RECOMMEND that the impact of long shifts on front line staff is fully evaluated by the LAS, especially in relation to the impact of 12 hour shifts, without adequate meal breaks and rest on: clinical care; the health of staff; training and complaints against staff, e.g. in relation to attitude and behaviour. Staff should be interviewed about the effects of shift work on their health and clinical practice during annual appraisals, and be involved in development of improved alternatives.

10. APPROPRIATE CARE PATHWAYS SHOULD BECOME FULLY OPERATIONAL

It is critical for the LAS to work with partners across health and social care to integrate services so that patients get better, more appropriate care and experience better clinical outcomes. „Right Care First Time“ should become the norm.

WE RECOMMEND that care pathways are developed by the LAS in conjunction with CCGs, acute trusts and providers of community care that are robust enough to give confidence to LAS crews, patients and carers that these pathways are available when required, clinically appropriate, fully-funded, subject to regular clinical audit and tests of reliable and continuous access, i.e. effective governance.

11. LAS SHOULD ACTIVELY SEEK TO BE INFLUENCED BY PATIENTS AND THE PUBLIC IN ALL THAT IT DOES

We welcome the decision of the LAS to involve patients and stakeholders in the development of their strategy and a new culture of “no decision about us, without us”. The recent meeting on the PPI strategy was exemplary. The LAS should secure public involvement in the planning, development and consideration of all significant proposals for changes and decisions affecting the operation of the LAS.

WE RECOMMEND:

- **Engagement with FT members, the Patients’ Forum, patient groups, the voluntary sector and Healthwatch to ensure patient involvement in all aspects of the LAS’s work.**
- **Holding wider public engagement around prioritisation and service re-design.**
- **Promoting the public education role of the LAS.**

- **Developing a wide range of methods to seek public views on LAS services and providing feedback.**
- **Acknowledging the value that the LAS places on the knowledge, insight and understanding of the contribution of patients and carers.**
- **Trust Board members should enhance their public accountability by listening more to and meeting the public and acting on what they say.**

12. EQUALITY AND DIVERSITY

Excellent work has so far been done in relation to LGBT colleagues and the employment of women. Reflecting on the LAS workforce and comparing its diversity to the current diversity of London and its future growth demonstrates a substantial need for development. We have argued this point for several years but have seen little change in the diversity of the LAS workforce and no change in the ethnic and cultural diversity of the LAS Board. We would not be satisfied to be told this matter will be dealt with in the post 2020 period bearing in mind that the difficulties experienced by the LAS to recruit locally, despite the very fulfilling professional opportunities for front line staff, and the need to recruit from Denmark and New Zealand.

WE RECOMMEND that the LAS embed diversity into all aspects of public education, recruitment and training and ensure full inclusion and sensitivity toward patients and staff with any protected characteristics, not solely LGBT. Changes must be made at all levels in the LAS, including the Board, to embed these duties.

Patients" Forum for the London Ambulance Service