



NHS

London Ambulance Service

NHS Trust

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019



70
YEARS
OF THE NHS
1948 - 2018

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Foreword

The London Ambulance Service is the only pan London Trust and is the busiest ambulance service in the country responding year on year to increasing demands. Our Trust was inspected February 2016 by the CQC, who gave us an overall rating of 'requires improvement' in their final report. The care we give to patients was rated as outstanding, a number of services were rated as 'good' but the standards observed were not consistent nor of the quality the Trust aspires to deliver. During the year we have delivered a comprehensive action plan and external assessment confirms what we know, that our services have improved over the last two years. However we also know there is further improvement to make to achieve our vision of providing a world class service. Through this strategy, we want to strive for 'outstanding' Care Quality Commission (CQC) rating across our sites and services by 2020.

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing and growing population. However, with these challenges, we have an exciting opportunity when it comes to improving healthcare quality.

We hope our commitment to improvement and our determination to get things right for our patients, people and stakeholders is clear in this strategy. We are working to harness opportunities to continuously improve in order to provide safe, high quality, patient-centred care for all our patients. In addition we need to ensure that our staff are provided with the skill and support to deliver the right care and feel motivated and able to do so.

To achieve this, we are rolling out a programme of quality improvement and human factors training and developing our systems and processes to build an organisation-wide culture of continuous improvement. At the same time, patients will have a stronger voice than ever before, and we have begun and will continue to work more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

This strategy is the plan by which we will continue our journey to achieve our ambitions and a positive outcome in subsequent CQC inspections as continuous quality improvement becomes our business as usual.

Dr Patricia Bain
Chief Quality Officer

Statement of Directors responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHSI has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporates the above legal requirements) and the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account. The London Ambulance Service, whilst not a Foundation Trust has prepared the annual quality account in line with this guidance ensuring directors have taken steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2017 to March 2018
 - papers relating to quality reported to the board over the period April 2017 – March 2018
 - feedback from commissioners dated April 2018
 - feedback from Overview and Scrutiny Committee dated March 2018
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
 - the 2017 national staff survey
- The quality report presents a balanced picture of the NHS trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Chair Date

Chief Executive Date

Section 1:

Introduction to our Quality Strategy and Accounts 2018/19

The quality strategy for the Trust, aims to bring together our plans in line with our overarching strategy, business planning process and the CQC quality assessment framework. The purpose of the strategy is to set out the goals and targets for London Ambulance Service (LAS) in providing high-quality services over the next year and, therefore, delivering our vision and objectives.



Developing our Trust-wide strategy

We recently published a document entitled 'Our strategic intent 2018/19 – 2022/23', it sets out our ambition and describes how we plan to evolve in order to achieve improved outcomes and a better experience for patients.

It formed the basis for a six-week period of consultation that took place with internal and external stakeholders during November and December 2017, the main purpose of which has been to ensure that we fully address the needs of patients, our staff, partner NHS organisations and other business partners across London.

We are working with many of our stakeholders and business partners, including the CQC, to co-design our final strategy, which is due for release early 2018.

Our trust strategy focuses on improvement, and therefore supports delivery of our vision and objectives. It sets out a number of the key enablers and examples of the projects required to improve performance to illustrate the breadth of our work programme.

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.



The Trust's vision

The London Ambulance Service is uniquely placed to play a wider role within the London health economy.

Our ambition is to become a world-class ambulance service for a world-class city: London's primary integrator of access to urgent and emergency care on scene, on phone and online.

This vision will be delivered through the achievement of the Trust's strategic objectives, which are:

- Acting as a multi-channel single point of access and triage to the urgent and emergency care system across London.
- Providing a high quality and efficient differentiated clinical service that better matches care to patient urgent and emergency needs.
- Using our influence and working with partners to ensure a consistent approach to urgent and emergency care.

Our Purpose

We exist to:

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

What is the Quality Strategy?

Our quality strategy is the plan through which we focus on the quality of clinical care and to ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of everything that we do.



This strategy sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number one priority. It sets out our five domain quality goals and associated targets and a number of projects which we must focus on to ensure we can evidence that our services are safe, effective, caring, well led and responsive. It also describes the governance arrangements to ensure delivery and sustainability from 2018/19. The strategy also outlines our current position, showing the improvements we have made in our 2017-18 Quality Account priorities and what we are building on going forward.

It is ambitious, setting out our commitment to make quality central to all that we do. It also reinforces that wherever possible, our focus will be on embracing new ways of working to improve care for patients and integrating healthcare across the wider integrated urgent and emergency care system.

It provides a modern approach to continuous improvement and acknowledges that our people are central to delivering our strategy.

We will use the implementation of the Quality Strategy to strengthen confidence and pride in the services we provide. We want patients to be confident that the Trust is among the best in the world.

We want people working in and with the Trust to be confident that

they are providing the best service they can, are valued and are important. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so. We want a shared pride in the Trust and assurance that it is the very best it can be.

How we developed the strategy

The strategy has been informed by the reports and recommendations from key stakeholders, staff and patient representatives and the CQC framework. We also assessed our progress against priorities in our last quality account.

Comparison was also undertaken of trends and variation from a range of intelligence including:

- Patient surveys
- Staff surveys
- Governance data, e.g. incidents, complaints, claims and audit

This was then merged with feedback from key stakeholders, including our people and our commissioners.

We have therefore been careful to develop goals and targets that are measurable whilst trying to encapsulate our commitment to the qualitative elements of our work. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and

reportable goals to aim for. These targets will be redefined each year in our annual quality account, with progress monitored through the Trust's governance system. We believe that if we can meet our targets under each quality domain, we will see significantly improved outcomes for our patients and a better working environment for our people. Our goals and targets have been selected to have the highest impact across the Trust and are purposely challenging.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. A series of Trust-wide improvement projects, informed by our CQC inspection action plan and a review of the key lines of enquiry that the CQC use, have been established to deliver specific time bound programmes of work.

What is our definition of quality?

We have based our definition of quality on the CQC's framework, which draws on the Francis, Keogh and Berwick reviews and recommendations.

Our approach aligns Berwick's improvement principles which are embodied within safe, effective, caring, responsive and well led domain. The combination of performance in each of the five domains determines the overall quality of the healthcare we provide. We believe that we can improve services only by supporting continuous improvement in all areas hence our commitment to this driver.

The previous quality account and improvement programme for the Trust focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our CQC inspection, this strategy and our priorities for 2018-19 and beyond will strive to bring the trust to an 'outstanding' rating.



The quality domains

The quality domains are outlined below, together with the descriptor of what these mean. The domains match those used by the CQC to ensure we are focused on making improvements which are aligned with our regulatory body's expectations.

Safe

People are protected from abuse and avoidable harm

Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Responsive

Services are organised so that they meet people's needs

Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Delivering the Strategy:

How will the strategy be delivered and progress monitored?



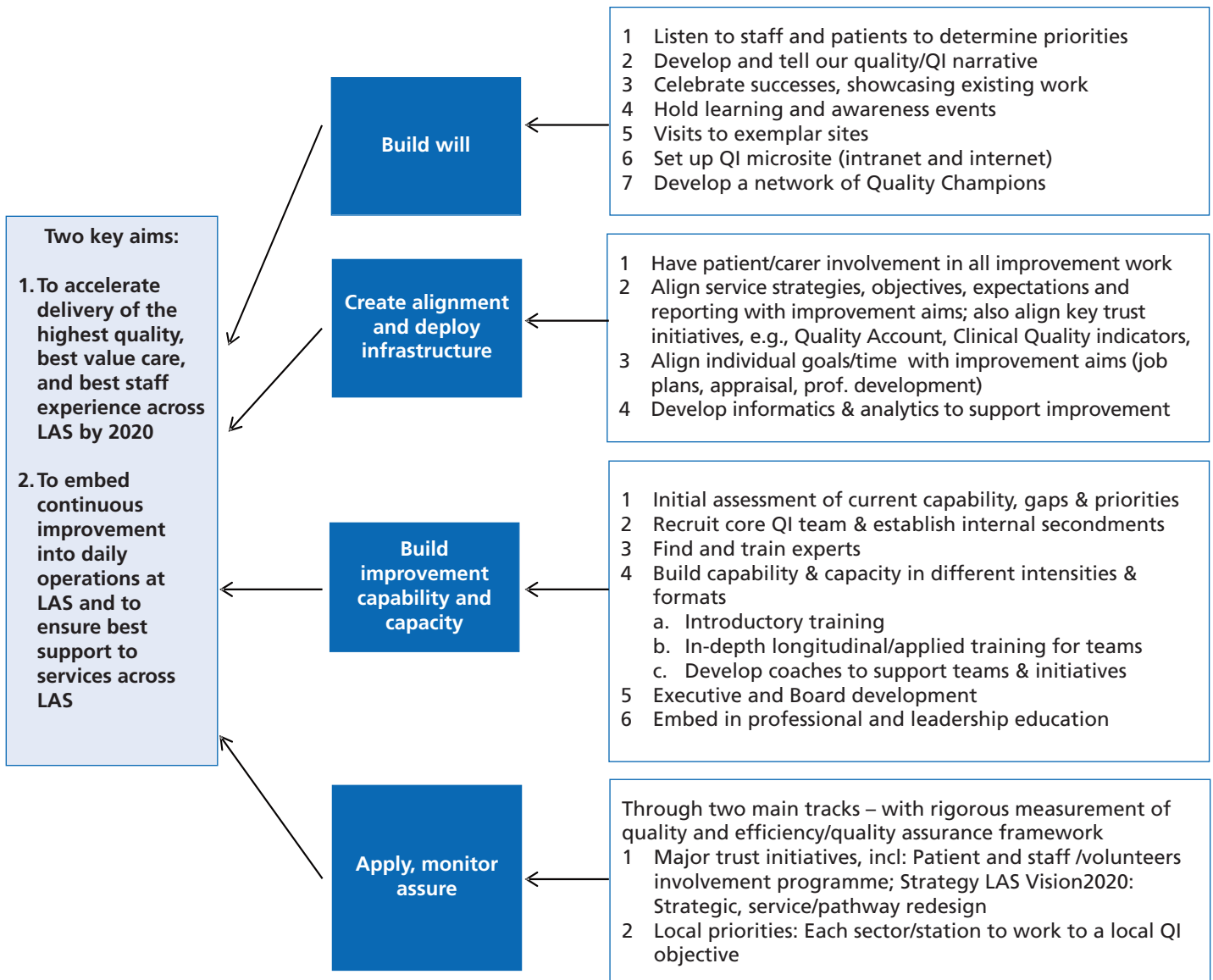
Quality Goals and Targets

The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. These are outlined under each quality domain and have been chosen to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our goals and targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff. The goals and targets under each domain will

be incorporated into the quality report and performance scorecards, ensuring they can be tracked from station to board. This will provide clarity on the Trust's priorities and will show the impact of the improvements we have made.

Building Delivery Capacity and capability

Delivering the strategy will be predicated on ensuring we have the right skills and capacity across the organisation. The outline plan below sets out the key activities to achieve this aim, are detailed in our implementation plan.



Building the Will

Integral to all programmes must be the aim of robust patient and staff involvement so they support the development of what represents a high quality and efficient service. It is important that we continue to explore further ways of getting feedback from staff via Quality Champions, patient and carers and community groups, in addition to our continued engagement with the Patients Forum. The patient involvement teams will develop a framework to ensure these aims and the successes they have already achieved are embedded.

The importance of ensuring that we take every opportunity to engage with exemplar sites partners in the redesign of services and pathways in order to secure the right outcomes is articulated in our organisational strategy. Supporting this programme will be a communication strategy that includes intranet and internet development.

Creating alignment

Alongside the quality goals and targets, we have developed measurable and structured improvement projects aligned to our strategic and business objectives. These projects have been informed by analysis of a number of measures of our performance including:

- Our strategic intent
- current performance against national and local targets
- our quality account
- areas of known risk
- our CQC inspection and report during 2018
- review of the key lines of enquiry that the CQC publish.

Each project has been assessed for their potential to positively impact on the Trusts strategic goals and targets and we are confident that we have the necessary work in

progress to deliver the required improvements. Progress with these improvement projects will be reported via the Trust's governance and performance management structures. This will allow us to measure and monitor the milestones, outcomes and timeframes of the projects, with clear lines of accountability and responsibility to the project owners. Executive oversight of quality of care in the Trust is through the Quality Oversight Group, which will report quarterly progress and exception to the Quality Assurance Committee. Trust board reporting will occur on a quarterly basis. Our annual Quality Account will report on progress against the strategy and confirm the targets for the following year.

Building Capability to deliver the strategy

We recognise that our staff are the key to delivering the strategy and we need to train and support people to make continuous improvement and improve systems and processes. We have therefore agreed to adopt a standardised approach to improvement Plan, Do, Study, Act (NHSI QSIR model) to ensure staff have the tools they need to sustain improvement. The capabilities needed to drive this system of wide improvement and which staff will be trained in includes:

- An understanding of Human Factors
- Concept of safety systems
- Driver diagram development
- Improvement methodologies, including Plan Do Study Act (PDSA), Lean, Patient flow studies
- Change management principles
- Measurement skills and knowledge
- Flow and service re-design management

Evidence internationally (IHI) suggest for an organisation the size of LAS that a commitment to training at a minimum, 1-3% of the workforce in improvement methods is required for continuous improvement (Table 2 below) A programme to identify and priorities the appropriate staff at all levels and utilisation of 'train the trainer' techniques will build the capacity required. A small team of staff trained in providing QI methodology and Human Factors approaches will provide the staff with the skills and tools to empower them to lead their own QI projects. QI improvement plans will be developed by staff at every level, with the focus to build capacity across, the workforce.

QI capability model for LAS – by staff group and role

Table 2 QI Capability Model

	Total potential needed	Eventual coverage needed	Knowledge/skills needed	What's involved
1. Front line staff	5,000	100%	<ul style="list-style-type: none"> • Introduction to improvement & model for improvement • Identifying issues, developing & testing ideas • Measurement & variation 	<ul style="list-style-type: none"> • Introductory e-learning sessions (incl. at induction) • Online/self-accessed • Over 3 year period
2. Clinical & operational leaders	400	100	<ul style="list-style-type: none"> • Deeper understanding of improvement methods, variation and measurement • Goal-setting, leading and managing for improvement 	<ul style="list-style-type: none"> • Applied learning in teams over time linked to opportunities in real work • Access to coaching • Embedding into existing programmes
3. Coaches*	Experts	10	<ul style="list-style-type: none"> • As above, plus sophisticated enabling and coaching skills for individuals and teams 	<ul style="list-style-type: none"> • Applied learning and reflection in coaching teams supported by classroom programme
4. Exec & Board	250	250	<ul style="list-style-type: none"> • Direction-setting, "mood" & leading for improvement • Link to strategy and overall priorities; appreciation of systems; making variation and trends visible 	<ul style="list-style-type: none"> • Self-determined but typically includes: mix of individual/group; sessions with external experts; peer visits/"Board-to-Station"; quality assurance visits"
5. Experts	n/a	All Board members	<ul style="list-style-type: none"> • Deep Dive methodology including of QI theory and science • Spread and implementation • Coaching/mentoring, teaching • Knowledge-generation and research • Measures for decision makers 	<ul style="list-style-type: none"> • Careful objective-setting, review and planned (career) development • Applied learning through doing/coaching • Reflection and peer support • "Masterclasses" • Individually-tailored • Board Development Session June

* Coaches drawn from wide variety of professions and grades

High Impact Innovations (DH 2012) requires NHS Trusts to prove to commissioners that they are implementing technological and innovative solutions to improve quality. As a Trust we are already exploring the use of technology via the roll-out of hand held devices to frontline staff, e-PCR development, tele-medicine/skype. Opportunities to explore technology further are outlined in our IM&T strategy.

Applying continuous assessment and improvement

Major trust initiatives, with rigorous measurement of quality and efficiency programmes and local sector and station QI objectives will be designed. Monitoring and

reporting on our programmes and ensuring we respond to any emerging risks will be achieved via our quality assurance framework. The main response to the outcomes from these various reporting mechanisms will be:

- Immediate risk mitigation (if necessary) and review/update of risk registers
- Identification of a quality improvement activity: station, sector and trust wide using an agreed criteria and methodology
- Consideration of 'intensive support programme' in areas that are not consistently meeting standards – using the approach

that is currently in place for the North East sector.

- Consideration of a Deep Dive review
- The streamlining of governance and **'floor to Board' assurance structures** will support the delivery of high quality and efficient care with early identification of risks, monitoring performance issues quickly to ensure we continuously improve. The further development and embedding of these frameworks will continue through to 2018-2019 and will support the development of a continuous improvement and learning culture.

Section 2:

Looking Forward: Our Quality goals and targets 2018-19

Our goals are set out under each of the quality domains. The targets which support the delivery of these goals have been developed for our year one of the strategy. Each year we will review progress and ensure our targets are focused on areas where improvement is most needed and will be defined within our annual quality account.



Safe

People are protected from abuse and avoidable harm

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable.

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal will be to be below the national average for the number of incidents causing severe and

extreme harm in year one and continue to reduce the number throughout the years of the strategy. Throughout year one of our Quality Strategy, we will be focusing on achieving sustainable improvements in the target areas outlined below; these targets aim to reduce avoidable harm in specific priority areas and set the trajectory to ensure that we can achieve our goal of eliminating avoidable harm by the end of year three.

Target 1

We will implement Health Assure reporting and Monitoring system to ensure that we have real-time monitoring of our compliance against the CQC key lines of enquiry, clinical audits, NICE guidance, national alerts, at every level in the organisation.

This system will provide assurance to the Board and our regulators and patients that we are meeting the high standards of care and safety consistently across the whole organisation. Scorecards will be available from station to Board and will be used to monitor progress via our governance and assurance processes. We will be able to identify areas for improvement more quickly and focus our effort in these areas. Our regulators will be able see, assess and access evidence with regard to our improvement status at the 'touch of a button'.

90% implementation of Health Assure functionality by December 2018

Target 2

Improving Hospital Handover Delays
National emergency care performance metrics set a standard for emergency patients arriving at hospital by ambulance to be

handed over to, and the ambulance trolley cleared by, the receiving acute Trust within 15 minutes of arrival to enable the ambulances to respond to the next 999 patient.

Ambulance handover performance across London remained challenging throughout 2015/16 and 2016/17; this continued into 2017/18 with patient's frequently experiencing handover delays in excess of 15 minutes following their arrival at emergency departments (EDs). Between January and September 2017, 62% of the patients conveyed by the London Ambulance Service (LAS) to an ED experienced a delay, waiting beyond the target of fifteen minutes for handover to on-going care. In the context of productive ambulance cover hours beyond that fifteen minute target, 49,494 hours were lost while delayed at an ED and this equates to 4,125 lost twelve hour ambulance shifts in the same period.

It is recognised that hospital handover delays is a multi-factorial system problem and we need to work together to identify issues at each stage and resolve them. The LAS will continue to work with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London during 2018-19.

Handovers over the 15, 30 and 60 minute target and total time lost, to reduce quarter on quarter against the same period in 2017/18

Target 3

During 2016-17 the Trust made significant improvements in medicines management in terms of ensuring the tracking and monitoring of drugs at station level. The next phase is to ensure that we have the most secure environments to store and monitor drug usage. The second phase of the secure drug room programme, that entails re-designing the station environment, fitting CCTV cameras and more secure locking systems will be rolled out across 2018-19. In addition we have re-designed the vehicle based bags that paramedics and other staff use when attending patients. This provides the teams with more secure storage and an ability to store all equipment that is required on scene in one holdall.

100% completion of secure drug rooms roll-out across all sectors by March 2019 to agreed stations

Target 4

During the latter half of 2016 it became apparent that there were a number of cases where defibrillation was being delayed during the management of cardiac arrest. This trend continued into early 2017 and triggered a thematic analysis. Whilst it was believed that the apparent increase in incidents might be related to the increased number of defibrillator data downloads by Advanced Paramedic Practitioners (APPs) coupled with a significant drive to increase reporting of potential incidents through the online incident reporting system (Datix). It was

identified that further work was needed to understand the root causes and ensure that learning to prevent recurrence was embedded across the Trust.

It is clearly recognised that the challenges of managing a pre-hospital cardiac arrest are very different to in-hospital where the cardiac arrest team is made up of different clinicians with per-determined and specific roles and who will have worked as a team together. The crew resource management challenges of pre-hospital cardiac arrest cannot be underestimated – the crews may never have met each other, there will be public and family to support

and manage and the equipment will initially be remote from the patient. The LAS has been accepted on human factors train the trainer programme supported by UCLH. During 2018-19, in conjunction with all other aspects of risk reduction and pathway development, we will deliver training to relevant staff to improve the management of these difficult scenarios with the aim of reducing these incidents further.

Increase the number of defibrillator downloads year-on-year to 20% by end of 2019.



Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Goal: To provide our patients with the best possible experience. Improving the care we give to vulnerable groups.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience, we need to listen to our patients, their families and carers, and respond to their feedback.

We will aim to improve our position, with our goal being to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently. The indicators outlined below will support this goal and help us determine whether our services are caring and patient centred in all aspects.

Target 1

Our work supporting patients with mental health and in sometimes complex medical conditions has been acknowledged as exemplary. As part of our Strategic Intent, we are aiming to improve and develop services that be recognised as 'pioneering' in relation to this patient group. Our aim is to ensure we have system wide collaboration with all healthcare services to provide 'seamless', timely and the most appropriate care for these patients.

We will continue to work with key stakeholders to provide the best possible outcome for these patients. This work will include supporting patients who frequently call the service during crisis or to request help that is not necessarily provided by the emergency services. We will be increasing our resource internally to enable our expert staff to work closely with providers for example, social services, to put key interventions in place more rapidly and consistently across the pan-London service provision.

Reduction in calls generated by those patients classified as frequent callers from April 2018 baseline

Target 2

Our strategy to become London's primary integrator of access to urgent and emergency care on scene, on phone, on line, requires significant changes to the way in which we deliver services to our patients. As part of this strategy is the recognised need to widen and increase our patient involvement in both the development of these new services and the monitoring of their success. The Trust will therefore develop a Patient Involvement Framework (PIF), with the support of patients, public, specific patient voluntary groups to ensure we have genuine involvement and participation and that the view of these groups are considered in any wide scale changes that we make. The new framework will also enable us to capture feedback from a more diverse patient population through the introduction of data collection methods, use of information technology, that will enable the trust to directly compare how different groups respond to and identify specific issues and the interventions to improve these.

Evidence of patient involvement in all QI and service re-design programmes.

Target 3

The LAS currently provides care to up to 9000 women a year at different stages in pregnancy, the service covers 26 maternity units and three standalone birth centres.

The services is recruiting the first Practice Leads for Pre Hospital Maternity Education across the LAS, and in the UK. They will form the Maternity team, alongside the Consultant Midwife, to lead the development of the Pan London Maternity Pioneer Service.

Maternity Pioneer Service:
The pan London maternity model will aim to:

1. a) Provide midwifery expertise within the control room environment allowing the ability to reduce the number of ambulance conveyances (up to 20% reduction)
 - b) Provide a midwife advice line to provide a resource to staff both in the control room and on scene at a maternity episode of care (increasing expert advice capacity to 50% of calls fitting criteria).
2. Provide midwifery expertise within a response vehicle alongside ambulance clinicians to be dispatched to imminent birth calls
Develop a commissioning model for pre-hospital birth, when provided by midwives within the emergency services.

The pan London model will pilot the response model in a sector across London (aligned to the Local Maternity System/STP footprint).

Alongside the Pioneer Model, a co-designed and co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model.

Reduce the number of ambulance conveyance (20%). Employ two whole time equivalent practice developments midwives and deliver a training programme 2018-19.



Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Goal: Ensure staff complaints in providing 'best practice' care and to be in the top quartile for all national clinical audit outcomes.

Clinical audit is a key improvement tool through which we continually monitor and improve the quality of care that we provide. By fully taking part in national clinical audit programmes, we are able to benchmark our performance against our peers, ensure the care we provide is evidence-based and measure improvements on a

year-by-year basis.

We aim to be in the top quartile for outcomes for all those national clinical audits in which we are eligible to participate and where data is analysed this way. This enables us to have evidence that each of our services is effective and promotes a good quality of life for our patients. Further assurance of this will be provided by compliance and training that meets the changing nature of service delivery.

Target 1

We have chosen this target to ensure that we get the best clinical outcomes for our patients. Changing the way in which we deliver care and increasing the delivery of care using a multi-disciplinary approach requires a fundamental review of the type and quality of training that we provide to our staff. In addition it is important that we ensure staff have the time to attend training, a constant pressure with the increasing demand on delivering the service we provide. We will carry out a root and branch review during the early part of 2018 to inform an improvement programme to ensure that : systems and processes are robust with strong governance frameworks; the training is appropriate and easily accessible; a revised training programme to include any further training requirements highlighted to meet the changing nature of delivery, the programmes of training align to operational delivery, and to ensure that staff are released to attend training and meet statutory requirements. We will also identify potential income generation, potential opportunities and have an identified 'training brand'. Ultimately the aim is to ensure our staff continue to provide clinically effective care based on best practice guidance.

Root and branch independent training review completed.

Implementation plan developed by September 2018

Target 2

During 2017-18 the LAS, as with all other ambulance services, implemented the Ambulance Response Pilot (ARP). The new response targets set out different response categories and set out an approach that requires Trusts to report on new quality indicators. During 2018-19 the LAS will work with the business intelligence team to ensure that we develop methods to collate and report on these new indicators. In doing so we will have clear evidence of areas where we have improved patient outcomes and also have the ability to highlight areas where we may not be meeting the standards of care that we strive to deliver.

New quality Indicators developed and being reported via performance scorecards by December 2018

Target 3

We recognise that people are the key to delivering our quality strategy. We therefore must make sure that we are supporting and training our people to make improvement continuously as well as carrying out their roles. We want to implement new ways of working to improve our processes, systems and services with transparent measurement and track progress. We have therefore decided to adopt a standardised approach to quality improvement to make this possible. The NHSI methodology is designed to support and encourage our staff by providing them with the tools they need to make sustained improvements. We want this to stimulate a culture of learning and development in improvement and ensure that change becomes the way of doing things in the Trust. As part of this process, the Trust has gained financial support during 2017-18 to increase the capability in relation to both Quality Improvement and Human Factors training programmes. We will set out an implementation plan that enables a critical mass of staff to be trained and also ensure this is aligned to our quality assurance processes to provide continual feedback, reporting and learning (see outline plan in section 1).

QI training plan agreed and 100% of identified key cohorts trained by September 2018

Target 4

The changing nature of our operating model, requires us to review the way in which our staff are allocated to their shifts. The Director of Operations will continue to work with colleagues to roll out this significant piece of work supported by our new Forecasting & Planning Team. A Trust-wide review of rosters will be completed by March 2018 with implementation due in summer 2018.

At least 2 Sector roster reviews completed by September 2018 and remaining sectors by April 2019



Responsive

Services are organised so that they meet people's needs

Goal: To consistently meet all relevant national performance targets standards through responsive patient pathways in year one, and exceed them by year three.

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events

have shown that our patients agree.

To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

As well as the national targets above, we will focus on the following targets to improve our responsiveness as a Trust to patients who complain.

Target 1

Over the last 12 months the Trust has consistently been one of the strongest performing ambulance services. It is currently the third highest national performer in implementing the new ARP standards.

Additional recurrent funding has been secured over the last six months for additional frontline and Emergency Control Services staff, and we have also introduced an additional Incident Response Team to further strengthen our resilience capability.

We will review our operational model by quarter three and work towards delivering the revised standards as set out in ARP.

in dealing with complaints from the patients and public we serve. We will undertake a review of our complaints responses, supported by our patients, to ensure that our complaints responses include the appropriate information and express our apologies in a genuine way. We will aim to further improve the turnaround time for our letters and include more information in relation to the lessons we have learned. In addition we will

continue with our patient and staff stories at the Board, which have been instrumental in making sure the executive team understand better the experiences of our patients and staff.

Over 75% of complaints letter being responded to within the 35 day timescale

Target 2

The Patient Experience Team is working with the sector teams to provide feedback and actions to enable learning from complaints. We continue to respond within timelines for complaints, meeting the majority of patient response within 35 days.

Throughout 2018-19 we will focus on improving further our processes



Well Led

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Goal: To increase the percentage of our people who have been trained and provided with leadership development.

Evidence shows that people who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their

patients. Our goal is to increase the percentage of people who would recommend our Trust as a place of work. By supporting our people to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a patient. This goal will be supported by the targets outlined below.

Well led

During 2017-18 we have strengthened our leadership team, our governance systems and processes and set out key strategies e.g. People and Organisational Development, IM&T, which will act as key enablers going forward to the delivery of our strategic objectives.

Target 1

Our statutory and mandatory training programmes ensure the safety and well being of staff and patients. During 2017-18 we moved the majority of our training to on-line e-learning and also implemented a new reporting tool on ESR to improve the ability to monitor and report compliance. We have chosen a target of 85% compliance to demonstrate that our staff comply with statutory and

mandatory requirements which have a direct impact on patient safety.

85% compliance with statutory and Mandatory training 2018-19

Target 2

Fully implement our leadership development programmes at all levels and develop a culture of professionalism, with all staff clear about their roles and responsibilities.

Leadership programme developed and implementation plan in place

Will continue to implement the P&OD strategy through 2018-19 and progress the addition of activity outlined below:

- Implement our Trust strategy and refresh supporting strategies. Working with STPs in developing and implementing system-wide improvements .
- Complete re-structures.
- Develop and implement staff communications and engagement model.
- Continue to strengthen Risk Management systems and processes.
- Continued implementation of the Quality Improvement Plan and Quality Improvement capability across the organisation.
- Maintain the focus on culture and holding people to account.
- Developing a culture of professionalism, with all staff clear about their roles and responsibilities.
- Complete re-negotiation in terms and conditions of annual leave and flexible working.
- Continue to strengthen IM&T resilience.
- Continue to develop and implement WRES improvement programme
- Continue to develop and implement Equality and Diversity Action Plans

Equality and Diversity

At LAS we are committed to promoting equality of opportunity and diversity to enhance our inclusion work. LAS has committed to ensure that equality, diversity and human rights are embedded in all areas of our employment, planning and service delivery. We strive to provide excellence in all we do and recognise the value that Inclusion brings. We are committed to ensuring that all our employees are treated with dignity and respect and given equal opportunity and encouragement to progress and develop within the organisation.

We strongly believe that diversity and inclusivity in all its forms delivers greater impact in the work we do and enhances the services we deliver to Londoners. Our commitment to the principles of Diversity and Inclusion informs all of our work with our people.

Section 3:

Looking Back: Quality performance 2017-18

The progress against our targets and goals we set out in our Quality Account 2017-18 are outlined here, under the quality domain headings.



Quality Priorities 2017-18

The priorities for 2017-18 as set out in our previous Quality Account (2016) are highlighted below against the 3 domains for quality, Patient Safety, Experience and Effective care. Progress against each of the domains is provided, where relevant impact key performance indicators are included

Patient Safety

During 2017-18 we introduced and established a new integrated Quality & Assurance directorate which aligns quality functions into one directorate. Recruitment to new posts has now concluded and the structure brings both an increase in capacity and capability to the quality agenda across the trust. Quality governance frameworks have been reviewed and rationalised with clear lines of reporting via new Terms of Reference, minutes and key issue reports to provide assurance and allow escalation of issues from 'floor to Board'. A risk management improvement programme has also been developed and continues to be implemented to identify key safety and quality risks more accurately and to ensure staff are trained in identifying risks and regularly review and assess risks to patient safety and quality of care.

Target 1: Development of pathways for patients who fall, have mental health issues, are at the end of life and bariatric.

Our strategic intent document, developed during 2017-18, sets out the further system wide pioneering services we aim to develop and deliver during 2018-19 and onwards. This year work has progressed in relation to mental health support, with increased training, alternative care pathway development, data sharing alongside the recruitment of an additional 3 mental health professionals to provide advice in the clinical hub and support the initiation a mental health response car. This is a pilot to enable mental health clinicians to work alongside paramedics to respond to patients undergoing a mental health crisis, and commenced in December 2017. This will be evaluated and, if successful, rolled out to other sectors.

In addition the Trust has been successful in gaining funding for three full time staff to provide dedicated support to End of Life care providing advice and training for staff in giving support to families and patients at end of life. In addition clinical audit, alternative care pathway utilisation and service development will also be part of this remit.

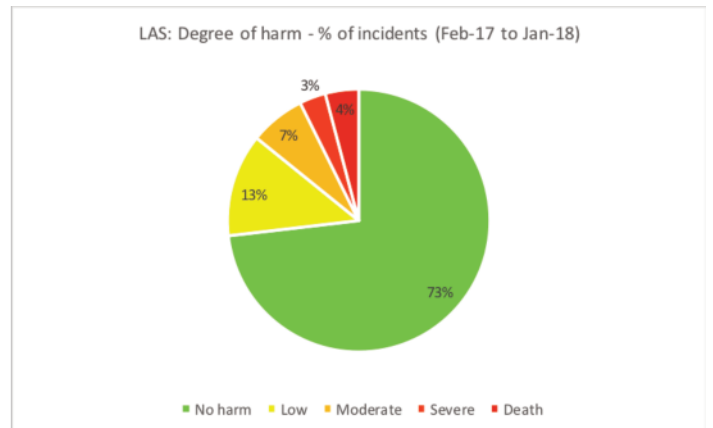
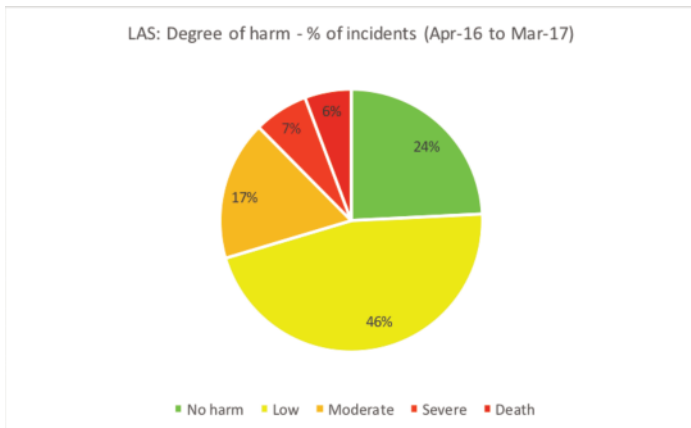
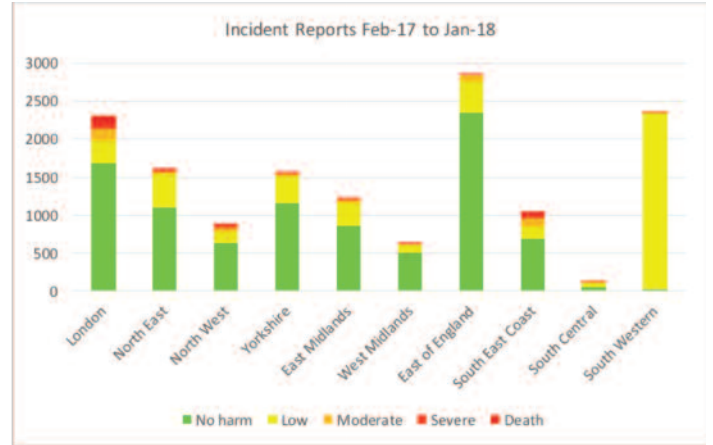
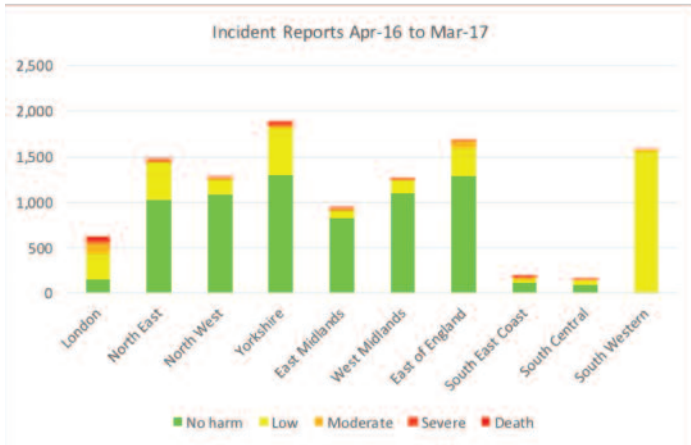
A Bariatric equipment business case is being presented to ELT at the end of February 2018, this outlines a significant investment, this will need to align to the current logistics work programmes and consider the impact of the ARP future operating models. In addition considering the type of equipment and support we require to ensure these patients have effective and dignified care.

Target 2: Improve and embed learning from incidents

A learning and quality improvement framework was agreed by the Board in November 2017 and is now being implemented, supported by a communication strategy. Implementation will be complete by March 2018 and continuous embedding of the framework will continue, supported by the revised quality assurance framework. In addition monies to train a cohort of staff in quality improvement methodology and human factors was also provided by NHSI. This programme of work will start in July 2018 and continue throughout 2018.

We have evidence of learning from incidents from the inclusion of feedback in core skills refresher courses, various changes to working practices, i.e. ventricular fibrillation, managing patients with spinal injuries. During 2017-18 we had an independent review by our internal auditors (KPMG) who gave the Trust Significant Assurance rating with regard to the serious incident investigation and learning process.

In addition our no/low harm reporting rates have improved to a currently in the higher quartile compared to national benchmarked levels during 2017-18. LAS are now reporting over 90% of incidents within the no/low harm category (see charts opposite).



Learning from experience

Below show some examples of where the Trust have made improvements as a result of serious incident investigations:

- 1 Change in practice regarding the management of cardiac arrests as a result of a significant number cases concerning delayed defibrillation
- 2 Changes within the Gazetteer system to improve the accuracy of locations across London
- 3 Policies that have been identified to be unfit for purpose have been reviewed and updated
- 4 Improved training, compliance audits and the development of a new policy for the management of breached Patient Group Directions
- 5 Guidance issued to staff on the management of paediatric patients with particular focus on the measurement of oxygen saturations
- 6 Development of a feedback mechanism of all maternity related incidents to the maternity training programme
- 7 Process for investigating and managing thematic reviews of similar incidents. For example; delayed defibrillation and the Non-emergency Transport Service
- 8 Equipment concerns highlighted to the equipment replacement programme which assisted in the development of business cases to replace specific pieces of equipment
- 9 Learning from incidents training delivered to all EOC staff and included on the paramedic academy courses
- 10 Incorporation of case studies to the internal leaning from incidents Insight magazine
- 11 Changes to practice included in core skills refresher courses for both EOC and frontline operations
- 12 Case studies included in the internal Clinical Update magazine

Patient Experience

Target 1: Effective and consistent risk assessment completed for patients presenting with a mental health crisis

Revision to the risk assessment tool and training have been introduced during the year, we have seen an improvement in the quality of mental health assessments, with a current average of 91% of core criteria being recorded as demonstrated through the monitoring of monthly clinical performance indicators. In addition bespoke training has been delivered by our mental health nurses to staff within our emergency operation centres, call handling staff and clinicians; to specialist response teams such as the joint response unit; to specific cohorts of staff such as incident response officers and clinical team leaders (with over 200 staff trained in specific areas such as mental capacity). We anticipate the introduction of mobile devices will further improve our ability to carry out and record assessments real-time with guidance immediately available from various 'apps' that staff can access quickly on-scene.

Target 2: Improved compliance with Infection Control standards

Infection control issues identified internally and through CQC, have improved significantly, we are seeing the majority of sectors showing over 90% compliance

against their monthly performance on hand hygiene. Infection control practices at A&E have also improved, vehicle cleaning remains an area of focus as does hygiene standards in some identified stations. These are being closely monitored through regular quality assurance visits. We will utilise more fully the Perfect Ward app to allow digital uploads of data from station visits during 2018-19

Target 3: Ensure patients have timely and appropriate access to services

System wide demand management projects to improve care and experience of patients have seen improved response times, with the Trust meeting the majority of targets consistently.

Work undertaken with specific frequent callers has shown

considerable reductions utilising a multi-agency approach to case management to our highest volume callers. However we are reviewing the resources required to support the delivery of a programme to increase the potential of reducing the significant impact this patient group have on demand in 2018-19. The aim will be to enable case management to be undertaken for a larger number of cases through increasing capacity within the current dedicated frequent caller team, allowing increased involvement in system wide initiatives, evaluation of interventions on patient outcomes, patient experience, operational and system wide performance.

Trust-wide performance:

Consistently meets response targets under the new operational model as outlined on page 38, Table 12.

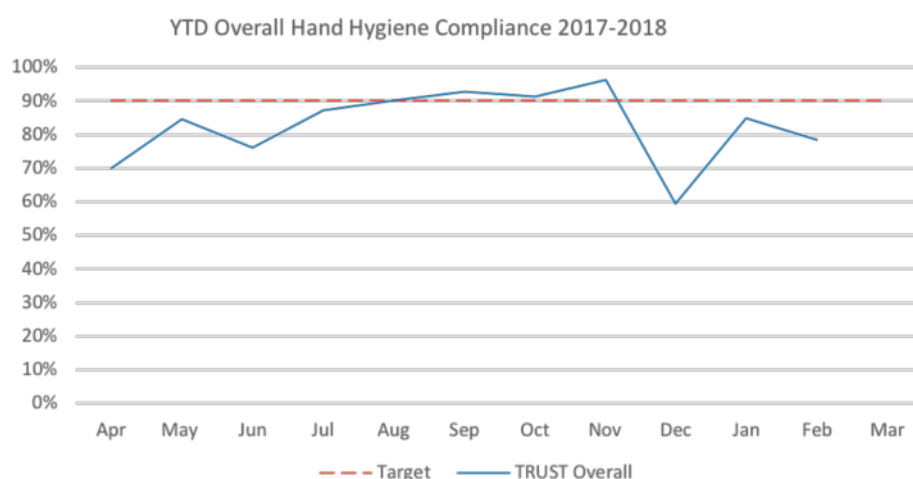


Table 3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Trust Overall	97.0%	97.0%	94.8%	94.3%	96.8%	95.7%	93.0%	95.0%	95.0%	93.0%	91.0%
North East	95.0%	95.0%	97.8%	96.2%	96.0%	97.0%	98.0%	98.0%	98.0%	98.0%	97.0%
North Central	99.0%	99.0%	82.5%	91.2%	97.0%	97.0%	97.0%	90.0%	97.0%	91.0%	97.0%
North West	99.0%	99.0%	98.3%	98.0%	98.0%	96.0%	96.0%	93.0%	96.0%	98.0%	98.0%
South East	99.0%	98.0%	98.3%	95.5%	97.0%	98.0%	99.0%	97.0%	95.0%	95.0%	99.0%
South West	97.0%	97.0%	94.0%	94.0%	96.0%	98.0%	99.0%	97.0%	95.0%	95.0%	96.0%
Others							95.0%	95.0%		100.0%	91.0%
HART							65.0%	81.0%	89.0%	80.0%	65.0%
NETS	93.0%	93.0%	9.3%	91.0%		88.3%	96.0%	95.0%	83.0%	87.0%	85.0%

Clinical Effectiveness

Target 1: Improve outcome as reported Ambulance Quality Indicators

We have implemented and constantly measure best practice models of care following the introduction of the Ambulance Response Programme (ARP) in October 2017. Currently we are 3rd best performing ambulance trust nationally against these response time indicators.

We have maintained our programme against the Stroke Care bundles at 96%. However, in relation to STEMI patients we are below the national average. We will continue to focus on this.

Target 2: Standardise hospital handovers including the use of NEWS for the sickest patients

We recognised that hospital handover delays is a multi-factorial system problem and we needed to work together to identify issues at each stage and resolve them. The LAS has worked with key stakeholders from across London in an approach to assuring the safety of ambulance handovers and delivering improved performance and a reduction in the average duration of ambulance handovers across London.

ED Site visits up to October 2017

The Emergency Care Improvement Programme (ECIP) were tasked to complete a series of site visits and assessments leading to improvement recommendations at various acute hospitals. Follow up visits commenced in October/November to measure progress against the individual recommendations made by ECIP. This work has also included widespread sharing of Patient Flow guidance with operational leads at each acute site and the identification of LAS contacts for trusts.

LAS engagement managers have worked with their local EDs to support ECIP led initiatives designed at reducing the potential for handover delays to occur. By identifying patients who could either wait or be seen in a hospital chair (#fit2sit). Or through reviewing the conveyance choices made by LAS clinicians (Front Door Challenge); for example could their patient of been seen in another area of the department, or have been conveyed/referred to an alternative pathway.

Sharing of LAS predicted data
Predictions of LAS activity for conveyance numbers by day of week/hour to each ED were shared to support stakeholders in their winter planning. LAS predicted activity is shared weekly with the NHS E Winter Room for inclusion in its daily update report

Cohorting process

Patient cohorting is a process whereby ambulance clinicians handover the care of their patient to an ED clinician immediately after triage regardless of bed availability. This can allow ambulances to become available for dispatch to another incident more quickly; it is the responsibility of Acute Trusts to implement and staff this. Ambulance-led cohorting is the same process, but is implemented and staffed by the LAS because it is felt that the risk of not doing so would be to the significant detriment of the Trust and patient safety. A standard process for Cohorting across London including the triggers and reporting process for when it can be used has been designed and implemented with the agreement of NHS E.

NEWS is based on a simple scoring system which allocates a score to physiological measurements in adult patients. The aggregate NEWS score provides an indication of how unwell the patient is. Patients are assessed and attributed a score and category (Red ≥ 7 , Amber 5-6 and Green < 5) the categories are regarded as high, medium and low risk respectively. The trial started on 21.12.17, a NEWS card is attached to the patient whilst waiting where handover is delayed and/or cohorting is implemented. The card is contained within a plastic wallet, an elastic band is used to attach the card to the patient's wrist. The card is folded to ensure that the appropriate red, amber or green

Table 4

	2017-18*		2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)

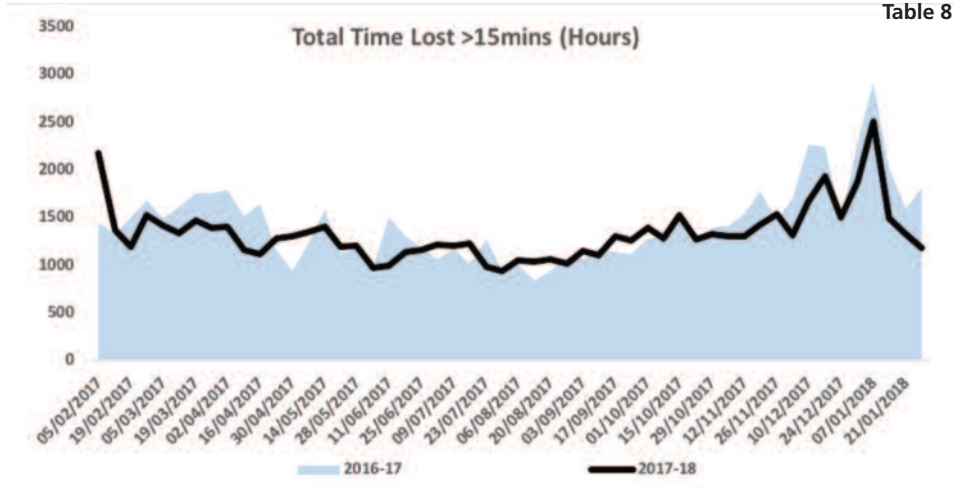
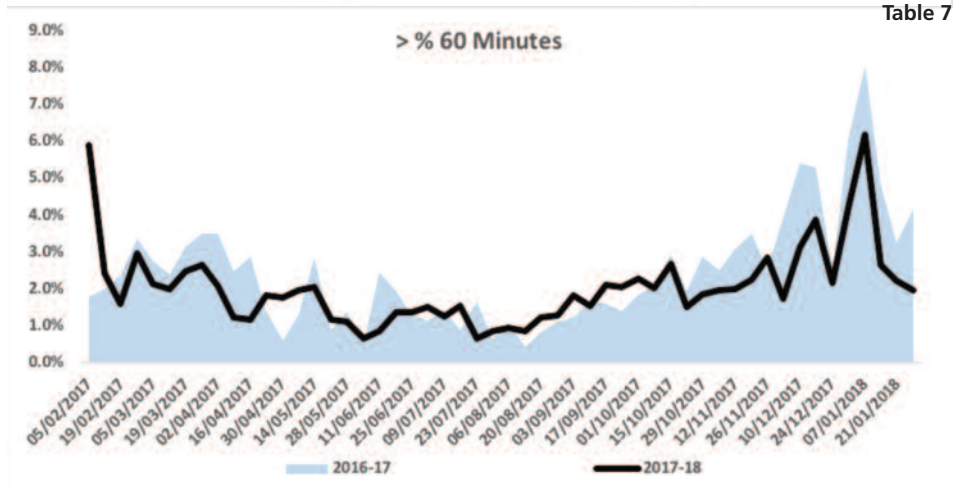
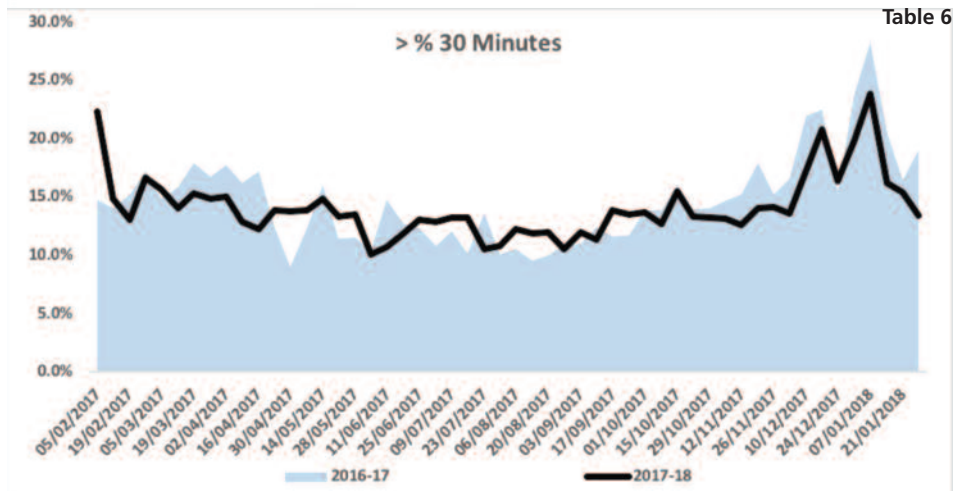
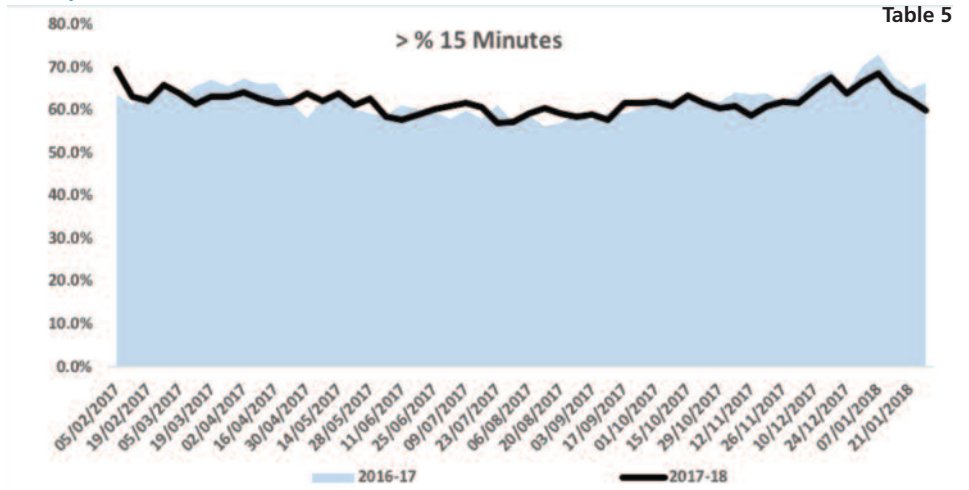
*At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.

page is visible before being placed into the plastic wallet which is then attached to the wrist of the patient. It is intended that staff would commence use of NEWS cards where the anticipated wait is likely to exceed 30 minutes and in all cases where Cohorting is commenced. The NEWS is reassessed every 30 minutes until the patient is handed over to ED staff. The trial aims to assess the impact of handover delays on patients, assisting in the identification of unwell or deteriorating patients.

Performance update Jan 2018

As the following charts highlight hospital performance in 2017/18 when measured by handovers over the 15, 30 and 60 min target and total time lost has improved against the same period in 2016/17

Our work on hospital handovers has been recognised as outstanding practice and has played a significant role in reducing waiting times for patients, we will continue this work through 2018-19.



Target 2: Develop a mortality and morbidity review process

We have introduced a mortality review group to ensure information is available in relation to specific groups/themes to target learning and improvement. We are also working with other ambulance trust to ensure we have a standardised approach to share learning across different organisations. The outcome of the analysis is aggregated with information from SIs, incidents, complaints, claims to provide identification of themes and focus improvement efforts. Preventing Future Deaths notices are now reported into this group and also discussed at Quality Oversight Group to enable thematic analysis of trends across all incidents.

We are also working with other ambulance services to agree a standardised approach to mortality reviews and to share learning across different services.

Conclusion

Our progress during 2017-18 has been significant and has brought about much improved outcomes for our patients, as demonstrated in this section of the report. We will strive to continually improve and sustain that improvement through our quality improvement plans for 2018-19 and beyond.



Section 4:

Statements of assurance from the Board

Statements mandated by NHS England

Each year we are required to report a number of mandatory statements, which you will find reported in this section:

Data Quality Assurance

The London Ambulance Service manages data quality for Accident & Emergency information, using a bespoke application developed internally. All information received from the 999 CAD system, Command Point, Mobile Data Terminals (MDT) and Patient Report Forms (PRFs) is processed through this application. Within the application, records that satisfy any of the pre-defined validation rules are presented for reviewing, and can be amended where necessary, if there is adequate evidence available to do so.

Records are reviewed for:

- Illogical time sequences between timestamps
- Unlikely gaps between timestamps
- Incorrect hospital codes
- Missing timestamps where one would be expected
- Conveyances by non-conveying vehicles
- Patient Handover breaches at hospital
- Mismatched Patient Report Forms (PRFs)
- Discrepancies between Command Point, MDT, and PRF data

A facility is available to allow staff outside of Management Information to request a review of any data items. These data quality queries are submitted via the

Business Intelligence (BI) Portal for consideration by the Data Quality team to ensure that they meet agreed rules. No-one outside of the Data Quality team within MI can make amendments to any records. There is an audit history for any record flagged for reviewing, and all changes and actions taken (or not taken as the case may be) are logged with the username/change made/date/time.

All reports produced by the Business Intelligence team follow a pre-determined check list to ensure accuracy and compliance with Ambulance Quality Indicator guidance. Every report is peer reviewed and approved by a senior member of the team prior to publication

A report demonstrating compliance against the Ambulance Quality Indicators (AQI) guidelines is submitted annually to Executive Leadership Team (ELT) for approval. A data quality strategy is under development to be approved by the Trust Board in 2018.

Income

The income generated by the NHS services reviewed in 2017 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2017/18.

Clinical Effectiveness and Audit

The London Ambulance Service NHS Trust has a robust clinical audit and research programme that focuses on both local and national areas of priority. In 2017/18 the LAS examined the care provided to a wide range of patients including those that had a heart attack, cardiac arrest, stroke, trauma, mental health related conditions and paediatric care. Our research programme continued to grow and alongside our existing cardiovascular studies (including the world's largest randomised controlled trial of adrenaline in cardiac arrest), we launched a new randomised control trial examining whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest.

In addition to continuously assessing the care provided to

cardiac, stroke and trauma patients, during 2018-19 we will focus on sepsis care with the introduction of a new continuous registry. We will also continue to audit the appropriateness of decisions made for patients who are discharged at scene and then re-contact the Service within 24 hours having severely deteriorated or died unexpectedly.

Clinical audit

During 2017/18, only one national clinical audit 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 audit and national confidential enquiries that the London Ambulance Service NHS Trust was eligible to participate in during 2017/18 are as follows:-

NHS England Ambulance Quality Indicators: Clinical Outcome measures 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

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2017/18, 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.

The London Ambulance Service NHS Trust submitted the following

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
NHS England AQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 1,962 b) 263	a) 1,962 b) 263	100%
NHS England AQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 1,881 b) 235	a) 1,881 b) 235	100%
NHS England AQI: Outcome from acute STEMI a) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. b) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 658 b) 1,531	a) 658 b) 1,531	100%
NHS England AQI: 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) 3,737 b) 6,411	a) 3,737 b) 6,411	100%

Table 9

	2017-18*		2016-17	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	69.9%	76.5% (64.3% – 91.7%)	70.6%	79.3% (60.5 – 90.8)
Stroke patients	96.9%	97.1% (94.1% - 99.8%)	96.8%	97.6% (94.4 – 99.2)

*At the point of preparation of this Quality Account, NHS England reported data for April to September 2017.

information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2017/18 and 2016/17.

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

The reports of the above national clinical audits were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust has taken actions to improve the quality of healthcare provided as set out in Appendix 1.

CQUINS

A proportion of London Ambulance Service NHS Trusts income in 2017/18 was conditional on achieving quality improvement goals within the contract. The 2017/18 CQUIN schemes were set according to the Commissioning for Quality and Innovation payment framework and either set nationally, or agreed with the lead Commissioner, Brent CCG, acting on behalf of the pan-London CCGs. Further details of the agreed goals for 2017/18 are detailed in Appendix 2. Achievement will be confirmed following the final Q4 submission, due in April 2018.

Serious Incidents (SIs)

A total of 459 cases were reviewed by the Serious Incident Group in 2017/18. Of these, 92 incidents were deemed to meet the criteria to be declared as serious to NHSE.

In July 2017 the SI investigation process was reviewed and significant changes made. The process was launched in August 2017. Improvements were made to the DatixWeb system to enable clearer monitoring and enhance compliance with internal and external deadlines. Current Lead Investigators across the Trust attended an update/refresher training day and the Quality, Governance and Assurance Team provide serious incident investigation training each month for new investigators. As of March 2018 a total of 57 managers have been trained to investigate serious incidents. To assist in times of high operational demand, significant efforts have been made to utilise managers from other areas of the Trust. Of the 57 trained investigators 38 are operational managers and 19 are from non-operational backgrounds.

Currently the Trust does not have any serious incident investigations that have breached the 60 working day deadline to the CCG. During January 2018, the Trust instructed KMPG to undertake an independent audit of the revised serious incident process. The outcome of this provided significant assurance that the Trust was investigating incidents effectively, actions were taken in a

timely manner, patients and relatives were informed and staff were supported.

Quarterly thematic reviews have shown issues concerning call handling and dispatch and clinical treatment. Themes from the reviews have been shared across the Trust and actions to address the concerns have been incorporated into an intensive actions plan for the Emergency Operations Centre (EOC). Additional actions have been taken in relation to the clinical treatment concerns and are detailed below.

Learning from experience

Below show some examples of where the Trust have made improvements as a result of serious incident investigations:

- 13 Change in practice regarding the management of cardiac arrests as a result of a significant number cases concerning delayed defibrillation
- 14 Changes within the Gazetteer system to improve the accuracy of locations across London
- 15 Policies that have been identified to be unfit for purpose have been reviewed and updated
- 16 Improved training, compliance audits and the development of a new policy for the management of breached Patient Group Directions
- 17 Guidance issued to staff on the management of paediatric patients with particular focus on

the measurement of oxygen saturations

- 18 Development of a feedback mechanism of all maternity related incidents to the maternity training programme
- 19 Process for investigating and managing thematic reviews of similar incidents. For example; delayed defibrillation and the Non-emergency Transport Service
- 20 Equipment concerns highlighted to the equipment replacement programme which assisted in the development of business cases to replace specific pieces of equipment
- 21 Learning from incidents training delivered to all EOC staff and included on the paramedic academy courses
- 22 Incorporation of case studies to the internal leaning from incidents Insight magazine
- 23 Changes to practice included in core skills refresher courses for both EOC and frontline operations

24 Case studies included in the internal Clinical Update magazine

Future developments

During 2016/17 the Chief Quality Officer led an in-depth review of the serious incident process with the objectives to review the time taken to investigate incidents and improve the sharing of learning from investigations. The reviewed process amended and three nominated Executive Directors now form a panel for reviewing and signing off reports.

The focus for 2018/19 will be centred on the development of the Quality Governance and Assurance Team. To date the team has a newly appointed Head of Quality Governance and Assurance, current roles have been reviewed, job descriptions developed or updated and clear lines of responsibility have been assigned. Work will continue to appoint a dedicated risk manager and a team of business partners to provide an additional level of support to the serious incident process and lead investigators.

Duty of Candour

Duty of Candour training is part of the mandatory training for all relevant members of staff and is valid for three years. Currently 4,446 (87%) members of staff have completed the training. Additionally all Lead Investigators are provided with the regulation 20 compliance requirements, its place within the serious incident process and the history of the regulation.

The role of the lead investigator will include the requirement to have a robust working knowledge of the Duty of Candour process and these individuals will be responsible for ensuring compliance will all investigations assigned to them. Further support regarding the Duty of Candour is found in both the revised Duty of Candour Policy and Serious Incident Policy. To improve the monitoring of Duty of Candour compliance in relation to serious incidents and those graded as moderate harm, the Datix Web system was developed to include a section dedicated to the individual stages and allows for compliance reports to be reviewed.



CQC

Following the June 2016 Care Quality Commission (CQC) inspection of the service, the LAS developed a Quality Improvement Programme (QIP) which was a single overarching plan to address quality improvement in the Trust. A clear programme of delivery, accountability and governance was established, led by the Chief Quality Officer and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our QIP via Executive Leadership Team meetings and via Quality Oversight group, Quality Assurance Committee and Board.

This Quality Improvement plan has been delivered the majority of actions completed, with a number of actions being incorporated into business as usual for Directorates; projects of a more complex nature, which are yet to be completed, are being incorporated into the 2018/19 Business Plan.

The CQC has conducted a Well-Led inspections of The London Ambulance Service NHS Trust on March 21st and 22nd 2017 . Two unannounced visits were also carried out in:

- Emergency Operations Centres
- Urgent and Emergency Care sites

The final report will not be available prior to the publication of the annual Quality Account, however initial feedback is positive and the report will be available in May 2018.

Safeguarding

The London Ambulance Service NHS Trust are continuing to ensure the safeguarding of children and "adults at risk" this remains a focal point within the Trust, which is committed to ensuring all persons within London are protected at all times.

The Trust has seen an increase of incidents and safeguarding concerns raised by our staff to 1.95% reporting around 1800 concerns a month to the local authorities. The Trust has recruited a full time administrator to assist with the increased workload.

During the year we have introduced two new policies:

- Safeguarding supervision policy
- Chaperone policy

We have also improved our governance arrangements and introduced several quality assurance practice review groups that scrutinize concerns raised by staff and ensure best practice to protect those at risk.

- Child Death Review Group
- Safeguarding Incident Review Group
- Care Home Review Group
- Prevent Review Group

The Trust continually seeks to learn from practice and detailed below is some of the learning from safeguarding cases in 2017-18:

- A Safeguarding Adult Review (SAR) Found that the LAS and other agencies failed to notify the police of severe neglect, we are now working in partnership with the police and have produced materials on the importance of involving the police in safeguarding cases and provided training to over 90% of clinical staff.

We have also written an article for the Trust "Clinical News"

- Following a Serious Case Review (SCR) it was felt staff did not gain enough information about a situation and missed vital facts. We have since improved our safeguarding training and included a section on professional curiosity.



- The Trust has also introduced an escalation policy for repeat safeguarding concerns raised by staff, this is a result of several case reviews which identified we made multiple referrals for patients, but these were unsighted and no additional action was taken.

The Trust continues to improve its safeguarding practice and during 2017-18 has:

- Established pathway for young violence referrals to "Red Thread"
- Increased partnership working and engagement
- Introduced safeguarding supervision
- Fully integrated 111 safeguarding into Trust processes
- Improved response for safeguarding information to partners through recruitment of a full time administrator.

The Trust has a good working relationship with a wide range of partners. Working in Partnership is vital to protect people from abuse and neglect. The Safeguarding Team continues to support and educate staff to recognize the signs of abuse and neglect, report concerns and monitor and assure safeguarding practices through on going audit review groups.

Staff Survey

For 2017 the survey was sent to all Trust staff electronically for the first time. Of 4970 eligible employees 2664 questionnaires were completed, giving an overall response rate of 54%. This is the highest ever response rate for the Trust and supports the determination of the Executive Team to gain extensive feedback on the employee experience to inform developments and focus for 2018/19.

The average response rate across all Ambulance Trusts was 46%. LAS' response rate is therefore significantly higher than other Ambulance Trusts.

The main published report sees the findings of the questionnaires summarised by the national survey centre Picker Europe, on behalf of the Department of Health, presented in the form of 32 Key Findings (KF). This year the Key Findings are presented under nine themes listed below:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

Overall indicator of staff engagement

The staff engagement score ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their Trust) and 5 indicating that staff are highly engaged.



The Trust score was 3.36 compared with 3.39 in 2016.

The overall indicator for staff engagement is calculated using three key findings:

- Staff recommendation for the Trust as a place to work or receive treatment
- Staff motivation at work
- Staff ability to contribute towards improvements at work

Summary of Key Improvements and Developments

The categories where the Trust has performed better are:

- Working patterns
- Patient care and experience
- Reporting incidents

The categories where the Trust performed less well are:

- Violence, harassment and bullying
- Equality and Diversity

The key findings which benchmarked higher than other Ambulance Trusts were:

- % satisfied with the opportunities for flexible working
- Effective team working

By key finding, the areas where the Trust needs to focus improvement is:

- % staff appraised in last 12 months

- % believing the organisation provides equal opportunities to career progression/promotion
- % reporting good communication between senior management and staff
- % agreeing that their role makes a difference to patient/service users
- % experiencing harassment, bullying or abuse from staff in last 12 months
- % reporting most recent experience of harassment, bullying or abuse

Key staff groups

Gender

Women had more positive scores overall than men (26 out of the 32 key findings). Women had a staff engagement of 3.43 compared with 3.34 for men. Slightly less women had appraisals (73% v 75%) and also scored higher in levels of work related stress and attending work despite feeling unwell. None of these scores were statistically significant differences.

Black and Ethnic Minority staff

In 21/32 key findings BME staff had a more positive response than white staff. An additional 2 key findings had the same score. BME staff had a staff engagement score of 3.43

compared with 3.36 for white staff. BME staff had higher levels of job satisfaction except for their perceived ability to contribute towards improvements at work. BME staff reported higher rates of experiencing bullying and harassment from white staff (38% v 31%) and a slightly lower rate of reporting (30% v 31%). Levels of appraisal were 5% less for BME staff and they also rated the quality of training lower.

The scores with the most significant difference were in relation to Equality and Diversity. 37% reported experiencing discrimination at work compared with 26% of white staff and 47% felt that the organisation provides equal opportunities for career progression and promotion compared with 62% of white staff.

Taking Action

All actions will be later found by a network of Staff Survey Champions, these have been identified to create

and deliver action plans locally across all areas of the Trust. Champions have been encouraged to work with their local union reps in taking forward this work. Each Champion has been provided with a survey report for their area and will engage with their colleagues to identify the areas for improvement and potential actions. It was recommended that each action plan focused on 3 actions.

Champions came together to provide them with an overview of the staff survey outcomes and a toolkit to support the development of action plans. Follow up events will be planned during the year to provide an opportunity to update on progress, share ideas and provide support in the development and delivery of action plans. Basecamp (an online sharing platform) has been set up as a document repository and as an area to share information and provide peer support.

As each local area has been asked to

identify 3 actions, the Trust decided upon a Corporate action plan to supplement this with 3 Service wide actions based on the 3 key findings which had a statistical decrease in 2017.

These are:

- % believing the organisation provides equal opportunities for career progression (by 14%)
- % able to contribute towards improvement at work (by 4%)
- % reporting good communication between senior management and staff (by 3%)



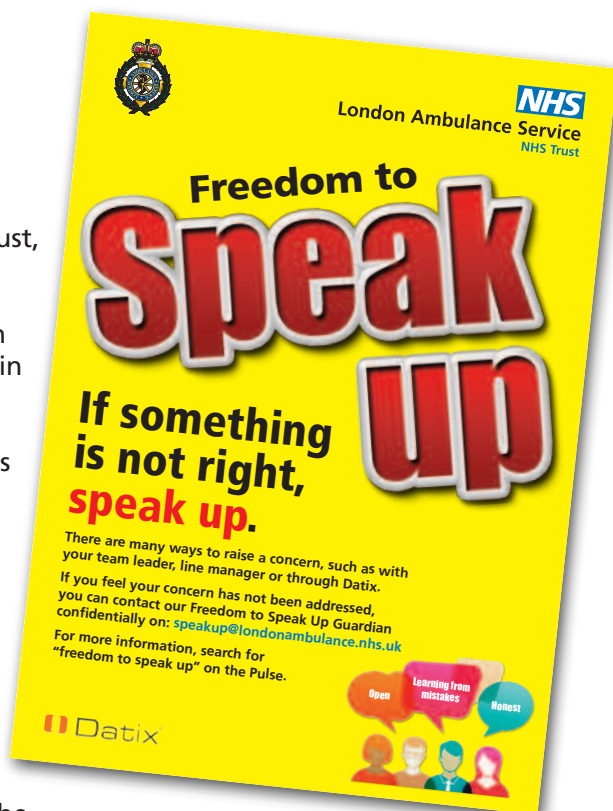
Freedom to speak up

Freedom to Speak Up Guardians have been introduced in each NHS Trust, as a result of the recommendations in the Francis Report. A Guardian was appointed at the LAS in October 2016, and undertook this role in addition to her core role as Head of Patient & Public Involvement and Public Education. She stepped down at the end of December 2018, to be replaced by a full-time interim Freedom to Speak Up Guardian, who was tasked with promoting the role in the Trust and facilitating the recruitment of a permanent Guardian.

Since the role was introduced the Trust has:

- Announced the role in the internal Routine Information Bulletin and produced a leaflet to be attached to staff payslips.
- Established a Freedom to Speak Up LAS group, with dates to meet quarterly.
- Agreed reporting arrangements to the Trust Board.
- Designed a secure recording and reporting module on Datix, which is only visible to the Freedom to Speak Up Guardian.
- Hosted a successful visit by colleagues from the National Guardian's Office.
- Had its Freedom to Speak Up arrangements audited by KPMG. The LAS was the first NHS organisation to have taken this action.

The LAS Guardian has attended the national launch and undertaken the Freedom to Speak Up training. He is a member of the London regional network and national ambulance



network for Freedom to Speak Up Guardians.

Since the role has been introduced, a total of 9 concerns have been reported. The majority of these have related to a bullying culture across a team or part of the organisation, two have related to trust processes, two to patient safety concerns, and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements. Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.

Information Governance

London Ambulance Service NHS Trust Information Governance Assessment Report overall score for 2017/18 reached 83% satisfactory, Level 2 for all requirements.

National Reporting

London Ambulance Service NHS Trust did not submit records during 2016/17 to the secondary users service for inclusion in the Hospital Episode Statistics.

London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Section 5:

Reporting on core indicators

Table 11

In October 2017/18 the ambulance response categories changed following the national implementation of Ambulance Response Programme. The figures below will therefore represent the category achievements to October and the changed categories from October to March 2018.

April to October categories

Cat A These are calls or incidents categorised as immediately life threatening, Cat A subdivides into Red 1 and Red 2. The categories are based on AMPDS codes provided by the Department of Health.

Category A % reached in 19 mins:

The percentage of Cat A incidents where any responder capable of conveying a patient arrived at the scene of an incident within 19 minutes. This is measured from clock start to when the first conveying vehicle (MRU/CRU – if only vehicle) arrives on scene. The target is 95% within 19 minutes.

Red 1

This is a subcategory of Cat A, these are the category of calls that are deemed the most time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from call connect to when the first responder arrives on scene.

Red 2

This is a subcategory of Cat A, these are the category of calls that are deemed serious but less immediately time critical, with a requirement for an emergency response arriving at the scene of an incident within 8 minutes (75% Target). This is measured from either first dispatch, determinant or 240 seconds and the clock stops

	A8			A19		
	R1	R2	A	R1	R2	A
Apr-17	79.38%	73.63%	73.83%	98.98%	95.44%	95.56%
May-17	73.71%	71.90%	71.96%	98.60%	94.94%	95.06%
Jun-17	73.61%	69.75%	69.88%	98.38%	94.26%	94.39%
Jul-17	72.51%	68.55%	68.69%	98.64%	94.01%	94.17%
Aug-17	74.47%	72.05%	72.14%	98.54%	94.32%	94.47%
Sep-17	70.70%	68.47%	68.54%	98.23%	93.75%	93.90%
Oct-17	73.28%	68.65%	68.82%	98.90%	94.79%	94.94%
2017/18	73.90%	70.40%	70.52%	98.61%	94.50%	94.64%

when the first responder arrives on scene.

Table 11 demonstrates our achievement of these category calls during 2017-18 from April to October.

The month on month performance for A8, A19 and the year end position. As the Ambulance Response Programme was implemented on the 1st November 2017, year end position is calculated from April to 31st October 2017. By way of comparison, the 2017/18 year end position shows a considerable improvement at the same point for 2016/17. (from April to October 2016). This improvement is more noticeable for the A8, Red 1 (R1) and Red 2 (R2) measures. The overall A8 measure increased by 4.51% from 66.01% in 2016/17 to 70.5% in 2017/18. Red 1 performance increased by 5.27%, from 68.64% in 2016/17 to 73.9% in 2017/18. Red 2 performance improved by 4.47% from 65.93% to 70.40%.

Table 12

System Indicators Post ARP implementation	C1 Mean (00:07:00)	C1 90 th Centile (00:15:00)	C2 Mean (00:18:00)	C2 90 th Centile (00:40:00)	C3 90 th Centile (02:00:00)	C4 90 th Centile (03:00:00)
November 2017	00:07:03	00:11:28	00:18:25	00:36:28	02:13:10	02:28:48
December 2017	00:07:23	00:12:04	00:24:07	00:51:08	02:58:23	02:51:44
January 2018	00:07:08	00:11:43	00:20:23	00:42:05	02:24:59	02:19:05
Current YTD (2017/18)* * From 1 st November 2017 – 11 th February 2018	00:07:13	00:11:46	00:21:14	00:44:13	02:32:34	02:31:55

System Indicators – Post ARP Implementation

The above table shows the six key indicators and our performance since the Ambulance Response Programme was implemented (November 2017). Performance in all 6 measures improved in January 2018, seeing a reduction of the time taken to respond to patients compared to December. The most significant improvement was seen in categories 3 and 4 where there was

a reduction of over 30 minutes for C3 and C4 90th centiles. The C1 mean performance has been stable week on week since November 2017, which is reflected in the monthly performance. January 2018 shows a reduction by 15 seconds to 7 minutes and 8 seconds. This is marginally above the national standard of 7 minutes. C1 90th centile shows each monthly performance successfully within the national standard of 15 minutes, this is also reflected in the year to

date position at 11 minutes and 46 seconds. C2 mean is above the 18 minutes by a few minutes each month. The year to date position shows 3 minutes and 14 seconds above the national standard. C4 90th centile has remained within the national standard of 3 hours every month since the implementation of ARP. The year to date performance is within the national standard by a substantial 28 minutes and 5 seconds.



Complaints and Patient Advice & Liaison (PALS)

Introduction

Patient experience and feedback is a rich source of information that allows us to understand whether our services are meeting the standards we set ourselves and meeting patients' expectations. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously and do our best to offer a comprehensive response, clearly identifying any lessons and using these to improve our service, where appropriate.

It is important to ensure that patients' voices can be heard. To this end, and to compliment the information we already have available, this year we introduced two new leaflets under the banner of 'Talking With Us'. The first is available on all ambulances,

providing information about how to make a complaint or to thank our staff; the second is sent out with every complaint response, inviting complainants to feedback on their experience of making a complaint.

Activity

Year ending March 2018, the volume of complaints dropped slightly, totalling 938 against 1016 in 2016/17. Enquiries continue to increase 4277 against 4215 being received in 2016/17. The PTS service has reduced dramatically, now operating as NETS. NHS 111 complaints (via LAS) are also hosted by the team.

The Resource Escalation Action Plan (REAP) was used during persistent periods of high 999 call demand meant that the REAP level for this year was mostly implemented at moderate or severe. The daily average for 999 calls is currently 5185. The average percentage of complaints received against calls **attended** is [0.08%].

Complaint risk score – to 21/02/18

During 2017/18, 26 complaints and one PALS enquiry were referred to the Serious Incident Group. Of these, eight were declared as a Serious Incident.

Risk grade 2017/18	Data
Low	807
Moderate	125
Significant	5
High	1
Total	938

Complaint outcomes details

If a complaint is upheld, learning will be noted and actioned accordingly. This can involve a range of measures including feedback, reflective practice and bespoke training held locally, with emerging themes reported to the relevant department/Governance Committee to consider action. The Patient Experience Annual Report, published later this year, will provide a comprehensive analysis.

Table showing complaint outcomes of **closed** complaints 2017/18

2017/18	Data
Not upheld	483
Partially upheld	117
Referred to other Agency	102
Upheld	83
Actioned	29
Under investigation	124
Total	938

Month on month 2017/18

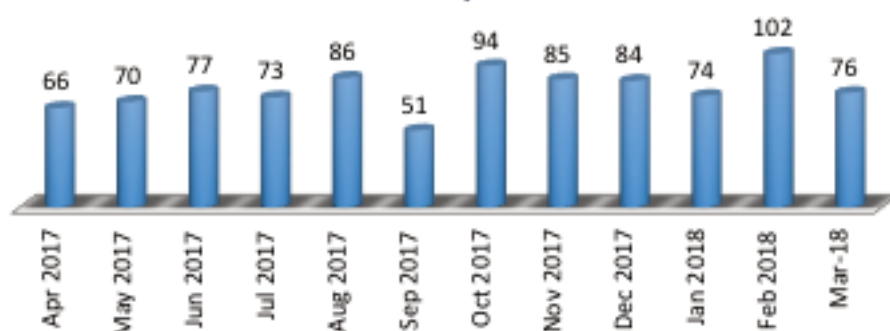


Table 13

Complaints by subject 2017/18	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Delay	21	17	16	14	26	9	22	33	19	17	40	21	255
Conduct	16	19	24	19	19	16	17	25	20	22	23	20	240
Road handling	12	11	13	14	10	7	14	9	7	6	10	6	119
Treatment	1	2	5	1	7	5	16	8	9	8	14	4	80
Non-conveyance	3	0	4	12	0	1	6	1	7	6	3	4	47
Totals (above)	53	49	62	60	62	38	75	76	62	59	90	55	741
Annual totals	66	70	77	73	86	51	94	85	84	74	102	76	938

Themes

These continue to be dominated by delay and staff conduct. However, many complaints increasingly involve multiple issues, for example, call management + a delayed response + attitude of crew staff + care provided.

The top five key subjects were as show in table above:

Performance

We have been able to achieve a significant improvement in throughput performance targets. Year to date performance is 82% responses within 35 working days.

To achieve this the following measures have been actioned

- Improved resourcing to Quality Assurance team
- Closer relationship with QGAMs
- Changes in some of the methodological processes the team use
- Changes in administrative practice at the Executive Office.
- Weekly review of complaints against target response times

We do however continue to experience external factors that can influence performance, for example telephony and IT problems.

Examples of learning

Complaints continue to be a powerful tool to describe patients' experiences and the learning that has resulted are presented to the Patient Feedback and Learning Group.

Staff attitude

Our practice when we receive a complaint about staff attitude and behaviour is to additionally review the care provided, which has often demonstrated a correlation.

Example one - delay/call management

Complaint from patient's mother that there was a delay in attending her daughter when she experienced a seizure.

On assessment questioning, it was confirmed that the patient was had experienced a grand mal seizure, which was still in progress. This presentation amounts to a high priority emergency with a Fast Responder and an ambulance being sent whilst the call was in progress. The call handler stayed on the line and the patient stopped fitting and recovered. At this point, her symptoms were determined at a lower priority. The Fast Responder was duly stood down (as they are maintained to be sent to patients determined at a high priority. The ambulance crew were similarly diverted in favour of a patient assessed as a higher priority emergency. Satisfied that the patient was not at any immediate risk, the call handler concluded by explaining that an ambulance would be arranged but it could take up to 45 minutes for help to arrive, so a further 999 call should be made if the patient's condition changed in the interim.

The Quality Assurance evaluation found that the initial highest priority should have been maintained as the event should be assessed as a continuous fit in view of the duration. Given the complexity of the patient's care arrangements, we agreed to arrange a specific emergency care component of the patient's care plan.

Example two - staff attitude call handler

Complaint from relative about the way she was spoken to when she made the 999 call about a patient who had collapsed

The call handler had difficulties in establishing whether the patient was breathing and was very assertive in trying to calm the caller down so that she could clarify this. However, they did not manage the situation very well, deviating from the prescribed questioning, omitting to use the breathing detector tool, failing to verify the location or to apply appropriate customer service skills. As well as feedback being given to the call handler concerned, we recommended the case be used as a training example in managing challenging calls.

Example three - attending staff attitude

Complaint from the patient about the aggressive manner towards her

The patient was a familiar caller to 999 and made multiple complaints about ambulance staff We had worked with the health and social care professionals responsible for her care to establish an emergency care component of her plan but we continued to look at each case on its merits. On this occasion, although we found that the overarching care provided was reasonable and that the paramedic needed to be assertive, his use of pain stimulus was unnecessary.

Example four – treatment

Complaint from patient that a nebuliser was not administered after she suffered an asthma attack

It would seem that the paramedic felt the patient had a chest infection. However, the information detailed in the assessment record was minimal, which made it problematic to conclude a nebuliser should have been used. This is because a chest infection of itself does not mandate a nebuliser, chest infections can precipitate asthma. We concluded that if there was any suggestion of a wheeze or exacerbation of asthma, then a nebuliser probably should have been given. Extensive feedback was given to the Paramedic with an emphasis on the importance of recording the assessment record to an optimum level. They were also asked to jointly review the treatment protocols in relation to patients with symptoms similar to this presentation.

Example five – treatment – Ombudsman/EOC

Notes on methodology:

For recording purposes, complaints about a delay in an ambulance response are attributed to EOC although we recognise that local operational resourcing may have played a contributory role.

As far as the outcome category, we take the view, accepted by the Health Service Ombudsman that a delay in an ambulance response does not of itself indicate a failure in service delivery.

The criteria we use in upholding a complaint is where a significant shortcoming is identified, for example that the EMD applied the wrong clinical triage protocol which in turn gave a lower priority determinant than should have been the case. This is applied in accordance with our holistic approach, which has been cited as best practice by the Ombudsman. This means that we look into related issues irrespective of what the complaint is about, or where we identify issues not complained about. Thus where a complaint is nominally about the call handler's manner, we will arrange a Quality Assurance (QA) evaluation review to ensure the call was triaged at the appropriate level of priority. We

also apply the Ombudsman's principles for remedy, including making financial recompense where appropriate.

In terms of performance, we concur with the Francis report in that complaints management is an organisational, not a departmental, responsibility. As such, throughput is a largely determined by the contribution of other departments, which can be compromised by significant demand to the Trust. We have now devised a means by which we can provide evidence of performance across the departments concerned.

Those cases where there has been a protracted delay reflect where the matter under investigation was declared as a Serious Incident (SI), the ensuing report being used to as the substantive response to the complaint. The delays were therefore once again completely outwith the control of the PED team although the Trust are now making strides in achieving improved SI completion.

Themes

- Delay caused by demand exceeding resourcing. On some recent occasions, less than adequate resourcing to EOC has been identified.
- Triage errors, including technical and procedural errors
- Poor staff attitude
- The practice of applying ‘workarounds’
- Confusion in the application of the health professional protocol, both internally and externally, post ARP.

Ambulance Response Programme (ARP) standards. Finally, we agreed to share the learning from this case with all UK ambulance services

Ombudsman cases

The Ombudsman continues to investigate a high proportion of complaints across all NHS Trusts, especially where a death has occurred.

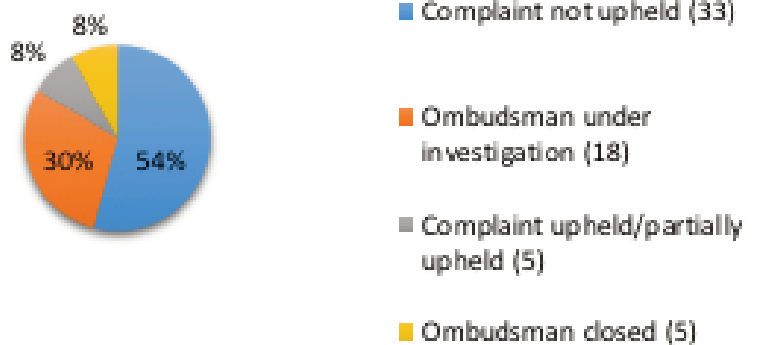
Pie chart showing requests by the Ombudsman and outcomes:

Learning from these themes

1. *Complaint from family who were unhappy with the Serious Incident report, the key issues being the delay in an ambulance being sent and the care provided to the patient, who later died. Although the Ombudsman did not uphold the complaint in relation to the matters complained about, the report found that the practice in applying ‘workarounds’ to enable a higher priority response to particular patient symptoms amounted to maladministration.*

The ‘workarounds’ the Ombudsman referred to were limited to very specific circumstances and put in place having been determined locally and based on other drivers (for example a Preventing Future Deaths notice, issued by the Coroner in an unrelated case) to ensure a more commensurate level of priority could be achieved, in the interests of patient care. We explained that some of these would no longer be needed when the Trust moved to use a newer version of MPDS. Solutions for the remaining issues, including the workaround that was at issue in this case, have been resolved following liaison with the International Academies of Emergency Dispatch and the Association of Ambulance Chief Executives, in the light of new

Complaint files requested by the Ombudsman
June 2015 to March 2018



Patient Engagement

The LAS Patients' Forum

The Trust continues to work closely with its Patients' Forum, an independent lay organisation that takes an overview of the Trust from the point of view of service users, carers and the public. The Forum provides representatives for all the Trust's governance committees and its own monthly meetings are hosted at LAS Headquarters, supported by the Patient & Public Involvement Team.

In the year 2017-18, Patients' Forum meetings included the following topics and speakers:

- Delivering safe and effective emergency and urgent care in London, presented by the Director of Operations
- Developing higher quality care, presented by the Deputy Director of Nursing & Quality
- Demand management, presented by the Deputy Director of Operations (Emergency Operations Centre)
- The CQC report findings, presented by the Chief Quality Officer
- Race equality in the LAS, presented by the Director of People and Organisational Development
- The Ambulance Response Programme, presented by the Assistant Director of Operations for Service Improvement
- Patient & Public Involvement in the LAS, presented by the Head of Patient & Public Involvement
- The flu epidemic and vaccination

campaign, presented by Dr Sam Perkins from Public Health England

Patients' Forum members meet regularly with senior LAS colleagues, LAS commissioners and other key organisations such as the CQC, to highlight areas of good practice and areas where development is required.

Patients' Forum members have been directly involved throughout the year in the development of the LAS Academy. Together with staff from the Academy, they have formed a Patient and Public Involvement Panel, and attend steering group meetings. They have developed a teaching programme detailing patient and public involvement in the Academy's syllabus, and take part in assessment centres for the recruitment of students.



Friends and Family Test (FFT)

The Trust continues to record Friends & Family Test (FFT) responses from Patient Transport Service and See & Treat patients, although the response rate remains low. The total number of FFT responses received in the year 2017-18 was 334. Almost all patients who responded to the question said they would either be “extremely likely” or “likely” to recommend their friends and family to the LAS if they needed similar care or treatment.

The National Ambulance Service Patient Experience Group is in discussions with NHS England and NHS Improvement, to highlight the limitations of this methodology for ambulance service patients and discuss alternative methods of patient engagement.

Community Engagement Events

The LAS remains committed to supporting a wide range of patient engagement and public education events with LAS presence requested at 654 events in the year 2017-18. Of these, we were able to attend 506, 77% of all requests made. This is due to the ongoing support of over 1,200 staff on our database, with over 300 individuals taking part in multiple events, often in their own time.

We have created a closed Facebook group for staff involved in public engagement, as another method of communication. Through this group we provide information about the team and about forthcoming events, and staff can post their own ideas and questions for members of the team to answer. This has been extremely successful and the group has over 600 members.

The four part-time Public Education Officers continue to focus mostly on activities involving children and young people, such as awareness sessions on the dangers of carrying knives and of using alcohol and other legal highs, careers in the LAS, and multi-agency road safety events



Talking with us

Complaints and thanking our staff

such as Safe Drive Stay Alive and Biker Down. Many of these are carried out with partner organisations.

Blue Light Collaboration

We are working closely with our partners on the “prevention” sub-group of the Blue Light Collaboration project, to ensure we make the best use of the resources available and share good practice. The Head of Patient & Public Involvement and Public Education is an active member of the steering group and has now also facilitated the inclusion of the LAS Head of First Responders in the group.

One of the Public Education Officers has led on a key project as part of this work, piloting a scheme which involved all the blue light services attending schools in the London Borough of Haringey. Pupils participated in a range of sessions, rotating between them during a

school day. The London Ambulance Service sessions focused on the consequences of carrying knives, and CPR (basic life support) training. The pilot has been evaluated and has been shown to be highly effective. A bid is now being submitted, with the aim of rolling out the scheme to other London boroughs.

Co-production and co-design activities

Co-production and co-design are powerful ways to maximise the benefit of patient involvement, both for patients and for staff.

Following the Insight Project, funded in 2016-17 by the NHS England Insight Team, a range of co-production activities have continued to gather momentum. These have focused on three specific patient groups: those with sickle cell disease, COPD (chronic obstructive pulmonary disease) and personality disorder. Some patients from those groups (sickle cell and personality disorder) have taken part in developing and delivering training packages for LAS staff, whilst others have taken forward ideas such as carrying health information “passports” or crisis cards (COPD and sickle cell) and how to get information across in a 999 call. Members of the personality disorder group delivered a presentation at the Safeguarding Conference this year, and have made a film for use in staff training. We are talking to the Sickle Cell Society about children and young people making a film about pain, for use in the LAS Academy’s module on pain management.

Discussions have commenced with Healthwatch London, with a view to commissioning a local Healthwatch group to carry out co-production and co-design activities to support the new LAS Strategy. This work is likely to focus on the four ‘pioneer’ services: mental health, maternity, falls and end of life care.

The Trust also hosted an event for its Partnership Reference Group (PRG), which is made up of Healthwatch and voluntary sector organisations, to get the group's feedback on its strategic intent. Earlier in the year we held a PRG event focusing on volunteering, to share information about different schemes and learn from PRG members' experiences.

Staff development and training

The Patient & Public Involvement Team ran a four-day course in October for staff who volunteer to undertake patient engagement work for the Trust. The course has been running for a number of years now and is well-established, being updated and adapted each year according to the feedback received and the Trust's changing public education priorities. The course

includes skills training (e.g. presentation skills), knowledge (e.g. disability awareness) and self-awareness activities such as an introduction to the Myers-Briggs Type Indicator (personality types). This year, because of the links made through the Blue Light Collaboration work, we were able to use the London Fire Brigade's training facilities, free of charge.

The Patient & Public Involvement Team has purchased an online disability awareness training programme, which any member of LAS staff can use at no extra cost. The course includes modules on a range of disabilities and gives practical tips and information about how best to communicate with people affected by those disabilities, and how to provide and adapt services for them.

Every other month the Trust Board hears a patient story, usually told directly by the patient involved. This helps to ensure patients feel heard by the organisation, and provides an opportunity for Board members to hear about patients' experiences first-hand.

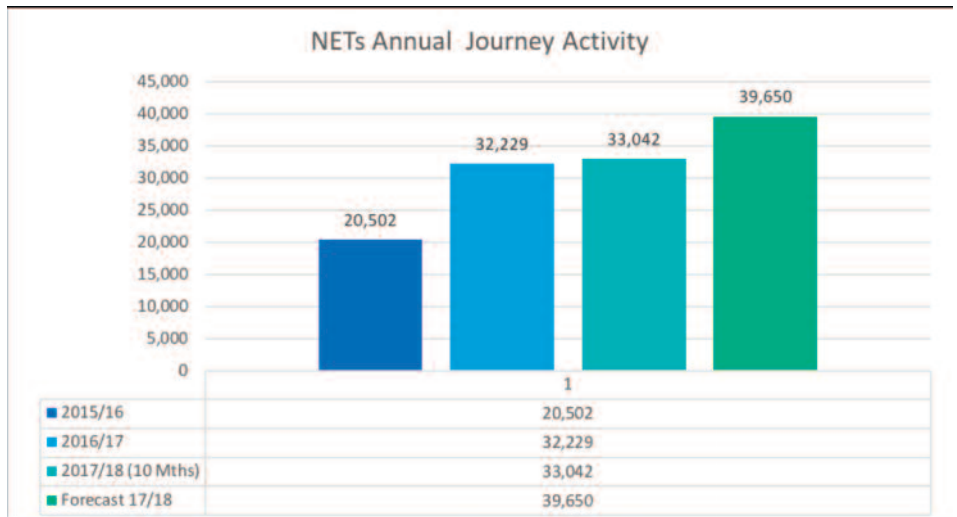
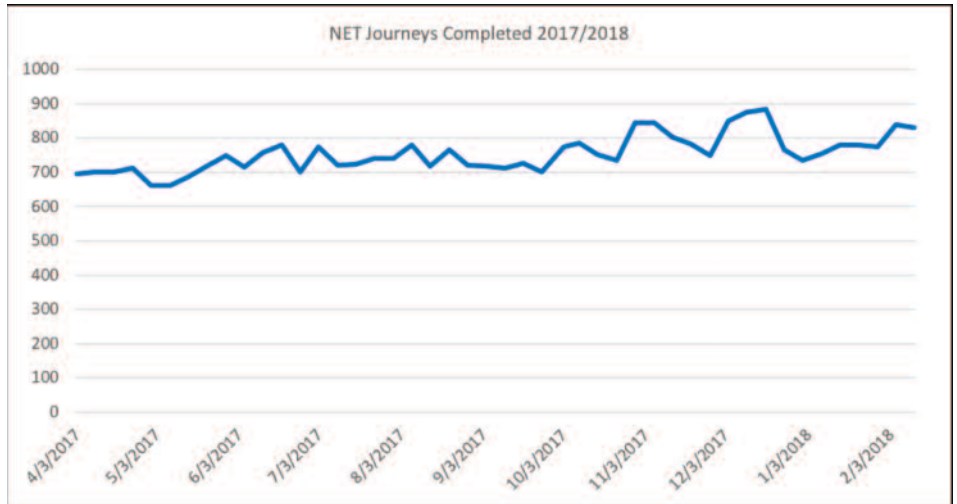


Section 6: Other services

5a : Non-Emergency Transport Services

The **Non-Emergency Transport service (NETs)** which commenced in June 2015 has continued to grow. This service supports our core A&E service in transporting the lowest acuity patients to healthcare facilities where there is little or no clinical intervention required en route. As a result we are able to increase the availability of frontline crews to attend life threatening calls made to the service and ensure lower acuity patients receive transport within an agreed timeframe providing for a better patient experience.

The number of journeys completed by NETs has continued to grow in line with the development of the service with delivery rising from approximately 100 journeys a week at commencement to approximately 800 journeys a week by the end of the financial year. We are implementing plans to reach a target of 900 journeys per week. The increase in delivery of journeys is shown in the following graph:



The NETs pre-plan mental health community assessment journey requests via our e-booking system and use have now been rolled out to all the Mental Health Trusts in London. This project has been highly successful with the majority of this cohort of mental health service users now seeing transport arriving at the commencement of their assessment or within 30 minutes. Following on from the Mental Health Transport project the Service has also seen the pre-booking of journeys for end of life care patients where journeys are time critical rolled out and this service is now operating from three hospices. The service is currently

engaged in the roll out of this service to all other Hospices operating within the London area.

In line with the growth of NETs, there has been an increase in the number of NETs operational staff from 90 to 120. The introduction of 13 apprentices last year under the national apprentice scheme have now completed their first year with us and have been employed by the Service with some working on NETs and some have been successful in applications to further progress and are now currently training to become TEACs.

All existing staff (PTS and NETs) have completed Core Skills Refresher training during the year which has included Infection, prevention & control, Safeguarding, Prevent, Sepsis, Dementia, Patient report forms and End of life care. In addition other statutory and mandatory training was delivered by e-learning.

Both of these services are an important part of our core business and they are fully integrated into our quality governance processes.

5b: South East London 111 - 2017/18

This report has been prepared to review the activity within LAS 111 South East London (SEL) for 2017/18 and has been broken down into nine key areas.

- Care Quality Commission Update
- Workforce Transformation
- Procurement of future services
- Incidents, complaints and feedback
- Call Quality and monitoring
- Safeguarding
- Patient Experience
- Training
- Pilots and Innovation

Care Quality Commission Update

Following CQC recommendations from the inspection in September 2016 (rated "Good" overall) SEL111 has continued to improve substantive staffing, more than halving the percentage WTE vacancy rate since April 2017. A gap analysis has been undertaken and there is an IM+T Project Plan in place to address the remaining issues. Finally open forums have commenced whereby Staff have an opportunity to meet with the HR Manager and 111 Operations Manager.

Workforce Transformation

By 31st March 2019 all NHS111



**when it's less
urgent than 999**

services are required to have evolved into an Integrated Urgent Care service, providing a "consult and complete" service, reducing referrals to other areas of the NHS. SEL are undertaking Phase 1 of the work required, having employed an Integrated Urgent Care Workforce Transformation Manager to oversee the process.

Procurement of Future Services

In January 2018, LAS was awarded the NHS 111 Integrated Urgent Care and clinical assessment service in North East London.

Mobilisation of the new service is in progress and LAS are due to commence Service delivery from August 2018. Future Annual Quality Account reports will include NEL Service performance.

Procurement has commenced for the future service for South East London and a bid will be submitted by 13 March 2018 for the service which is currently due to go live in October this year.

Incidents, complaints and feedback

Incident details

Two Serious Incidents were declared this year, both related to clinical advice and have been investigated, with all actions completed to ensure mitigation of future incidents. Incidents reported relate to a range of issues at LAS 111. A key trend identified over the last year has been errors in the referral of patients into an Out Of Hours (OOHs) service. The process for reporting and feeding back these incidents has changed and an action plan put in place to decrease the amount of incorrect referrals.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the LAS crews and the GP Out of Hours (OOH) providers. The majority relate to the perceived inappropriateness of the referral and whilst several have been upheld, some are due to a lack of understanding of the 111 system. Considerable effort has been put into improving understanding and communication channels between the 111 and 999 services; and also improving understanding between the 111 service and OOHs services, e.g. including them in End to End reviews and engaging in workshops to promote collaboration between services.

Type	Mar 18	Feb18	Jan 18	Dec 17	Nov 17	Oct17	Sep17	Aug17	July 17	Jun17	May 17	Apr 17
Serious incidents			0	0	0	0	0	0	0	0	1	1
Incidents			120	184	112	150	133	180	88	80	87	82
Complaints (formal)			8	19	3	5	7	7	5	4	2	8
HCP feedback			2	3	2	2	4	0	3	2	2	5
Compliments			4	6	1	1	3	2	3	2	0	6
Authorised confidentiality breaches			18	11	8	8	15	12	11	7	18	18
Wrong OOHs GP referrals			39	68	39	39	39	32	36	32	25	18

Table 14

Feedback to Health Care Professionals

12 feedback forms have been sent to other providers of care. Staff are encouraged to raise issues where the actions of other healthcare providers have resulted in a delay in patient care, or where a procedure appears to be unsafe or inappropriate. The most common issues are with regard to communication issues and handover of patients between services such as GP OOH Providers failures to accept patient referrals due to patient location, or disputes causing delay to patient care.

Authorised confidentiality breaches

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.

Compliments

Twenty-eight (28) compliments have been received relating to both the service and individuals undertaking patient contact duties. Recognition for staff has increased, as compliments continue to be published in the Trust's weekly bulletin in addition to being

displayed on site noticeboards.

Call quality and monitoring

We have continued to exceed the required standard for 1% of call audits every month including the winter months where demands on the service increased. Each staff member has a minimum of 3 calls audited each month. Where performance issues are identified the level of audit is increased. Since October 2017 compliance percentage (target 86%) has not been achieved. An action plan is in place to improve compliance with a focus on key themes identified during audits.

End to End call audits

Monthly end to end call reviews are undertaken at LAS111. This year a total of 50 calls were audited by the senior management team, including the Trust's Assistant Medical Director and South East London Clinical Lead. The audits are attended by healthcare professionals from the areas of focus which ensures their input and to improve partnership working, communication and practice. The end to end audits have all highlighted areas of good practice but also areas that require some improvement and action plans have been put in place to address concerns.

Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 415 people in total to Social Services which equates to

circa 0.15% of all calls taken. Referrals for adults were predominantly for welfare concerns and for children for safeguarding issues.

As a large proportion of referrals stem from information provided in a patient's Special Patient Notes (SPN), a deep dive into the timeliness and validity of these SPNs is underway. Early data has been presented at the South East London Clinical Governance meeting. It suggests more can be done by external agencies to increase the reliability of this information.

Patient Experience

The 111 patient surveys are sent each month to around 300 patients, an increase from 250. The average response has increased from last year to 38 a month (from 29 a month). Work is ongoing to examine new ways to enable patient feedback, including the possible use of email or text messaging. This includes engagement with the SE London patient representative to design a survey which will encourage a higher response level.

Language line

Spanish continues to be the most requested language, followed by Arabic and Portuguese. The average calls per month has increased from 106 in 2016/17 to 137 in 2017/18.

Training

All staff have undertaken mandatory training relating to changes made to the 111 call

Call Audit Data	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sep 17	Aug 17	Jul 17	Jun 17	May 17	Apr 17
Calls answered at 111			34,941	35,721	22,361	22,346	25,361	20,242	28,321	26,015	28,656	28,381
% Call audits (target >1%)			1.2%	1.1%	1.7%	1.6%	1.4%	1.5%	1.2%	1.5%	1.4%	1.4%
No. Call audits			423	376	378	427	356	308	341	379	406	398
No. Call Handler audits			246	218	224	254	210	191	177	211	225	223
No. Clinical Advisor audits			177	158	154	173	146	117	164	168	181	175
% Compliance (target >86%)			80%	85%	83%	84%	88%	90%	89%	90%	88%	88%

Table 15



management system "Pathways" with two version updates (13 and 14) being completed, the latter in November 2017. Following the response to a Serious Incident, a TOXBASE calculation and overdose management training refresher was introduced to all clinicians. A pilot demonstrating the success of critical thinking and probing skills work shop led to the mandatory introduction of this training. This training is in addition to the full compliance to statutory and mandatory training as required by the London Ambulance Service NHS Trust. Agency staff are given all mandatory training including safeguarding and also offered places on all workshops that are appropriate.

Pilots and Innovation

- LAS 111 has been actively involved in a number of pilots throughout the year including
- Direct booking patients under 5 years old into OOHs appointments
- Direct bookings in to GP hubs across additional boroughs
- Implementation of *567 access lines into BAU
- Expanding direct referral pathway for patients presenting with Mental Health difficulties to cover all 6 boroughs.
- Introduction of 111 online for SEL
- Enhanced clinical assessment for ED dispositions
- Working groups to introduce the ability to access additional patient records to inform clinical decision making and allow staff access to electronic prescription tracker.

Section 7:

Feedback 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.

- The London Ambulance Service Commissioners 27 April 2018
- Patients' Forum response dated 14 May 2018

- Healthwatch were provided with the draft Quality Accounts in March 2018 for comment

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

NHS
Brent, Harrow and Hillingdon
Federation of
Clinical Commissioning Groups

27 April 2018

Mr Garrett Emmerson
Chief Executive
London Ambulance Service NHS
Trust
220 Waterloo Road
London
SE1 8SD

Diane Jones
Executive Office
BHH Clinical Commissioning Groups
3rd Floor, The Heights
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Re: London Ambulance Service NHS Trust Quality Strategy: Vision 2020 and Quality Account 2018 – 2019

The North West Collaboration of CCGs has welcomed the opportunity to review your Quality Strategy and Account for 2018–2019. We have reviewed the content of the Quality Report and are able to confirm that this complies with the requirements for NHS Trusts as set out by the Department of Health and NHS Improvement. The Quality Report provides an open and transparent declaration of the status of the quality of the services the Trust provides which is generally easy to read, and seems very comprehensive and particularly ambitious considering your goal of striving for an 'outstanding' Care Quality Commission (CQC) rating by 2020.

The Trust had previously set 8 targets against the domains of Patient Safety, Patient Experience and Clinical Effectiveness for 2017/18, and we are pleased to see the progress the Trust has made against these. There is clear evidence in the report demonstrating how the Trust has embedded their quality work to improve care provided to its patients. We note that the focus on mental health crisis continues as reported in the LAS Strategic Intent 2018/19 – 2022/23 under the 'pioneer differentiated services'. It is also encouraging to see how well LAS are performing against the new Ambulance Response Programme (ARP) response standards, as benchmarked nationally.

The 2018/19 Report includes 14 targets divided between the five CQC quality domains, ensuring that services are safe, caring, effective, responsive and well-led, which will assist in supporting the Trusts endeavours to strive for an 'outstanding' CQC rating by 2020. It is encouraging to see that the Trust has responded positively to previous CQC findings demonstrating good progress made against infection prevention and control (IPC) standards, as well as evidence of organisational learning from incidents. We take note of previous CQC comments surrounding vehicle checks, equipment and skill mix issues, and are encouraged by the inclusion of roster reviews under the 'Clinical Effectiveness' (Target 4), as well as the Target 1: review of the operational model under the 'Responsive' domain in line with ARP and the new ambulance quality indicators (AQIs), and assume that these will be sufficient to address issues identified.

NHS
Brent, Harrow and Hillingdon
Federation of
Clinical Commissioning Groups


Harrow CCG Chair: Dr Amol Keshiker
Brent CCG Chair: Dr Ethie Kong
Hillingdon CCG Chair: Dr Ian Goodman
Chief Officer: Rob Larkman

We recognised significant improvements made in the processing of Serious Incident (SI) investigations, and it is pleasing to see how responsive the Trust has been towards improving standards of care, for example: delayed defibrillation. The incidence of SIs involving the Emergency Operations Centres (EOCs) remains high, and we look forward to working with you towards improving the quality of services in this area, also to include the prioritisation and timely response to inter-facility transfers and urgent Health Care Professional (HCP) requests for transport. Furthermore, the CCGs recognise the significant impact staff training can have on quality improvement, and are pleased to note that the Quality Report includes comprehensive focus on staff training under the effective and well-led domains, including a root and branch independent training review, a quality improvement (QI) training plan, compliance with statutory and mandatory training, and leadership development.

As per feedback from Commissioners and Sustainability and Transformation Partnership (STP) leads, it is pleasing to hear that LAS have taken note of the Workforce Race Equality Standard (WRES) requirement and that this will now be included under the 'Well-Led' section of the WRES plan. It is also very pleasing to see that the Trust is exploring the use of technology for improving services, including the roll-out of hand-held devices to frontline staff, future electronic patient record form (e-PRF) technology, and the use of tele-medicine/skype. The impact on quality improvement from the use of e-PRF technology cannot be underestimated, and may prove to be the single most significant influence on standards of care yet.

We would concur with the Trust that the five priority focus areas and 14 associated targets you have set for 2018/19 are appropriate considering previous CQC feedback, recognising pressures on the Trust in these areas during 2017/18 across London, and considering the LAS strategic intent leading up to 2023. We would like to thank all the LAS staff for their continued commitment to the delivery of a high quality service to the local residents of London. We look forward to continuing to work with the Trust to monitor progress against set priorities for 2018/19 through the Clinical Quality Review Group (CQRG), in order to gain assurance of continuous improvement of the quality of ambulance services provided across London.

Yours sincerely



Diane Jones
Director of Quality & Safety
NHS Brent, Harrow & Hillingdon
Clinical Commissioning Groups

Cc: Dr Trisha Bain, Chief Quality Officer, LAS
Dr Kuldhir Johal, Chair, LAS Clinical Quality Review
Dr Ethie Kong, Chair, NHS Brent Clinical Commissioning Group
Philip De Bruyn, Assistant Director for Quality & Safety (LAS Lead)
Jennifer Roye, Deputy Director for Quality & Safety, BHH CCGs

Trisha Bain
Chief Quality Officer
London Ambulance Service

May 14th 2018

QUALITY ACCOUNT (QA) 2018 – PATIENT FORUM RESPONSE

Dear Trisha, we are delighted to present the Forum's response to your 2018 Quality Account. We have valued working with Briony Sloper and yourself over the past year and appreciate your tireless work to implement critical changes to the operation of the LAS and enhance the quality of care for patients. This has included the development of the Quality Oversight Group that brings together all of the major players responsible for the safety and quality of services. The continuing development of end of life care, mental health care and midwifery services are major areas that we commend in terms of enhanced patient care.

Our assessment of the Quality Account and our Recommendations to the Board are as follows:

1) We welcome the following statements of LAS commitment to patient and public involvement contained within the QA:

- Patients will have a stronger voice than ever before (page 1)
- The patient is at the centre of everything that we do (page 5)
- Listen to staff and patients to determine priorities (page 9)
- Have patient/carer involvement in all our improvement work (page 9)
- Integral to all programmes must be the aim of robust patient and staff involvement (10)
- We need to listen to our patients, their families and carers, and respond to their feedback (15)
- Our goal being to have patient involvement in all service redesign programmes and a patient involvement framework developed to apply this goal consistently (page 15)
- We need to widen and increase our public involvement in both the development of these new services and monitoring of their success. (15)

care will improve when the workforce better understands and mirrors the population treated and cared for by the LAS.

RECOMMENDATION- 3: ALL LAS PUBLICATIONS SHOULD ENSURE THE VISIBILITY OF ETHNIC DIVERSITY IN ITS WORKFORCE

4) **"Quality is our number one priority"**. (page 6)
We would suggest that "Safety and Quality" should be the first priority for the LAS.

5) **"Goals and targets that are measurable"** (page 6)
We would expect this to include recommendations arising from the public and patients' voices.

6) **Safe – (page 13)**
We suggest that this section should refer to 'moderate harm, severe harm and death' in compliance with the statutory Duty of Candour.

Target 2 – Hospital Handover Delays – We fully support the LAS goal (to reduce handovers in excess of 15 minutes by a quarter), although we believe that there should be no handovers at all in excess of 15 minutes. There are no 30 or 60 targets as suggested in the QA. A 30 and 60 minute handover is a breach of the national agreement on handovers.

We suggest that the QA states what the LAS expects of STPs, CCGs and hospital trusts to deal with this appalling problem. Patient safety is at the heart of everything the LAS does, and in our view more assertive action is required to protect patients from unacceptable delays.

RECOMMENDATION- 4: THE LAS SHOULD PUBLISH ITS STRATEGY TO OBTAIN GREATER SUPPORT FROM STPs, CCGs AND HOSPITAL TRUSTS TO SUBSTANTIALLY REDUCE HANDOVER WAITS IN EXCESS OF 15 MINUTES.

- A co-designed and co-developed patient and staff engagement model will be used to drive quality improvement across the maternity care model (16)
- Services are organised so that they meet people's needs (19)

RECOMMENDATION-1: THE LAS SHOULD CONTINUOUSLY DEMONSTRATE THAT ACTION IS BEING TAKEN BY THE TRUST AS A RESULT OF RECOMMENDATIONS MADE TO THE LAS BY THE PATIENTS' FORUM AND HEALTHWATCH IN THE ANNUAL QUALITY ACCOUNT.

The LAS accepts this recommendation

2) Integration of PPI work-streams in the LAS

PPI work-streams in the LAS are not yet integrated. The PPI team led by Margaret Luce carries out excellent work, e.g. the Insight project and continuous work with communities across London. This team has a well developed PPI Action plan and Patient Engagement Strategy (2016-2020) (see also PPI Annual Report). This work is not integrated with other major PPI work-streams, e.g. the engagement exercise which preceded publication of the LAS strategy and the streams of work that are being progressed following adoption of the LAS overall strategy. We would strongly recommend integration of all PPI streams of work to ensure effectiveness, consistent quality and evidence-based practice, e.g. to ensure that the public voice influences LAS practice, policy and strategy.

RECOMMENDATION-2: THE LAS SHOULD INTEGRATE ALL PATIENT AND PUBLIC INVOLVEMENT WORK-STREAMS IN ORDER TO ENSURE THAT THE SHARED EXPERTISE OF THE PPI TEAM AND OTHER DEPARTMENTS INFORMS ALL PPI WORK IN THE LAS INCLUDING THE PIONEER PROJECTS

3) Ethnic Diversity within the LAS

Images of LAS staff in the QA and other document show virtually no diversity, which is recognised as a major issue by the communications team. This happens repeatedly in LAS publications, suggesting that the Communications Department needs to ensure that they produce more relevant material. The LAS public website has been positively modified in its presentation in this respect.

We commend the proactive and continuous work that is now taking place across London to recruit staff that reflect the city's population. Patient

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7) Caring – (page 15)

Target One – Mental Health Care

- a) The publication which described the LAS mental health work as exemplary should be referenced in the QA.
- b) We strongly support the employment of mental health nurses in the clinical hub, the enlargement of the team and the development of Advanced Mental Health paramedics. We also support the trial of a paramedic and mental health nurse working together to enhance mental health care. We see this as an important step in the direction of developing LAS Advanced MH paramedics.

RECOMMENDATION-5: THE LAS SHOULD DEVELOP IN LIAISON WITH THE FORUM A PROPOSAL FOR ADVANCED MENTAL HEALTH PARAMEDICS

- c) We would like to see effective methodologies developed to obtain information from patients who have been sectioned under s135 or s136, and cared for by LAS staff. Similarly, patients who use the NET service should be able to comment on the service when NETS is used to provide transport for them, in connection with assessment or sectioning under the Mental Health Act. Methodologies need to be specifically designed for this purpose (see for example the Insight methodology).

RECOMMENDATION- 6: THE LAS SHOULD DEVELOP IN LIAISON WITH THE FORUM, METHODOLOGIES TO GATHER QUALITATIVE DATA FROM PATIENTS RECEIVING MENTAL HEALTH CARE AND THOSE RECEIVING BARIATRIC CARE, TO ASSESS THE QUALITY OF CARE THEY HAVE RECEIVED.

Target Two – PPI – PIF

- a) We strongly support the LAS goal of having patient involvement in all service redesign programmes and a patient involvement framework (PIF) developed to apply this goal consistently (page 15). However, we note that there is already an LAS PPI strategy and LAS Action Plan, which should be integrated.

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- b) The Patient' Forum is a centre of excellence for PPI work and many of our members have considerable expertise in the field. We hope that the learning from the recent LAS strategy engagement exercise, will provide valuable reflection for the next steps in the development of PPI in the LAS.
- c) We would suggest considerable care is needed in agreeing a methodology to a collect data from patients, as there are no effective generic systems for collecting data from patients who use emergency ambulance services. A great deal of money could be wasted on ineffective systems. The Friends and Family test demonstrates this point well and led to the development of the Insight projects.
- d) We strongly support the Target 2 recommendation regarding evidence of PPI in all QI and service design programmes.

RECOMMENDATION-7: THE PROPOSED PIF SHOULD BE DEVELOPED IN LIAISON WITH THE TEAM THAT HAS DEVELOPED THE LAS PPI STRATEGY AND ACTION PLAN

Target Three – Development of a team of practice leads for pre-hospital maternity education

We strongly support Target Three and have been involved in the selection of the two midwives to carry out this role.

8) Effective –

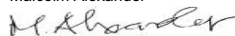
Target Two – ARP – We are pleased that more work is being carried out on the presentation of data. Compared with previous data sets (pre-ARP) we find the current data sets unhelpful in determining the how well the LAS is performing. Handover data is now of good quality.

RECOMMENDATION-8: ARP DATA SHOULD BE PRODUCED THAT IS ACCESSIBLE TO THE PUBLIC AND BASED ON PERFORMANCE IN EACH LONDON BOROUGH.

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Yours sincerely
Malcolm Alexander



Chair
Patients' Forum for the LAS
07817505193

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EXECUTIVE COMMITTEE	Lynn Strother	CITY OF LONDON HEALTHWATCH
EXECUTIVE COMMITTEE	Beulah East	
EXECUTIVE COMMITTEE	Adrian Dodd	WALTHAM FOREST HEALTHWATCH

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- 9) Responsive – Target 2– Complaints investigations** – This section is excellent. We would like to see the investigation time for complaints reduced to 30 working days in 2018, and to have access to systematic data on the findings and recommendations from complaints. We have been attempting to review complaints for the past year without success, despite the support of the Chief Quality Officer and Patient Experiences Department for this audit activity. We believe the 75%, 35 days target is much too low and compares unfavourably with most other NHS and Foundation Trusts.

RECOMMENDATION- 9: THE LAS SHOULD REDUCE THE TARGET TIME FOR INVESTIGATION OF COMPLAINTS DOWN TO 30 DAYS

RECOMMENDATION-10: THE LAS SHOULD DESIGN A SYSTEM TO ALLOW ACCESS, WITH THE CONSENT OF THE COMPLAINANT, FOR THE FORUM TO EXAMINE COMPLAINTS DATA FOR THE PURPOSES OF AUDIT

Quality Account – we believe it is essential that the LAS works with the Forum to implement recommendations made to the LAS in the Forum's submission to the QA. This would be a good test of responsiveness and would demonstrate that the LAS values public involvement in the development of its services.

RECOMMENDATION-11: ISSUES RAISED BY THE FORUM IN THE QUALITY ACCOUNT SHOULD BE SUBJECT TO ONGOING DISCUSSION WITH THE LAS REGARDING IMPLEMENTATION.

10) Well Led – Target 2 – LAS Strategy

- a) The LAS did not carry out a reasonable consultation exercise on the overall LAS strategy during the engagement period. Only one small short meeting was held with public participants. The Forum's detailed submission received no response despite several requests, until May 2018. We strongly **Recommend** the LAS carries out a detailed public involvement exercise on the content and implementation of their strategy and follows the lead of the Quality team which is inclusive and works closely with the Forum. We commend Whose Shoes PPI event of May 12th
- RECOMMENDATION-12: ALL LAS STRATEGIES SHOULD BE SUBJECT TO AN AGREED PUBLIC ENGAGEMENT AND INVOLVEMENT PROTOCOL AND METHODOLOGY BEFORE PUBLICATION.**

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Appendix 1: Clinical Audit : Learning outcomes

Below are the actions taken following audits during 2017-18:

- Continued clinical education provided to staff through face-to-face training and publication of updates in bulletins and newsletters
- Release of infographics promoting the key monthly findings
- Feedback regarding inappropriate triage decisions and extended times provided to clinical staff by Quality, Governance and Assurance Managers
- Continued use of the “Clinical Information and Support Overview” tool to facilitate discussions with clinicians and Clinical Team Leaders regarding clinical audit findings, illness coding and time spent on scene

The reports of **10 local clinical audits** were reviewed by the provider in 2017/18 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided against each as detailed below.

Documentation of EZ-IO® Intra-osseous System use

- Distribute an infographic reporting improvements made and reiterating the importance of documenting needle size and a named anatomical site and side when gaining intra-osseous (IO) access
- Publish an article in the Trust-wide clinical newsletter to share key findings and actions
- Create a prompt card documentation reminder to be inserted in EZ-IO kit bags
- Amend the Patient Report Form (PRF) User Guide to specify that IO needle size should be documented in millimetres
- Share report with the LAS Clinical Education and Standards Department

Assessment and transport decisions of patients with major head injuries

- Define the illness codes for major and minor head injuries in the PRF User Guide
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Make the ‘Management of Minor Head Injuries’ assessment tool more available for all clinicians
- Share report with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guideline Developers and Contributors and seek further clarity regarding the assessment and management of head injuries

- Re-audit whether there has been an improvement in the recognition and management of clinically significant head injuries

Patients who severely deteriorated or died unexpectedly within 24 hours of being discharged at scene

- Declare seven serious incidents identified by this continuous audit
- Flag one case to another organisation for them to declare as a serious incident
- Provide constructive and positive feedback to individual crews, where necessary
- Share the findings of this audit with NHS England and suggest the Ambulance Quality Indicator re-contact data guidance is amended to exclude public places
- Continue with the Continuous Re-Contact Clinical Audit in 2017-2018, with the inclusion of NHS 111 referrals and Hear & Treat assessments
- Write an article for the Trust-wide clinical newsletter focussing on the importance of consistent discharge documentation
- Create a short animation focussing on consistent discharge documentation for the LAS intranet and Facebook group
- Write a case study for the LAS Insight Magazine demonstrating good patient assessment and discharge documentation and evidencing full patient assessment on the PRF
- Continue to monitor the decisions made for 50% of patients not conveyed to hospital and facilitate the provision of individualised feedback to clinicians

Administration of dexamethasone

- Share report with the JRCALC Guideline Developers and Contributors and seek further clarity regarding whether mild croup is an indication for dexamethasone
- Distribute the key findings in a Trust-wide newsletter, together with an infographic displayed in all ambulance stations
- Share the findings with the LAS Business Intelligence Team, specifically the number of times dexamethasone was miscoded in the sample
- Undertake a re-audit to assess whether there has been an improvement in documentation of indication for dexamethasone administration

Administration of ondansetron

- Share key findings and necessary actions with clinicians through the publication of an article in a Trust-wide clinical newsletter and a corresponding infographic to be displayed at all ambulance stations
- Distribute an infographic highlighting how ondansetron and other drugs should be given
- Share report with the LAS Medicines Management Group and Clinical Tutors
- Care provided to the patients with a genuine illness or injury at Exercise Unified Response
- Explore the feasibility of including event call signs in the Clinical Performance Indicator audit programme
- Consider the suitability and training needs of clinicians not normally deployed on frontline duties at events
- At events, share the LAS PRF User Guide with clinicians not normally deployed on frontline duties
- Share report with the LAS Department for Emergency Preparedness, Resilience and Response, the Medical Directorate, Cycle Response Unit and Community First Responders
- Analgesia given to adult patients
- Distribute to all ambulance stations the key findings in an infographic
- Share report with the LAS Medicines Management Group, the Medical Directorate and Clinical Tutors
- Include whether or not adequate analgesia was given in future clinical audits

Care given to patients with a suspected mental health disorder

- Consider continuously auditing the care provided to patients with an undiagnosed psychiatric problem, or carry out a re-audit once all actions have had sufficient time to take effect
- Record a Q&A session with the Service's Mental Nurses outlining the importance of undertaking a thorough patient assessment
- Share findings with clinicians in a Trust-wide clinical newsletter, together with physical conditions which may mimic a mental health condition
- Share key findings in an infographic to be displayed at all ambulance stations
- Promote the LA383 (Adult Mental Health Assessment Form) at Sector Quality Meetings
- Review the wording of the 'psychiatric problem – undiagnosed' illness code

Use of adrenaline (1:1,000) re-audit

- Produce an allergic reactions and asthma tool for the LAS Digital Pocket Guide application
- Create a short video presentation of the stages of allergic reaction and asthma, and when adrenaline (1:1,000) is indicated for publication on the Service's intranet and Facebook page
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review all training materials related to adrenaline (1:1,000)
- Share report with the LAS Medicines Management Group
- Undertake a re-audit once all actions have had sufficient time to take effect to determine whether there has been an improvement in adrenaline (1:1,000) administration

Documentation of mental capacity assessments

- Produce a guidance animation of the key principles of the Mental Capacity Act and what constitutes a thorough mental capacity assessment
- Write a case study for the LAS Insight magazine which promotes positive learning from experience
- Distribute the key findings in a Trust-wide clinical newsletter, together with an infographic displayed in all ambulance stations
- Review the current LA5 (Capacity tool documentation for the treatment of patients who are unable to consent)
- Update the downloadable LA5 on the LAS intranet and arrange removal of the old LA5s in circulation
- Share report with the LAS clinicians and Mental Health Nurses in the Clinical Hub

In addition, a further **5 local clinical audits** were started by the provider in 2017/18 as detailed below.

Management of paediatric pyrexia re-audit

The LAS 2012 Paediatric Pyrexia Clinical Audit found that patients aged 2-8 years with pyrexia of unascertained origin were often not appropriately re-assessed before a decision was made to discharge them at scene, and the patient's medical history was not always considered. Following training and raising awareness of the guidance and protocols, this re-audit assesses the appropriateness of discharge decisions for paediatric patients with pyrexia.

Decision making surrounding paediatric conveyance

Following national concerns from the Royal College of Paediatrics and Child Health regarding the amount of

infants left at home following ambulance attendance, a baseline clinical audit was undertaken on patients aged under 1 year old who were discharged at scene. As a result, the LAS issued a paediatric conveyance policy stating that: all patients under 2 years should be conveyed to a hospital; patients aged 2-5 years who are not conveyed must be referred to their GP or suitable Health Care Professional (HCP), and patients aged 6-12 years who are not conveyed should be strongly considered for referral to their GP or a suitable HCP. This clinical audit aims to assess whether conveyance decisions for patients aged 0-12 years are in line with this LAS protocol.

Administration of hydrocortisone re-audit

In 2013 the LAS Hydrocortisone Clinical Audit identified an underuse of hydrocortisone in the treatment of acute severe and life-threatening asthma. A number of actions were taken as a result. This re-audit will assess whether the actions implemented following the previous clinical audit have led to increased use of hydrocortisone for patients with acute severe and life-threatening asthma.

Transient loss of consciousness (TLoC) re-audit

The LAS 2013 TLoC Clinical Audit found that whilst some elements of history taking and assessment were well completed; aspects more specific to TLoC required improvement. A voluntary study day was run to highlight the importance of history taking and a prompt card was produced and issued to assist clinicians with the management of TLoC. Despite the initiatives to improve care, in 2016 a review of the National Institute for Health and Care Excellence (NICE) quality standard for TLoC showed improvements were still needed. In addition, in 2016/17, two incidents were reported relating to the care of TLoC patients. This clinical audit aims to determine whether patients presenting with TLoC are being assessed, treated and managed in line with the LAS, NICE and UK Ambulance Service Clinical Practice guidelines.

Management of intentional overdose

This clinical audit aims to address concerns raised by the LAS 2013 Overdose Clinical Audit which found patients triaged as having no life-threatening symptoms often received a response outside of the commissioned target, when some of them required a pre-alert to hospital. In addition, five incidents have been reported on the Trust's incident reporting system where there was a delay responding to a patient who had overdosed, two of which were declared as serious incidents. This clinical audit aims to: assess if patients who have taken an intentional overdose are being triaged appropriately; examine any reasons for longer than average on scene times, and determine if patients who have taken an intentional overdose who

are not conveyed are being appropriately assessed and referred.

The London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to six patient groups (cardiac arrest, difficulty in breathing, glycaemic emergencies, mental health, severe sepsis and patients that were discharged on scene) and quality assures the documentation on 2.5% of all clinical records completed. We also undertake five continuous audits that monitor the care provided to every patient who falls within the following groups: cardiac arrest, STEMI, stroke, major trauma, discharged at scene but re-contacted the Service within 24 hours having severely deteriorated or died unexpectedly.

The Trust also submit data to the National Out-of-Hospital Cardiac Arrest Outcomes project, a registry of out of hospital cardiac arrests in England. This registry is being used to look at the national variations in outcomes of cardiac arrest and provide evidence to help inform treatment and improve survival amongst this patient group. During 2017/18 we provided 4,432 cases to the registry.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and contributing to wider healthcare improvement. Clinical research ensures our clinical staff keep up to date with the latest possible treatment options and their active participation leads to improved patient outcomes. The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service NHS Trust in the first 3 quarters of 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 683. These patients were recruited into a range of interventional and observational studies. These studies were:

ARREST: A randomised controlled trial exploring whether immediate coronary angiography and percutaneous coronary intervention can improve survival from cardiac arrest

RIGHT-2: A randomised trial that aims is to determine whether glyceryl trinitrate (GTN) improves outcome in patients with ultra-acute stroke when administered as soon as possible after onset.

In 2017/18 145 members of clinical staff received protocol training to enable them to participate in interventional and observational research at the London Ambulance Service NHS Trust.

Appendix 2: CQUINS 2017-18 and 2018-19 : UPDATE

Table 16

Goal No.	Goal Name	Description of goal
1A	National: Introduction of Health and Wellbeing Initiatives – Improving Staff Health and Wellbeing	Percentage point improvements to staff survey results on 3 questions against a 2015/16 baseline.
1B	National: Introduction of Health and Wellbeing Initiatives – Healthy food for NHS staff, visitors and patients	Continuing improvements to healthy food provision delivered in 16/17 and extending requirements for 17/18, 18/19.
1C	National: Introduction of Health and Wellbeing Initiatives – Improving the uptake of flu vaccinations for front line staff within Providers.	Achieving an uptake of flu vaccinations by frontline clinical staff of 70% for 2017/18
12	National: Ambulance Conveyance	A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department.
STP1	National: Supporting Local Areas	Support engagement with local STP initiatives
STP2	National: STF Control Total	Delivery of financial controls – Risk Reserve
L1	Local: Implementing the Digitalisation Enablers	Providing the frontline, clinical staff at London Ambulance with personal issue mobile devices.

Table 17

CQUIN Description		Total Available	Estimated Achieved	Estimated Percentage Achieved
National Health and Wellbeing	Improvement of health and wellbeing of NHS staff	£260,562.00	£65,140.50	25%
	Healthy food for NHS staff, visitors and patients	£260,562.00	£260,562.00	100%
	Improving the uptake of flu vaccinations for front line staff	£263,701.00	£65,925.25	25%
Ambulance Conveyance		£784,825.00	£549,377.50	70%
Mobile Devices for Frontline Staff		£3,139,299.00	£3,021,575.29	96%
STP Engagement		£1,569,650.00	£1,506,864.00	96%
STF Delivery (Control Total)		£1,569,650.00	£1,569,650.00	100%
Total CQUIN		£7,848,249.00	£7,039,094.54	90%

Quality Strategy : Vision 2020 and Annual Quality Account 2018-2019



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