



London Ambulance Service



NHS Trust

Quality Account 2010-2011



Vision



Priorities



Quality Statements



Looking Back

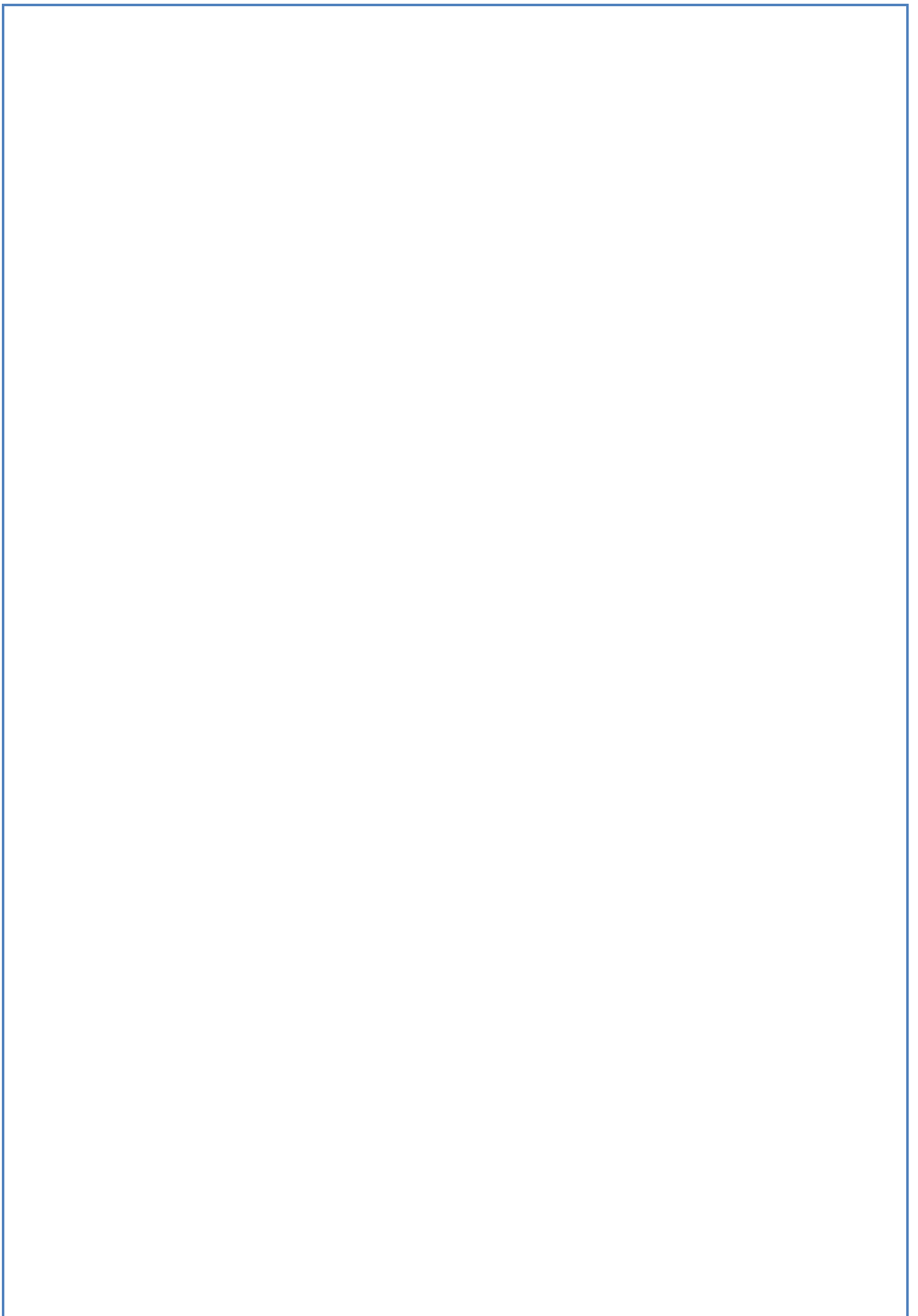


Stakeholder Feedback



Summary





Section 1. Introduction

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Statement by the Chief Executive

Statement by the Chief Executive

The London Ambulance Service NHS Trust is the busiest ambulance service in the UK. We respond to the emergency needs of up to 8 million London residents, commuters and tourists. We help patients of all ages who require unplanned assistance for all health conditions including trauma, cardiac emergency, mental health, maternity and stroke. The work we do is varied and can range from dealing with a major incident, providing clinical support to mass gatherings such as the Papal Visit to helping vulnerable elderly patients in their homes who have had a fall. In addition, we also provide a transport service for patients who require assistance in travelling to various hospitals and clinics, and run the Emergency Bed Service that includes as one of its roles reporting on hospital A&E capacity across the capital.

This past year has been a challenging year for us. We saw the coldest winter in a lifetime which affected health needs in London and also brought on adverse driving conditions through persistent low temperatures. We also saw a large number of demonstrations and public events which required our clinical support. These changes, amongst others, resulted in the highest number of 999 calls requesting assistance that we have ever received with 1.5 million calls made during 2010/11.

While it was challenging we successfully met our most significant quality standard set by the Department of Health to reach 75 per cent of our patients with a potentially life threatening condition within eight minutes and 95 per cent within 19 minutes. Unfortunately, we didn't meet the Department of health standard for our less urgent patients. The standard is to reach 95 per cent of those cases within 19 minutes and we achieved 87 per cent. This is disappointing. But speed is not always the priority with this group of patients and while we will endeavour to improve

our response times this quality standard has now been replaced with more meaningful clinical outcome measures which we will report on next year.

We are committed to providing our patients with the best possible clinical outcomes and experience. Safety and quality are at the very top of our priority list and our vision is to be a world class service.

This, our second ever Quality Account, reports on some of the progress we are making in achieving our vision. Last year we identified a number of quality areas where we would make improvements and this report describes the progress we have made. In addition, we identify new priorities for the coming year and will report on their progress in next year's Quality Account.

The account reports on a number of successes. However, we are not complacent and recognise that further improvements can always be made. We want to raise the profile of the patient voice and improve our understanding of what it is like to be a patient who uses our service. For this reason we are moving towards quality indicators that are described and presented in a way that are meaningful to the public and that will over time provide greater transparency and accountability for what we do. This is reflected in the style of this account. We have tried to make it more accessible to patients and welcome patient feedback on the report or their experience of our service.

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



Peter Bradley CBE
Chief Executive

Introduction

The London Ambulance Service NHS Trust is the only NHS Trust that serves the whole of London. Our role is to provide healthcare that is free to patients at the point of delivery in an out of hospital environment

This year, like every year, has been interesting and challenging. There have been a number of high profile activities that have looked at the quality of our service. All Ambulance Trusts participated in a National Audit Office review and the results will be published in 2011/12. We have been reviewed by the Greater London Authority and are awaiting its conclusion. Most significantly is the outcome of the inquest led by Lady Justice Hallett into the London Bombings of 7 July 2005. Her conclusions were published in May 2011.

As a result of our own learning we have already implemented a number of quality improvements. For example, we now have an event control room and have implemented a second hazardous area response team that can respond to events involving hazardous materials or environments.

We now also have an urban search & rescue team which consists of specially trained staff who are able to respond to patients in challenging and hard to reach environments such as places of height and depth.

These developments have been very positive in improving the quality service we provide. However, we regularly face significant operational challenges and our ability to respond rapidly to requests for help is our priority and is monitored continuously by the Strategic Health Authority, Primary Care Trusts, and the Department of Health. We view the speed of our response as the cornerstone of our ability to demonstrate to everyone that we place safety and quality at the very top of our list of priorities.

But speed of response is only one small component of safety and quality. Other elements are identified in this, our second ever, Quality Account which presents other information for patients, the public, and our Trust Board on safety and quality.

The structure of the Quality Account requires us to identify a number of key priorities for the coming year and to report on the progress against the priorities we set in last year's Quality Account.

In addition, we have included short quality reports from some of our service areas where quality priorities were not explicitly identified within last year's Quality Account (for example, patient transport).



Vision and Values

Our vision is:

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

As an NHS trust we developed seven values that underpinned the culture of the London Ambulance Service and these became our critical values, representing the culture of the organisation and reflecting the values enshrined in the NHS constitution. These values are:

- **Clinical excellence** – we will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs
- **Respect and courtesy** – we will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy
- **Integrity** – we will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right
- **Teamwork** – we will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed
- **Innovation and flexibility** – we will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to
- **Communication** – we will make ourselves available to those who need to speak to us

and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on

- **Accept responsibility** – we will be responsible for our own decisions and actions as we strive to constantly improve
- **Leadership and direction** – we will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

We identified a number of factors that would assist us in delivering our long-term vision. These were the following.

1. **Service Improvement Programme (SIP)** the aim of our service improvement programme is to bring about change in terms of service, performance and culture and achieve the SMART targets. The service development plans are integrated within the Service Improvement Programme
2. **SMART targets:** The achievement of these Specific, Measurable, Attainable, Relevant, and Time-bound targets signifies achievement of our corporate objectives
3. **Corporate objectives:** The collective achievement of these objectives signifies achievement of our strategic goals.
4. **Strategic goals:** The collective achievement of these goals signifies progress made towards our vision.

Corporate objectives

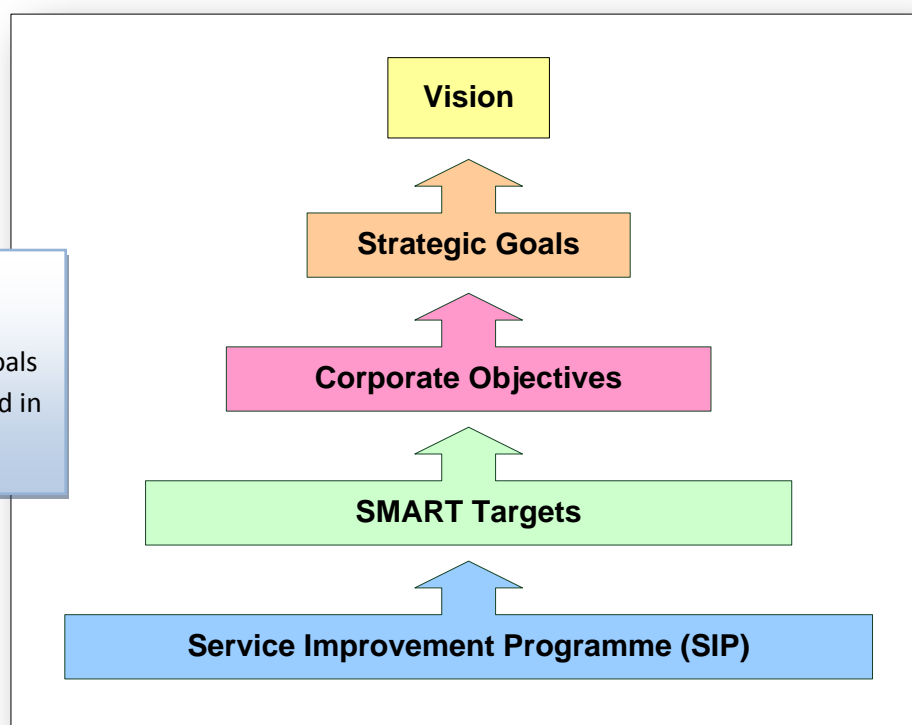
We have 10 corporate objectives and these are identified within the Service so those relating to safety and quality are listed first

1. To improve outcomes for patients who are critically ill or injured
2. To provide more appropriate care for patients with less serious illness or injury
3. To meet response times routinely
4. To meet other regulatory and performance targets
5. To develop staff so they have the skills and confidence they need to do their job
6. To improve the diversity of the workforce
7. To create a productive and supportive working environment where staff feel safe, valued and influential
8. To use resources more efficiently and effectively
9. To maintain service performance during major events, both planned and unplanned, including the 2012 games
10. To improve engagement with stakeholders

Our Strategic Goals are

- To improve the quality of care we provide to patients : to improve our delivery of safe and high quality patient care using all appropriate pathways
- To deliver care with a highly skilled and representative workforce: to have staff who are skilled, confident, motivated, feel valued and who work in a safe environment
- To deliver value for money: to be efficient and productive in delivering our commitments and to continually improve

Illustration to show how our strategy and goals were structured in 2010/11



Writing the Quality Account

We have actively met with a number of patient groups to ask how we are doing and to ask what our quality priorities should be for 2011/12

We believe that in order for us to accurately know how well we are doing it is fundamental for us to ask our patients. While we recognise that we can make improvements in how we consult and have learnt lessons for next year it was the over riding principle that this account should reflect the views of patients.

In addition, we believe that patients should be invited to help us identify our quality priorities for 2011/12.

Therefore, we invited a number of patient groups to participate in a series of focus groups. There were no specific factors for identifying the patient groups that we approached except we targeted groups that represented patients who could use our services regularly (such as support groups for patients with chronic disease).

Not all of the groups we approached responded. However, we were able to meet with The Sickle Cell Society, The London Gay, Bisexual and Transgender Group of Age Concern, the London Older People's Forum, MENCAP and a number of patient groups that had been specifically created for patient education.

The meetings were well attended and the feedback was very positive. Overwhelmingly the common theme was the need to respond quickly to emergency requests and this remains a Trust priority for 2011/12.

The quality priorities for 2011/12 emerged from the focus groups and all focus groups identified the need to consider some of the quality issues for patients who need assistance but do not fall into our emergency category. This is a fundamental component of the quality priorities for this year.

The focus groups were supported by an invitation for our Foundation Trust membership to make quality suggestions via a designated e mail in box. In addition, the Director of Health Promotion & Quality undertook a number of interviews with patients that had used our services.

On completion of the Quality Account a number of stakeholders were invited to make comments on the report and their feedback is contained within the report.



How are we prioritising quality?

Quality is at the heart of what we do and we are continually looking at ways in which we can improve our services or improve the outcome for patients.

Our Trust Board receives information on quality at every board meeting and a number of our non executive directors are members of other committees where quality is a significant part of the work plan.

However, quality is the responsibility of all of our staff and each of our three areas has a governance mechanism for monitoring the quality of the service we provide and for monitoring any action taken to improve.

We have started to develop a new quality dashboard that will help the organisation monitor quality more consistency and this will sit alongside our well established performance dashboard.

However, we know there is more work for us to do. We have identified the further development of the quality dashboard as one of our key quality improvement priorities for 2011/12 but we also need to consider how we structure the feedback that we receive from patients and how we evidence that this has led to us making improvements to our service. We have strong and valuable links with the London Ambulance patients' forum who are represented at various committees but we also need to consider other ways we can involve patients. This will be a key component of a new quality indicator on the dashboard called "Service Experience".

In addition, we need to improve the way we learn and share the learning from serious incidents. We cover a large geographical area and we need to be confident that lessons learned in one area of London are shared across our teams regardless of their location.

We have actively embedded quality within our core business of the Trust and in 2010 established a board level Quality Committee that is chaired by a non executive director

In 2010, we developed a new quality strategy that brings together clinical research, audit, incidents and quality improvements into a single work stream

In 2010 we appointed a Director of Health Promotion & Quality to the executive team. This is a clinical post and the post holder is responsible for assuring the board on quality matters

Further improvements we need to make to our quality processes include the following:

- 1. We need to embed the quality dashboard**
- 2. We need to improve the way we structure and use feedback from patients**
- 3. We need to improve the way we learn and share the learning from serious incidents**

Section 2. Looking Forward

Introduction to Looking Forward

In December 2010 the Department of Health published the Operating Framework for 2011-2012. The framework is used to identify a number of areas that the NHS has to address as a whole and the quality section should be used to inform the quality priorities of all NHS organisations. Trusts are of course free to make additional priorities but there is an expectation that the national priorities will be addressed through local quality work.

This year, as we try to drive improvements against a backdrop of wider financial constraints, the Operating Framework asks us to consider quality in the wider context of health care and identify areas where our actions may release benefits across the NHS as a whole. This is called the "Quality, Innovation, Productivity and Prevention Plan (QIPP) and all NHS organisations are expected to have a plan in place.

We have developed a comprehensive QIPP plan that identifies a number of areas such as health promotion and the development of our workforce. However, the main focus of our QIPP plan is for us to reduce the number of patients we take to accident & emergency who could have their care needs met directly by us or by referral to another provider. This brings enormous benefits to patients as it could avoid an unnecessary period of hospital care and the disruption that is associated by hospitalisation. For the health system it releases benefits by reducing the demand on hospital assessment beds and minimising unnecessary hospitalisation.

The importance of this is reflected in our local Commissioning for Quality and Innovation (CQUIN) payment framework. This scheme allows our commissioners to financially reward us for achieving a successful change. Reducing the number of patients we take to accident & emergency is the largest of the five measures in our CQUIN scheme for 2011-2012.

The Quality Account asks us to take all of this into consideration and identify a small number of quality priorities for 2011-2012 that will lead our quality improvement agenda.

The Operating Framework alone identifies 15 subject areas that are relevant to the services we provide and there are also a number of local priorities.

In order to get this right we asked our patients through the quality work identified in the previous section of this Quality Account.

We then prioritised these against the national and local drivers and have identified four specific areas of quality improvement for 2011-2012.

The four areas are;

- Improving Mental health care
- Improving End of Life Care
- Improving the care for patients who have fallen
- Developing a quality dashboard

Having applied this selection process we are confident that these are the right areas for 2011-2012. They are reflected within the national Operating Framework, our QIPP plan, and our CQUIN scheme. They are consistent with our Strategic Goals and we know they are of importance to patients.

The following few pages outline the case for inclusion in more detail and highlight each example with a case study. This is then followed by an explanation as to what improvements we intend to make in each of the four areas

1. Improving mental health care

Through our accident and emergency work we are known as an acute provider but our work in response to a psychiatric emergency is often less well known. Consequently our links and knowledge of London's complex mental health services are not as strong as they are with accident and emergency departments.

In addition, calls for assistance with mental health problems represent approximately 9 per cent of our work but we recognise that it has not received proportionate attention in our service improvement work.

Mental health is a national priority. It is specifically highlighted in the Operating Framework and appears in our CQUIN scheme from our commissioners. We know from our discussions with patients that they widely support us in making improvements in this area.

However, this is not an easy area for improvement work. Unlike accident and emergency services mental health care is provided differently across London and there are a variety of access points. In addition, mental health patients often travel away from home and can present in crisis away from their care provider. Despite these challenges we have the ambition to make significant improvements to the patient experience.

We have also included a work stream on dementia care. This is to reflect the priority that this is given within the Operating Framework

Our improvement priorities for mental health are identified later in this report.

Case Study

Carol was in her early twenties and standing on the edge of a roof threatening to jump. Concerned passers by called 999 and asked for the police and an ambulance.

Ordinarily this challenging situation could result in the police applying an order under The Mental Health Act obliging us to transfer the patient to hospital for a mental health assessment.

In Carol's case we had already established good links with the local mental health team and had previously agreed that we could directly access their skills.

When we spoke to Carol it became apparent that she didn't wish to jump but she did need assistance. We took the decision that this situation did not need police intervention and Carol did not need to be taken to hospital. Instead, we contacted the local psychiatric liaison service who arranged a mental health assessment.

This avoided Carol being taken to hospital and the intervention of the police. This was only possible because of our relationship with the local mental health team.

2. End of life care

We recognise that the end of life can be a very distressing time for all involved. This is particularly the case when patients who have expressed a particular preference to end their life at home can not have their wish fulfilled.

This can happen when patients, friends or family call us for assistance. When we arrive we have very little information available to us and inevitably our desire to minimise the distress means we transport the patient to hospital for a medical opinion. This is clearly not always the best action to take.

End of life care is also a national priority. It is specifically highlighted in the Operating Framework and also appears in our CQUIN scheme.

A number of patients groups were specifically interested in this aspect of our work and appreciated how instrumental the ambulance service is in ensuring the preferences expressed by patients are maintained. This area of work was wholly endorsed by our patient groups.

Case Study

We were called to a young woman who was experiencing severe pain and distress. Silvia had lung cancer that, over time, had extended into her bones and she had also recently developed renal failure.

She had already been identified to us through the end of life project work so we had all the important information about her care plan. We also had all the relevant healthcare contact details to hand.

On arrival our clinical staff were able to assess and identify Silvia's main concerns.

Medications had already been prescribed and were in the house for other healthcare professionals to use. Our clinical staff administered the necessary drugs for Silvia's immediate symptom control. We then arranged further care and follow-up visits by a specialist palliative care team.

Silvia died peacefully later that night, in accordance with her own wishes, in her own bed with her family at her side. Without the sharing of information from the outset our clinical staff would have had limited options and Silvia could have been taken to hospital.



3. Patients who have fallen

Patients who have fallen are not specifically identified as a national priority within the Operating Framework. However, it is a local priority.

Inevitably with a population the size of London's we receive a significant number of calls regarding patients who have fallen. Every month approximately 6,500 people aged 65 years or over call an ambulance after a fall. The majority of these incidents occur in the patient's own home. Currently, 67 per cent of these patients are conveyed to hospital, 29 per cent are assisted and treated on scene, and the remaining four per cent are referred to other services.

With a year-on-year increase in the percentage of over 65s within the population, it is predicted that the numbers of people who fall will continue to increase. Some will obviously require transportation to accident and emergency but we need to undertake further work with those groups where an immediate hospital assessment is not necessary.

This is an important part of our QIPP Plan as there are opportunities to increase the proportion of patients that we don't take to accident and emergency by working with this group. Also, there are opportunities for us to improve the way we communicate our actions with other healthcare providers particularly when we decide not to convey a patient to accident and emergency following a fall. This is a specific measure within our CQUIN scheme.

Case Study

Having an agreed process in place can make a real difference to patient care. Some care homes have residents with low needs and therefore have limited clinical expertise.

On Christmas Day Emily was in a care home and fell. The staff in the care home had to adhere to their policy which states the need to call 999 and ask for an ambulance.

We had an agreed protocol in place with the primary care provider and were able to contact the GP ourselves.

Emily was pleasantly surprised that the GP came out for a visit and referred Emily directly to a falls team.

This prevented Emily from having to be transported to hospital and wait for her assessment away from friends and relatives.



4. Development of a quality dashboard

It is important that we also focus some attention on the wider quality measures identified within the Operating Framework and are able to demonstrate wider quality improvements.

Therefore, while they will not have a dedicated work stream to support implementation, the dashboard will capture a number of the other priorities and these are outlined in our Quality Strategy.

Our patient groups were supportive of us developing wider measures and we agreed that we would make these available to patients in due course.

In addition, the quality dashboard will be an important part of our portfolio of evidence when meeting with commissioners and they are also supportive of this development.

5. Last Year's Priorities (2010/11)

There is one final area for consideration. This is the on going work from the priorities identified last year.

In 2010/11 we identified six priority areas. These were to:

1. **Improve Cardiac care**
2. **Improve Trauma Care**
3. **Implement Alternative Care Pathways**
4. **Improve Stroke Care**
5. **Develop the Quality Dashboard**
6. **Free ambulances for care**

Unsurprisingly while this report highlights the successes there are a number of further improvements that can be made. In addition, three of the areas are explicitly identified within this year's Operating Framework. Therefore, we also commit ourselves to a continuation in making improvements in these essential areas of quality. The areas for improvements are identified later in this report.



Mental health care

We are pleased to see that the Trust intends to improve mental health care and acknowledges that this is an area which is neglected. We would suggest that as well as NHS Trusts the London Ambulance Service should look to work with the voluntary sector specialised in mental health care

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Improvements we need to make to mental health care include the following:

1. Improving the skill and competence in our clinical staff
2. Participate in whole system transformation work with partner organisations
3. Improve the advice and support available to our clinical staff
4. Improve the actual clinical intervention we provide to mental health patients
5. Improve our governance and safeguarding arrangements with mental health patients
6. Improve the care of patients with dementia
7. Consider how we can use health promotion work with mental health patients
8. Improve the management of alcohol related harm

Mental health (quality domain: patient safety)

We have agreed our improvement strategy for mental health with our commissioners and will launch our mental health group early in 2011/12.

Whilst our lead Director has a mental health qualification we will also need to recruit a mental health expert to lead some of the improvement work and we will do this early in 2011/12.

We will need to work in collaboration with other NHS Trusts and with our commissioners to ensure we make meaningful improvements to the quality of service we provide.

Patient feedback is also essential and we will engage with patient representation to ensure we are making the right improvements.

End of life care

“Patients should be allowed to choose to die at home and the London Ambulance Service should support their decision by offering them all the assistance they possibly can”

Minority Ethnic Elder’s Group of the
London Older People’s Forum

End of life (quality domain: patient experience)

The ability to support end of life care strategies across London is a growing priority for the Trust and fits with other ongoing strategic developments including the development of appropriate care pathways.

Last year we worked with Guy’s and St Thomas’ Hospital Charity on end of life care. The project required us to share the decisions patients had made about their end of life care and for us to ensure these wishes were taken into consideration along the whole care pathway.

We will build upon this work and continue to work with other end of life care providers in jointly providing that care. In order to provide fit for purpose end of life care support in the community we will develop a number of quality improvements.

Further improvements we need to make to end of life care include the following:

1. Improve the skills and competence of our clinical staff
2. Hold and share the information about a patient’s current care preferences
3. Clarify how we obtain clinical support from local providers
4. Improve the confidence in the systems so we can handover care
5. Have knowledge to take appropriate action if the agreed care provision breaks down
6. Improve the knowledge in the dying process
7. Improve the ability of clinical staff to make an examination and assessment
8. Improve the knowledge of drug use in out of hospital end of life care
9. Understand the challenges associated with end of life care for people with dementia

Patients who have fallen

We welcome the quality priorities for 2011/12 on improved pathways for Mental Health, End of Life Care and Elderly Fallers, which are fully in line with our commissioning intentions and we have incentivised by the Commissioning for Quality and Innovation (CQUIN) payment framework. These priorities have been supported by the new Clinical Quality Group, which has GP representation from across London, and clinical representation from the LAS

North West London NHS commissioners

there were two strands of work to be undertaken to provide additional training for all operational staff enabling them to understand the possible causes and management options for elderly people who fall and to engage GPs, out-of-hours services, and community care services providing specialist care for patients who have fallen.

Further improvements we need to make to the way we care for patients who have fallen include the following:

- 1. We will further develop the tool to assist our clinicians in decision making and make this more widely available to staff**
- 2. We will implement training so that staff are familiar with the developed tool**
- 3. We will improve our monthly referral rates following agreed falls protocol (back to GP) for uninjured people who have fallen**

Falls (quality domain: clinical effectiveness)

It is recognised by clinicians that there are a multitude of causes that can lead to an individual sustaining a fall, ranging from physiological changes related to the aging processes, acute medical episodes and slips or trips on furnishings or even pets. However, in order to establish the underlying cause of the fall, an in-depth history and a full physical assessment must be undertaken on each patient. Together these provide the clinician with the knowledge that enables them to construct a management plan to address patient's individual needs.

Historically, there has been no linking mechanism between our services and the wider GP community to share information about patients who have fallen but have not been taken to hospital. During 2010/11, a small working group was tasked to review our management of elderly patients who have fallen. It became clear that

Implementing a quality dashboard

The committee notes that the Trust invited patient groups to help identify quality priorities for 2011/12. This idea is welcomed by committee and members agree that quality indicators will be more meaningful to the public and those that use the service.

External Services Scrutiny Committee at
the London Borough of Hillingdon

Further Improvements we need to make to the development of our quality dashboard include the following:

1. Implement the use of the dashboard through our quality governance structure
2. The implementation of the additional quality measures identified within our quality strategy
3. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success

Quality dashboard (quality domain: all three domains)

During 2010/11 we started to develop a quality dashboard that will strengthen the way we assure ourselves that we are delivering on quality. The dashboard will regularly present the outcomes against a number of quality measures such as infection control and patient experience.

For 2010/11 the majority of the developmental work was focussed around the implementation of new measures from the Department of Health. However, as we progress through 2011/12 we will implement additional indicators so that we have a more complete picture.

These additional quality measures have been identified through an analysis of our incidents and through discussions at a number of patient focus groups.

Section 2. Looking forward

2010/11 priorities

Last year's priorities

In section 3 of this Quality Account we report the improvements made against last year's quality priorities. These are large pieces of work and, just like the mental health priority we have identified for next year, require us to work in partnership with other providers.

Consequently some of the work is continuing. It would be wrong to cease the improvement work on the grounds we have entered a new year. Therefore, we make the commitment to continue to drive the improvements in those areas alongside the new improvements we have identified for next year. In essence, our quality improvement programme has significantly enlarged.

The improvements for patients in those priority areas will be monitored via new indicators on the quality dashboard. This will allow us to corporately monitor, and then learn and share, the local improvement work.

Within the Quality Account we have also asked each of our service areas to contribute by identifying the quality improvements they made to their services areas last year and to specifically identify quality improvement areas for this year. These will be monitored through the local governance work and the service areas will be asked to report their improvements in next year's Quality Account.



Assurance statements

Section B: Statements relating to the quality of services (mandated)

The Department of Health identifies a number of mandatory statements that the Quality Account must report upon. These are predominately regarding data, audit and research and are as follows:

Statement area 1: Data review

During 2010/11 the London Ambulance Service NHS Trust provided three NHS services. The London Ambulance Services NHS Trust has reviewed all the data available to them on the quality of care in all three of these services.

Statement area 2: Income

The income generated by the NHS services reviewed in 2010/011 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2010/11.

Statement area 3: Clinical audit

During 2010/11, one national clinical audit and one national confidential enquiry covered NHS services that the London Ambulance Service NHS Trust provides. During that period the London Ambulance Service NHS Trust participated in 100 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was **eligible to participate in** during 2010/11 are as follows;

- National clinical performance indicators programme covering:
 - ST-elevated myocardial infarction (STEMI)
 - Cardiac arrest
 - Stroke
 - Hypoglycaemia
 - Asthma
- Centre for Maternal and Child Enquiries (CMACE formerly the Confidential Enquiry into Maternal and Child Health): Confidential enquiry into head injury in children.



Statement area 3: Clinical Audit (continued)

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust **participated in** during 2010/11 are as follows;

- National clinical performance indicators programme covering:
 - STEMI
 - Cardiac arrest
 - Stroke
 - Hypoglycaemia
 - Asthma
- CMACE: Confidential enquiry into head injury in children.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2010/11 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National clinical performance indicators programme covering:
 - STEMI (100%)
 - Cardiac arrest (100%)
 - Stroke (100%)
 - Hypoglycaemia (100%)
 - Asthma (100%)
- CMACE: Confidential enquiry into head injury in children (100 per cent for the cases for which the London Ambulance Service NHS Trust has been given full details)

Statement area 3: Clinical audit (continued)

The report of one national clinical audit was reviewed by the provider in 2010/11 and the actions that the London Ambulance Service NHS Trust intends to take are outlined in the research and audit section.

The reports of eight local clinical audits were reviewed by the provider in 2010/11 and the actions the London Ambulance Service NHS Trust intends to take are outlined in the research and audit section.

There are two additional mandatory statements reported in the research and audit section of this report

Statement area 4: Research

The number of patients receiving NHS Services provided or sub contracted by the London Ambulance Service NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 164.

Statement Area 5: CQUINs

A proportion of the London Ambulance Service NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework. The details of the agreed goals for 2010/11 are as follows.

1a. Care pathway role description and names of champions. £0.5m Achieved

1b. Care Pathway action plan by complex / sector £0.5m Achieved

1c. Monthly care pathway reports £0.5m Achieved

1d. Reduce conveyance rate to hospital A&E departments £0.5m Not achieved

1e. Increase rate of usage of clinical telephone advice, NHS Direct and not-conveyed cases. £0.75m Not achieved

2a. Response time to cardiac arrest. percentage of patients returned to spontaneous circulation (ROSC). Percentage of ST elevated myocardial infarction patients taken to catheter labs £0.25m Achieved

2b. Percentage of stroke patients taken to hyper acute stroke units. Percentage of trauma patients taken to major trauma units. £0.25m Achieved

2c. Establish falls referral pathways and refer patients. Establish and refer. £0.25m Partially achieved

Statement Area 5: CQUINs (continued)

The details of the agreed goals for 2011/12 are as follows.

1a. Reducing conveyance rate to A/E services. £1m

1b. Hear and treat resolution (no convey) via clinical telephone advice & NHS Direct. £0.75m

1c. Implementation of NHS Pathways in clinical telephone advice. £0.75m

1d. Clinical performance indicator non conveyed. £0.25m

2a. Falls and older people referrals to GPs. £0.25m

3a. End of life care patients held on our system. £1.25m

3b. End of life care usage of register by our staff to affect outcome 0.125m

4a. Mental health service improvement plan, including outcome of wider mental health review. £0.125m

4b. Development of MH protocols for direct access to MH crisis teams. £0.25m

5a. Whole system clinical group - established & effective including joint review of referral, treatment & discharge protocols, including specific review of protocol frequent callers, metropolitan police & high referring/call locations. £0.125m

5b. Whole system clinical incident reporting & resolution. £0.25m



Statement area 6: Care Quality Commission

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

The London Ambulance Service NHS Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

Statement area 7: Data quality

The London Ambulance Service NHS Trust will be taking a number of actions to improve data quality.

Data quality is an integral part of the data capture process. There is a data quality team in the department of Management Information with a specific responsibility for ensuring that data quality remains a priority for the Trust. All Accident & Emergency records are processed through an in house data quality system which checks for inconsistencies and records that are outside certain parameters. It also checks against a set of rules agreed by the Trust Board.

In addition to this there is a facility available to all staff which allows individual records to be flagged for checking by the data quality team. The data quality system is ever evolving where more “rules” are added to it on an ongoing basis to continually improve the quality of the data.

Team leaders also carry out CPIs (clinical performance indicators) on patient report forms against an agreed set of criteria. This is led by



Statement area 8: NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The London Ambulance Service NHS Trust was not required to submit records during 2010/11 using patient's valid General Medical Practice Code.

Statement area 9: Information governance toolkit attainment levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score overall score for 2010/11 was 61 per cent and was graded amber from the Information Governance Toolkit Grading Scheme.

Statement area 10: Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.



Introduction to looking back

The following pages present the progress made against the priorities that we identified in 2010/11.

Last year our strategic vision was **to meet the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.**

To achieve this vision we mapped a number of service objectives that would help us deliver the necessary quality improvements.

These service priorities were:

- Improve cardiac care
- Implement stroke and trauma strategies
- Make demonstrable progress with implementing appropriate care pathways
- Develop and publish a clinical dashboard to better inform the public about quality of care; and
- Improve operational support including the optimal availability of vehicles, equipment and supplies.

The following section presents our quality improvements against each of these five areas (except stroke and trauma work which is reported separately within this Quality Account).

In addition, the following service areas have reported their quality improvements:

- Emergency operations centre
- Patient transport services
- Emergency bed services
- Clinical audit and research



Accident & Emergency: Improving cardiac care

During 2010/11 we further developed the cardiac model, implemented in 2006/07 (which identified 8 specialist heart attack centres in London) and achieved the following:

The survival rate from cardiac arrest has risen dramatically from 4.2 per cent to 21.5 per cent in the past 11 years.

We took 11 per cent more patients (a total of 1779 patients) to specialist units in 2009/10 than the previous year.

In September 2010 the guidelines were expanded to accept a wider range of patients directly into the heart attack centres.

The terms cardiac arrest and heart attack can be confusing. For the purpose of the Quality Account a cardiac arrest refers to the event which causes the heart to stop beating and a heart attack is the death of heart muscle.

Patients diagnosed with a common type of heart attack, known as an ST elevation myocardial infarction, have been taken directly to one of eight designated Heart Attack Centres for angioplasty, 24 hours a day, since March 2006. These patients are taken to specialist centres to enable them to be given primary angioplasty, a procedure which involves inflating a balloon inside an artery to enable a blockage to be cleared.

How have we developed what we do since 2006?

We have become more experienced in identifying the correct patients. Feedback from all eight heart attack centres has revealed that 80 per cent of the patients we suspected as having this type of heart attack were correctly diagnosed, an extremely respectable diagnosis rate. The majority of the remaining 20 per cent were deemed to have associated high risk cardiac problems.

We now produce world class survival rates from cardiac arrests that occur in the out of hospital setting. Last year resuscitation was attempted on over 4,000 patients.

How do we continue to learn from the experience of the network?

Representatives from the service attend monthly meetings held at many of the heart attack centres. These meetings provide an opportunity to discuss patients individually, particularly regarding delays incurred or questions relating to diagnosis. Any issues are fed back to frontline staff and station management with training needs addressed. Incidents and issues are monitored for trends and appropriate action taken where necessary.

What changes to clinical practice have taken place during 2010/11?

Therapeutic hypothermia is now known to improve outcomes in specific groups of patients. This has been introduced in certain areas to assess the feasibility of the wider implementation in the pre-hospital setting.

In addition, we have a number of research areas looking at how we can make further improvements. For example, in October 2010 in conjunction with Barts and the London NHS Trust we commenced a new research study. The objective of this study is to determine the feasibility of pre-hospital administration of adenosine (to patients with very rapid heart

rhythm) by paramedics and subsequent referral to an electrophysiologist bypassing the need to attend an emergency department. This is the first such trial within the UK.

How have we improved the speed in which cardiac arrest patients receive assistance?

We know that early defibrillation is a significant factor to making a recovery. However, we are developing opportunities where cardiac arrest patients can receive defibrillation even before we arrive on scene.

We are now responsible for 520 automatic external defibrillators at over 192 different sites. Over 4,600 members of the public have been trained in their use and approximately 3,000 refresher training sessions were delivered. Since 2005 this initiative has produced 28 survivors from cardiac arrest.

In addition, our community resuscitation team continue to train members of the public in cardio-pulmonary resuscitation and has trained over 6,900 members of the public in the last year and over 60,800 people to date. The schools and events team travel around the capital teaching school children how and when to call for an ambulance and perform resuscitation.

How have we kept our staff up to date with developments in cardiac care?

In 2010/11 team leaders received a two week clinical leads update course covering various aspects of cardiac care and resuscitation. Intensive resuscitation training was also delivered on our paramedic courses.

Due to the rapid advancement of cardiac care within the service and the amount of information needed to keep staff up to date, numbered information sheets called 'cardiac information circulars' were developed. These circulars can be easily located on the intranet and provide guidance on a range of cardiac care topics. For the last two years, a quarterly clinical update' publication has been circulated to staff along with our staff magazine. This has contained information on resuscitation and cardiac care in addition to other clinical topics.

These cardiac and heart attack successes have been the result of several factors, which include the implementation of a detailed, service wide cardiac care strategy, appointment of a dedicated cardiac lead, the hard work of frontline staff and stringent audit of data.

It is important however, that we continue to strive to provide high quality evidence based care and continue to increase survival rates year upon year.

Further Improvements we need to make in order to improve cardiac care include the following:

- 1. Due to the abundance of data indicating the benefits of therapeutic hypothermia, and the fact that it is recommended in the 2010 Resuscitation Council UK guidelines, this treatment will be rolled out pan London as soon as the most feasible means of instigating hypothermia is determined**
- 2. Enable the downloading of information from defibrillators to be made as accessible as possible**



Accident & Emergency: Improving trauma care

In 2010/11 London dramatically reorganised the way emergency trauma care is delivered

The new system saw the implementation of four trauma networks. Each network has a hospital designated as a major trauma centre and a number of other hospitals supporting them as trauma units

Patients identified as having major injuries are taken directly to one of the four major trauma centres bypassing local hospitals. This gives patients rapid access to a specialist and experienced trauma team

The location of the major trauma centres should ensure that no patient should be more than 45 minutes away from a major trauma centre

The management of patients with major trauma has been identified as an area for improvement for well over 20 years. Studies have revealed that poor airway management and failure to recognise and control haemorrhage as major factors are areas of care that need improving.

The 2007 report “Trauma, Who Cares” highlighted the lack of progress, and in particular identified shortcomings in the pre-hospital management of these patients.

In addition, there has been significant learning from the experience of managing the military casualties in Iraq and Afghanistan. The National Audit Report (2010) reported the progress made in caring for military casualties and this was in stark contrast to the National Audit Office report on the management of major trauma in civilian practice.

These reports were the subject of scrutiny by the Public Accounts Committee and led to the Chief Executive of the NHS including major trauma care in the 2011 Operating Framework, and requiring all strategic health authorities to have robust plans in place for regionalised trauma care by the end of 2011.

London has been ahead of the recommendations and has implemented the new system ahead of other areas in the country.

How do we ensure our clinical staff take the patient to the right hospital?

Clearly the decision on which patients should be taken where is critically important. Our staff make decisions based on their assessment but this is supported by a tool known as the major trauma field decision tree,

The tool consists of four steps; any patient who triggers steps 1 or 2 is taken direct to an major trauma centre whilst patients who trigger steps 3 and 4 are discussed with the experienced trauma paramedic staff on our clinical coordination desk.

How long is it taking to get patients to get to the right hospital?

The changes do not affect the speed in which we arrive on scene. Journey times to the major trauma centres have been short with the average time from leaving the scene being 14 minutes.

How do we know the changes have benefitted patients?

All data regarding trauma is submitted to the Trauma Audit and Research Network. This is a national trauma database which collates all the relevant information. Approximately 10 patients sustain severe injuries each day in London.

Evidence from Victoria, in Australia, suggests that it can take up to five to seven years to collect enough data to identify the improved outcomes. However, we know that key factors that play a part in contributing to patient outcomes (such as access to CT scanning) have improved significantly through the implementation of the changes.

The London Trauma Office published its first half-yearly report in January 2011, with evidence that 37 additional survivors had been identified as a result of the implemented changes.

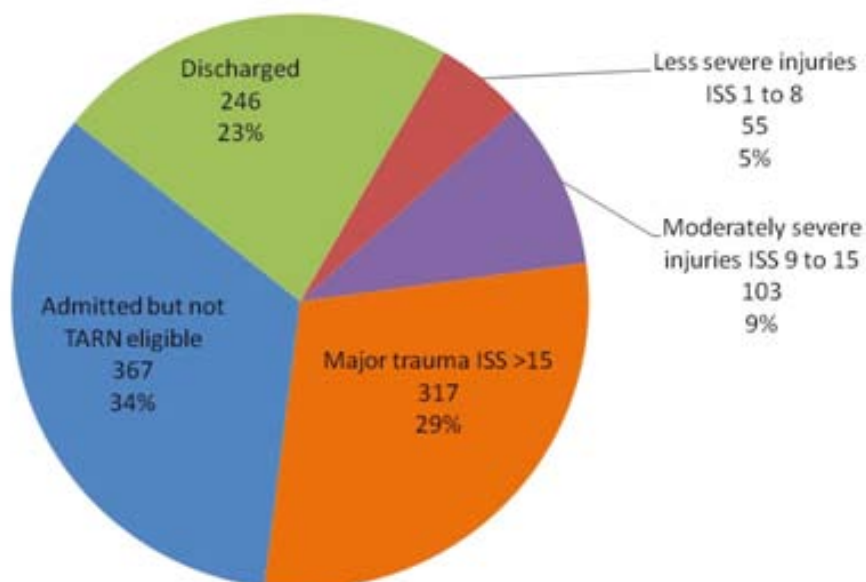
Further improvements we need to make to the care of trauma patients include the following:

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

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

Outcomes of all major trauma centres triage tool positive patients from 6 April 2010 to 31 July 2010 (total number 1,088)

Figure 1 demonstrates the severity of injuries found on over 1,000 patients from the four months following 'go live', with 29% of patients having major trauma (ISS >15), and a further 9% having moderately serious injuries (ISS 9 – 15).



Accident & Emergency: Alternative and appropriate care pathways

In 2010/11 we developed two large alternative or appropriate care pathways. A stroke pathway and a major trauma pathway

We have also developed a range of local pathways that prevent the need to take patients to hospital

A number of reports have been published, particularly 'A Framework for Action' by Professor Lord Darzi and 'Taking Healthcare to the Patient: Transforming NHS Ambulance Services' by Peter Bradley. Both of these publications make it clear that the ambulance service needs to have a far greater level of integration with other services to provide enhanced patient care.

The terms alternative care pathway and appropriate care pathway are used to describe a specific service or unit that has agreed to receive patients presenting with a clearly defined condition directly from us and where this has been constructed into a formal framework between the relevant parties. Without this agreement the patients would usually have been taken to hospital.

What new pathways have been developed in 2010/11?

Two pan-care pathways have been developed:

- Stroke alternative care pathway introduced from February 2010, where patients testing positive for possible acute stroke are taken directly to hyper-acute stroke units.
- Major trauma alternative care pathway introduced in April 2010, where those patients who have sustained significant traumatic injuries (as assessed using a decision tree)

are conveyed to one of four major trauma centres.

How has this benefitted the patients?

We have not specifically evaluated the introduction of alternative care pathways but have received some positive feedback from patients and will explore this further in 2011/12.

What else have we done to develop alternative care pathways?

Over the past few years, a number of walk-in centres and minor Injury Units have been developed, sometimes on the site of previous accident & emergency departments. These units are usually nurse-led and specialise in the less serious conditions. A 'core' list of basic conditions that could be accepted by all such centres was developed by us. Overall this has been a success, and with more urgent care centres opening over the forthcoming year, this approach will continue.

On a more local basis, some community services have approached our local management teams in order to demonstrate the benefits of us having direct access to their services (where a patient may be able to receive excellent definitive care in the community). In these cases the care pathway is developed on this local level, with support from a central team who will have final verification at a strategic level. There have been some real successes in these local pathways, where due to their nature, the local ownership has resulted in real engagement with local staff.

Further improvements we need to make to the development of alternative or appropriate care pathways include:

1. There are further opportunities to develop the care pathways and this has been identified as a specific quality priority for 2011/12
2. We will continue to explore opportunities within urgent care centres
3. We will look for ways to obtain patient feedback on how the pathways benefit patients.



Accident & Emergency: Improving stroke care

In 2010/11 we implemented a whole new approach to stroke care which involved taking patients with a suspected stroke directly to a specialist centre bypassing local hospitals

We have continually monitored the impact this has had on patient outcomes

Stroke has been identified as the second largest cause of death in London, and the largest cause of adult disability. Approximately 11, 000 Londoners suffer a stroke every year. Through NHS London, we have been involved in reforming stroke care across the capital from the beginning of the project.

What changes have taken place to stroke care in 2010/11?

From February 2010, we started to take all patients with a new-onset positive stroke test to their nearest hyper acute stroke unit, provided that they could be transported there within three hours of the onset of symptoms. This arrangement allowed the hyper acute stroke units to run-up to full capacity, whilst delivering thrombolysis to those patients that needed it most.

Later in the year the timeframe was increased from three hours to four and a half hours. All patients with symptoms suggesting a new stroke are now taken to a hyper acute stroke unit.

How have we kept our clinical staff up to date with the changes to stroke care?

All appropriate staff were trained before the go-live phase but since then we have published articles on stroke and transient ischaemic attacks which have appeared in our clinical updates for

staff. Stroke has also featured in our publication the LAS News

In November, the North-West London Stroke and Cardiac Network and Imperial Healthcare NHS Trust hosted a clinical education day for our staff. Speakers included network leads and senior clinicians addressing key issues on stroke prevention and acute treatment. Almost 100 people attended and feedback was overwhelmingly excellent. We plan to hold a similar event later this year.

Many staff have also had the opportunity to spend time in local hyper acute stroke units shadowing clinical staff, and feedback indicates that this is a very useful experience.

How do we monitor the capacity of beds in the Hyper Acute Stroke Units?

In order to monitor capacity and balance flows of patients (to maximise available bed-space) the clinical coordination desk was set up. Sitting alongside the clinical support desk, this has played a vital role in coordinating patient movements across all hyper acute stroke units, and providing decision support for clinical crews faced with patients with unusual symptoms.

How have these changes benefitted patients?

Clinical Audit of our stroke care started in May 2010. Since then, we have been able to demonstrate that ambulance crews consistently triage stroke patients to an appropriate hospital over 90 per cent of the time.

Ambulance journey times to scene have also consistently been within the appropriate target. On scene time averages at 33 minutes, although this is somewhat shifted by a number of difficult removals. Journey time to hospital is 18 minutes on average across London which is well within the limits agreed at the time the project was set up. The average call-to-hospital time is just over 60 minutes.

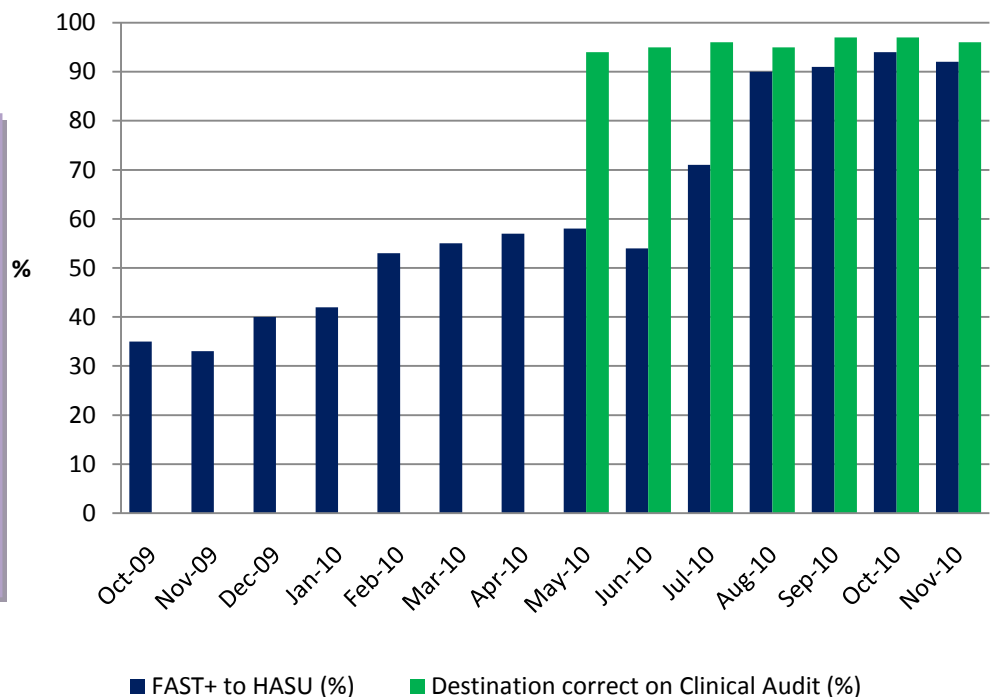
Feedback from all the hyper acute stroke units – and the networks has been good. They attribute the success of the stroke project in part to our ability to get patients directly to specialist centres. We have had several excellent patient testimonials, including a speaker who commented that “the competence of the Trust staff give him confidence in the whole stroke service”.

In little over a year, the London stroke system has developed into a system with one of the highest thrombolysis rates in the world. Over 80 per cent of patients spend more than 90 per cent of their hospital stay on a dedicated stroke ward and 85 per cent of TIA patients have their treatment commenced within 24 hours of symptom onset. Length of stay continues to drop, and over 30 per cent of patients are discharged home from a hyper acute stroke unit. The critical transfer and repatriation systems are working well.

Further improvements we need to make to improving stroke care include:

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

Graph 1. Patients conveyed directly to a hyper acute stroke unit and those conveyed to an appropriate destination following clinical audit



All areas: Implementing a quality dashboard

In 2010/11 we put in place the processes necessary for implementation of the new quality indicators from April 2011

We have identified a number of additional quality indicators for inclusion in a wider quality dashboard

We have developed a new Quality Strategy that outlines the direction of our future quality work and how the quality dashboard will look following implementation in 2011/12

In the Quality Account 2009/10 we reported that the Department of Health were introducing a set of new quality indicators during 2010/11. These were launched in April 2011 but much of the quality dashboard work in 2009/10 was spent preparing for these new measures.

However, we have taken the opportunity to expand the dashboard so that it goes beyond the minimum data and gives us a better measure of how we are delivering on quality.

How have we implemented the new quality measures from the Department of Health?

There are 12 quality measures for implementation. These are comprehensive and many have sub levels. Consequently there are actually 20 measures which require data collection and publication.

We will be required to publish the data on our website alongside the equivalent data from other Ambulance Trusts. This is so the public and

commissioners can benchmark our service against that of similar providers.

The data collection has commenced and the dashboard will be published in 2011/12.

What other quality indicators are we considering?

Our discussions with patient groups and an analysis of our complaints and incidents have revealed a number of additional quality measures. Some of these are developments of work we were already measuring such as safeguarding and infection control. Other indicators are new such as the recording of lost property or equipment availability.

How has our Quality Strategy assisted us in Improving Quality?

While we have a Director with specific responsibility for quality it is everyone's responsibility. Consequently the improvement work sits across a number of directorates. For example, the clinical audit team reports to the Medical Director and the patient experience team reports to the Director of Corporate Services. The report brings together all the essential components into a cohesive strategy to ensure all the work streams are striving to deliver the same improvement priorities.

Further Improvements we need to make to the development of our quality dashboard were identified in section 2 but include the following:

1. Implement the use of the dashboard through our quality governance structure
2. The implementation of the additional quality measures identified within our Quality Strategy
3. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success



Operational support: Ambulance availability

In 2010/11 we reviewed our blanket management processes to ensure we had enough supply for the winter months

We made improvements in equipment availability for our clinical staff

We have improved the availability of vehicles

Throughout 2010/11 there have been a number of initiatives to improve the effectiveness of the fleet and logistics department and improve the service given to frontline operations.

What specific improvements have we made in 2010/11?

A review of the management of blankets was undertaken and its recommendations approved by our senior management group. The result was a significant increase in the number of blankets in the system, prior to the bad weather in December. The new process takes account of blanket losses and replacements as well as aligning laundering with Primary Care Trusts to reduce the number of blankets being collected and returned to us.

Diagnostic packs, containing blood glucose monitoring kits, thermometers and sphygmomanometers were introduced along with a robust control system to reduce the number of losses and to ensure 100 per cent availability to frontline crews.

This was coupled with the introduction of managers drug packs, to improve the availability of paramedic drug packs and reduce the wastage and loss of out of date drugs.

What improvements were made to vehicle availability in 2010/11?

A number of initiatives were undertaken to improve vehicle availability during the year. The flexible fleet concept was challenged and deployment of the fleet brought into line with rosters. As a result 75 per cent of the fleet is now assigned to a specific station and only 25 per cent being moved between stations to meet peaks and troughs of demand throughout the week.

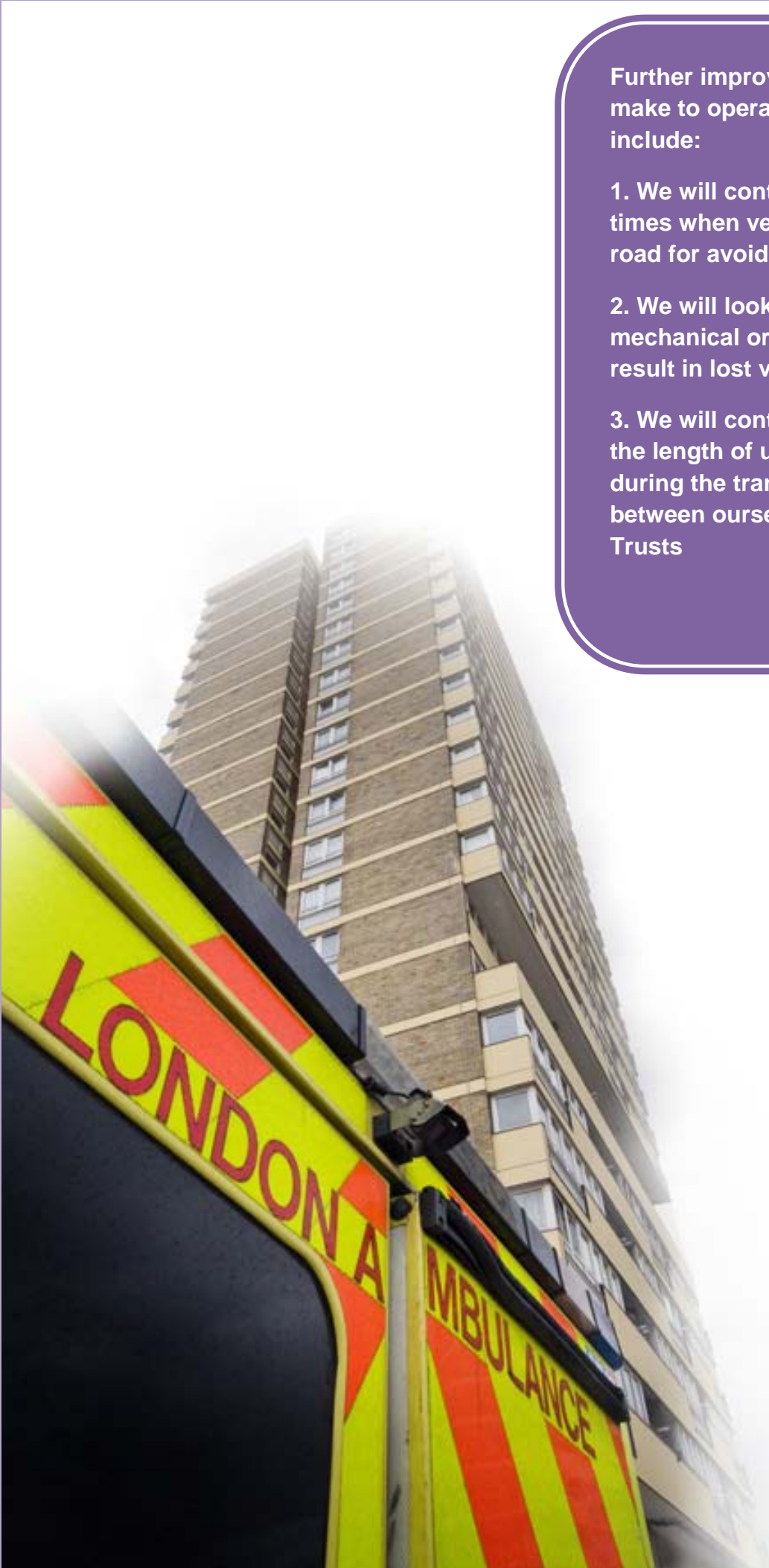
Aligning the fleet back to stations has had a number of positive impacts, there is a clear sense of ownership by station crews which in turn has meant that equipment is staying with the vehicle and vehicles do not have to be re-equipped each time they move. Servicing performance is improving as it is easier to withdraw a vehicle from use to undertake safety checks.

What improvements have been made to cleaning?

Deep cleaning performance is beginning to improve as it is easier for the deep cleaning crews to locate vehicles. By the end of the 2010/11 period we were able to report significant improvements in our compliance with our deep cleaning standards.

What impact have these improvements had on ambulance availability?

These initiatives have all contributed to improved performance by Fleet and Logistics and this can be demonstrated through the changes in the main Key Performance Indicator for Fleet and Logistics with vehicles off the road falling from 5.5 per cent in June 2010 to 4.3 per cent in February 2011.



Further improvements we need to make to operational support include:

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

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

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

Emergency operations centre: Quality improvements

In 2010/11 we have been preparing for the implementation of our new computer aided dispatch system

We have developed a demand management programme that ensures safety and quality at times of high demand.

We won control room of the year in this year's Emergency Services Awards

This has been a busy year for our emergency operations centre as we move towards the complex change in our computer systems.

How have we been preparing for the changes to our computer aided dispatch System?

This goes live on 8 June, 2011. Therefore, as this represents a significant risk and challenge for us most of 2010 has been about ensuring the quality implementation of the new system.

We have ensured that there are the right number of trainers in place to support the comprehensive training schedule that started in January this year until the go-live date. In addition, recruitment had to be front-loaded to support the number of people removed from "business as usual" to support the delivery of the system.

What other developments have taken place during 2010/11?

Early 2010 saw the successful release of version 12.1 of our medical priority dispatch system into the control room. This meant our triage system

was updated to ensure the latest standards and learning was incorporated into our processes.

We are beginning to fully use software which allows us to more accurately predict call volumes and understand our staffing requirements.

In addition, the new radio system was the subject of training for control room staff alongside the requirement to balance the skills mix within control services between those able to take calls and those able to dispatch vehicles.

Special funding was secured in order to host "away days" at which all of our 400+ staff had the opportunity to undertake training to help them manage change. With such a significant change agenda for control services it prompted staff to consider how they, and colleagues, might react to change and how they could best equip themselves to cope.

How did we ensure our staff were kept up to date?

A training plan has seen all control staff scheduled for dispatch and/or call taking training for the new computer system. Maintenance training sees every member of control staff spending 20 minutes of every rostered shift working on the new system. Such is the dynamic and responsive nature of this training that its content has already been modified to provide a more simulated set of workplace scenarios.

The 2010/11 winter brought bad weather which saw unprecedented demand for our services. What did we do to ensure quality and safety was maintained?

Managing demand safely and effectively when the service is placed under significant pressure, for example snow events and New Year's Eve, has been formalised and enhanced with the development of

the demand management programme. Complete with task cards, for every role in control services, it offers a pre-defined manner in which to prioritise demand and allocate resources accordingly. In particular, this has seen increased use of clinicians in the control rooms who play a key clinical role to ensure safety of calls awaiting a response within the demand management plan.

In addition, the clinical support desk has been continuing to support ever increasing volumes of patient specific protocols and supporting the end of life initiative in allowing people to die at home.

Given the demand pressures the clinical support desk has also been key in assisting with assessing inter-hospital transfers and healthcare professional requests for conveyance.

In order to support the new network of trauma specialist units & hyper acute stroke units our control services created the clinical coordination desk to liaise between crews and hospitals alike to ensure appropriate referrals and effective utilisation of this service.

How has our work been recognised?

In doing all of the above, control services won the control room of the year at the Emergency Service Awards 2011. What's more, having been awarded the Customer Services Excellence Award (the government standard) in 2010 making us the first Ambulance Trust to receive it we have had confirmation following this year's inspection of our right to retain it for a further year.

Further improvements we need to make to our emergency operations centre include.

- 1. Implement and embed the new computer system**
- 2. Embed new ways of working in dispatch**
- 3. Understand impact of the new Department of Health code changes**
- 4. Focus on developing our hear and treat activities to optimise response to certain categories of calls**
- 5. Introduce a new system for supporting our clinical telephone advice**
- 6. Move to dual control rooms**
- 7. Support the re-launch of our clinical response model**
- 8. Continue to plan for the Olympics and Paralympic Games**



Patient transport services: Quality improvements

In 2010/11 we invested in training for our staff

We took delivery of a number of new vehicles

We have improved our performance against all three quality indicators of our contracts

Patient transport is an important part of what we do and while this service has its own dedicated management team it is fully integrated into our quality governance processes.

How did we keep our patient transport staff up to date with changes?

Last year we developed two specific posts of full time patient transport services work based trainers and successfully appointed into one of the posts.

The new work based trainer has been delivering refresher training on key topics such as resuscitation and defibrillation as well as rolling out new core skills of our digital radio procedure and bariatric vehicle training. Alongside this we have been developing the monthly training schedule which will be re-launched in April 2011 with the topic of stroke test.

What have we done to update our vehicles?

During 2010 we took delivery of 53 new vehicles comprising of twenty five sitting case vehicles, 25 stretcher vehicles (to a modified design) and three specialist bariatric vehicles. These new additions to our fleet, along with the commencement of disposal of 60 older sitting

case and minibus vehicles has seen the average age of our fleet fall from seven years old at the beginning of the year to 3.5 years old by the end.

How have the new vehicles benefited patients?

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

The addition to the fleet of three specialist bariatric vehicles capable of conveying patients weighing up to 318Kg (50st) has provided added levels of both patient and staff safety. These vehicles are equipped with high capacity stretcher trolleys, specialist bariatric wheelchairs and automated stair climbers as well as kerb and threshold ramps.

How have we performed against our contracted quality standards?

There are three key performance measures that are common across all contracts and that are also reported on internally. These are:

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

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

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

Year on year we have seen a steady rise in our performance in all three of these targets (as shown in the chart below). This is set against a backdrop of the changing nature of healthcare provision within London such as the marked increase in on the day bookings where the patients is required to be collected within one hour of the request being made.

Table to illustrate performance against the quality indicators in the contract.

Quality standard	Appointment time	Ready Time	Time on vehicle
2008/2009	90.49%	92.40%	94.86%
2009/2010	91.58%	93.03%	94.98%
2010/2011	92.01%	95.20%	95.50%

Further improvements we need to make to our patient transport services include:

1. Continuing to lower the age of the fleet to a projected 1.2 years old by the end of 2011
2. We will see enhancements to the equipment carried on our bariatric vehicles as well as the introduction of a bariatric support vehicle. This will provide additional specialist equipment such as a hoist, lifting cushions and a variety of ramps for the most challenging situations



Emergency bed services: Quality improvements

We have achieved a number of staff development opportunities.

We have improved our process for safeguarding referrals

We have developed the work of the team

We are strengthening incident reporting

The emergency bed service provides a coordination service for London on the availability of specialist beds. In addition, the service provides a number of coordination functions for us.

How did we develop our staff last year?

A variety of training and development opportunities were achieved. These included the accreditation of our operations manager by the British Psychological Society in intermediate level B psychometric training. One staff member being selected for the Stonewall management training course and one staff member being accepted for the Prince's Trust course. In addition we have completed a number of internal courses across the team.

How have we strengthened safeguarding?

We have continued to improve the safeguarding process. We are now dealing with around 1,000 referrals a month, the vast majority of which are referred to a social services professional within an hour.

We have developed and continue to improve our reporting suite so that we are now able to provide detailed reports of delays in referral, and

feedback received, on a complex and thorough level. We are circulating these reports and addressing these issues both through area governance meetings and external forums such as London Safeguarding Adults Network.

We have commenced an audit so that we can understand some of the variation in referral rates across London and hope to assist in managing such variation out of the system.

How have we expanded the work of the emergency bed service team?

We have recently commenced a pilot in North West London working with Connecting for Health colleagues to design a web-based system.

In May last year we started to collect and share information about capacity in hyper acute stroke units. This information is used by control services to optimise the capacity, ensuring that patients accessing this time-critical pathway go to the most appropriate unit.

In January we began to act as the central point for maternity services to declare their status under the maternity alert policy. This information is shared with control services colleagues and others in the maternity community to support protocols aimed at optimising maternity capacity, both operationally via divert decisions, and also at a strategic level by providing the medical directorate with historical data about declarations.

In the autumn we introduced a web-based information system which allows Acute Trusts to enter data on pressure and capacity within the unit which is then displayed so that users are able to assess capacity across London.

How are we strengthening incident reporting?

March saw the implementation of a pilot to take our Incident Reports direct from clinical staff over the digital radio system. The aim is twofold:

- to improve the speed and robustness of the onward referral process, ensuring that all report forms are referred to the appropriate person quickly with an audit trail and accountability; and
- to make it easier and faster for clinical staff to report incidents, improving both crew and patient safety.

Further improvements we need to make to our emergency bed service include:

1. Roll out the incident reporting and critical care pilot work
2. Introduce a falls referrals support service
3. Implement call voice recording for safeguarding referrals



Clinical audit & research

The work of the clinical audit and research team is integral to the quality agenda and it plays a significant role in monitoring our adherence to quality standards and in identifying any issues from a range of audits that are undertaken through the year.

Clinical audit

Mandatory statement 3 (continued from section 2): National clinical audit

The report of one national clinical audit was reviewed by the provider in 2010/11 and we intend to take the following actions to improve the quality of healthcare provided:

- Increase the proportion of patients presenting with a STEMI (particular type of heart attack) who receive pain-relieving medicine.
- Increase the number of referral routes for diabetic patients in London.
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment.

Mandatory statement 3 (continued from section 2): Local clinical audit

The reports of eight local clinical audits were reviewed by the provider in 2010/11 and we intend to take the following actions to improve the quality of healthcare provided:

Clinical audit of obstetric patients transported by the London Ambulance Service

- Remind crews to exercise caution when attending all obstetrics cases, as ambulance services have only limited capabilities in identifying and managing obstetric abnormalities.
- Remind crews of the importance of taking more than one set of observations, as time allows, to detect any changes in the woman's condition. This is especially important in cases where the woman

presents with frank bleeding and severe, continuous abdominal pain.

- Produce a memory aide listing the key questions to ask and document for routine pregnancies, to include: history of the presenting pregnancy, history of previous pregnancies and live births, estimated date of delivery, the pain score and whether entonox administration is required. In addition, it will contain a reminder of when women should be conveyed to their booked maternity unit, the nearest maternity unit or to an emergency department.
- Remind crews to document an estimated volume of blood loss when a woman presents with bleeding, or a reason why this could not be documented.
- Work with maternity units and Healthcare for London to ensure dedicated emergency alert lines are placed in each unit.
- Explore ways of encouraging the further education of ante-natal women about what constitutes normal signs of labour and what constitutes signs of potential complications to help them to know when to call an ambulance.

Clinical audit of the care provided to patients under one year old left at scene by the London Ambulance Service

- Update our protocols so all children younger than two years old attended by our staff are conveyed to hospital, and where a child aged between two and five years old is not conveyed to hospital the attending crew refer the patient to their GP for follow up.

Clinical audit of airway management in the London Ambulance Service

- Remind crews to document all aspects of care on the patient report form, including the use of a bougie.
- Remind crews to evidence patency and effectiveness of both endotracheal intubation and laryngeal mask airway placement through documenting end tidal carbon dioxide readings (ETCO₂) and additional methods of verification.
- Remind crews of the importance of documenting oxygen administration, including the time at which this was commenced.
- Provide guidance on the management of the airway in patients with a tracheotomy as part of the airway management training.

Clinical audit of the use of adrenaline (1:1,000) in the London Ambulance Service

- Remind crews the indications for adrenaline (1:1,000) and contraindication for patients with chronic obstructive pulmonary disease.
- Remind crews of the correct doses of adrenaline (1:1,000) administration, with emphasis given to the side effects and possible dangers of incorrect administration.
- Provide guidance to crews regarding the dosage of adrenaline (1:1,000) that should be administered following the use of an EpiPen.

A baseline clinical audit examining the use of Salbutamol in the London Ambulance Service

- Remind crews of the clinically valid exceptions for taking a peak flow reading and its importance to clinical care.
- Remind crews of the guidelines regarding en-route treatment for patients with life threatening or acute severe asthma.

A re-audit of the management of sickle cell crisis in the London Ambulance Service

- Communicate guidelines followed by the service to hospitals.
- Update training slides with the new guidelines for treating patients in sickle cell crisis.
- Remind crews that a carry chair or trolley bed should always be used so that the patient's condition is not exacerbated.
- Remind crews that oxygen saturation readings should be checked regularly and oxygen administered, if required, to help stop tissue hypoxia and reduce cell clumping.
- Remind crews that oramorph is recommended for patients in sickle cell crisis experiencing severe pain.
- Remind crews that an ECG must be taken to rule out any cardiac causes when a patient reports chest pain.

Recognition of life extinct by the London Ambulance Service

- Remind crews that for patients eligible for resuscitation, they should perform advanced life support for at least 20 minutes and recognise life as extinct only if the patient has been in continuous asystole throughout.
- Remind crews of the importance of documenting all drugs and treatments given to the patient, including the documentation of oxygen administration, if a resuscitation attempt is made.
- Consolidate all current guidelines, procedures, bulletins and updates into one document to contain all necessary information related to recognition of life extinct, and provide clear instructions on how to complete the recognition of life extinct form.
- Ensure paperwork is secured so all sheets additional to the patient report form are collated and scanned together.
- Improve legibility of the recognition of life extinct form and add version numbers to allow for identification of the most recent form.

Clinical audit of the care given to patients treated for epileptic seizure by the London Ambulance Service

- Continue to ensure that a paramedic response is available to allow for automatic dispatch to patients who are still reported as having a seizure at the time the 999 call ends.
- Ask paramedics to consider if they are prepared should a patient have a further seizure en-route to hospital, including: if they are going to escort the crew; if they have already placed a line whether it is secure; if they have access to rectal diazepam and whether someone is available to help them should they need to roll the patient should it be necessary to administer this, and if the patient is on the trolley bed (not the chair) in the ambulance.
- Remind crews of the need to exclude other causes of seizure such as hypoglycaemia and cardiac arrhythmias.
- Remind crews of the indications for diazepam administration.

Mandatory statement 11: Clinical audit reports that have been discussed by the Trust Board

The results of 10 local clinical audits were presented to our Trust Board. The arising recommendations to improve patient care or compliance with guidelines are included in each of the reports. These reports are then disseminated to staff via our team leaders.

The Subjects discussed were:

- Emergency oxygen therapy
- Stroke care
- Trauma care
- Care of obstetric patients
- Naloxone (drug used to counter the effects of opiates)
- Stroke
- Trauma (additional data as the systems and data collection matured)
- Adrenaline 1 in 1,000
- Salbutamol
- Care of patients with sickle cell disease

The results of national audits were discussed on four occasions and these were regarding the national clinical performance indicators. The arising recommendations to improve patient care or compliance with guidelines are included in each of the reports. These reports are then disseminated to staff via our team leaders.



Clinical research

The vast majority of the 164 patients recruited into research programmes were from a Stroke study “Improving Stroke Recognition by Ambulance Services: use of the Recognition Of Stroke In the Emergency Room assessment (ROSIER) tool”. This is a service led research project funded by the Stroke Association and adopted on to the National Institute for Health Research portfolio.

It is important to note that as well as recruiting patients we also recruit staff and student paramedics. These recruitment numbers have not been included in the 164 figure that only records patient numbers.

Additionally, we have an extensive collaboration portfolio that for the 2011/12 period includes the following studies:

- DANCE (high risk acute coronary syndrome): Direct angioplasty for non-ST-elevation acute coronary events
- Paramedic SVT: Safety and efficacy of paramedic treatment of regular supraventricular tachycardia (pre-hospital administration of Adenosine).
- SAFER 2: Care of older people who fall: An evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance personnel to assess and refer to appropriate community based care.

- Smart-CPR (cardio pulmonary resuscitation).
- Identification of stroke symptoms in alert patients who fall without injury.
- PTSD: Identifying emergency personnel at risk of post-traumatic stress disorder.
- Cardioprotection study: Cardioprotective benefits of remote ischemic post-conditioning. The investigation involves the application of a blood pressure cuff to treat myocardial ischemia reperfusion injury.
- Psychosocial tools.
- ASCQI: Ambulance service clinician quality improvement survey.
- QSN: Quality and safety in the NHS: evaluating progress, problems and promise.
- An exploration of attitudes towards young people who self-harm and an investigation into the care they receive in hospital emergency departments.

In addition to research projects the team also authorise a number of data requests and evaluation studies. Some of the current active evaluation studies include:

- Can ultrasound paramedics be taught and retain the skills necessary to identify the myocardium using the subxiphoid approach?
- Ambulance personnel's reaction to epileptic seizures.
- Evaluation of airway management in simulated chemical, biological, radiological and nuclear (CBRN) environments.



Corporate quality improvements

We have made significant progress in infection prevention and control

We have made further improvements in safeguarding

We have made improvements in the way we receive feedback from patients and to take into account patient opinion when planning service change

The corporate departments all have a role in improvement work. We have decided to focus on three corporate led improvements in this Quality Account. These three areas have been included following the feedback we received on the draft Quality Account from our commissioners.

How have we improved infection control in 2010/11?

We have undertaken a number of improvement initiatives across all of our services but have particularly focused on our accident and emergency work as this is where there is greater risk of infection. We have undertaken the following changes;

- We rebranded the committee that is responsible for infection control to include patient and external representation. The committee now also has a clear work plan
- We have an in-depth action plan that identifies the opportunities for improvements and tracks the changes.
- We have promoted infection control at every opportunity; including internal bulletins and conferences.
- We have undertaken a series of audits that measure how well we are doing with our infection prevention practice.

- We have improved the cleanliness of our ambulances by ensuring they are cleaned to plan.
- We have improved our hand hygiene practice.
- We have created a scorecard where we record audit results against particular ambulance stations.
- We have undertaken some partnership work with Acute Trusts and with patient representatives in assisting us audit our services.
- Infection control is now discussed at every Trust Board meeting.

There is still more for us to do but overall these initiatives have seen us make sustained improvements across the service.

What changes have we made to our safeguarding arrangements?

We take our responsibility for safeguarding very seriously. We are required by law to safeguard children and in addition to this we are applying the safeguarding approach to vulnerable adults, people with learning disabilities, and mental health patients.

We now have a robust system in place for making appropriate safeguarding referrals and each referral is also quality assured. We are also able to monitor the number of referrals being made at station level.

We have started to create a scorecard where we can monitor our compliance with a number of safeguarding expectations and use this as a measure of safeguarding awareness across our services.

The large number of safeguarding boards throughout London means we have some difficulty providing representation on them all. However, we have provided some focus on this and have started to record our membership on the developed scorecard.

NHS London led a review of our safeguarding processes in January 2011. This revealed that we need to recruit a clinical expert who can advise and support clinical colleagues which we hope to do this shortly. In the meantime the safeguarding review found us to be in a good position. The recommendations that were made were integrated into our safeguarding action plan.

How have we improved the way we involve and engage with patients?

We are improving in this area and our future plans feature heavily in our Integrated Business Plan which is part of our Foundation Trust application process.

We are increasing the use of patient feedback to shape the decision making in all aspects of our services. One positive example is regarding the work we have been doing on our lower priority calls; these are known as category C.

A category C service user survey was carried out in 2008. This was to find out how changes in the management of category C calls had affected patients' perceptions of their care. Some of the scores we received were lower than those for other ambulance services and we also received comments suggesting the need for improvement.

An action plan was established by an internal action group. A number of improvements have been made as a result. These include:

- improvements in staff training
- improvements in communication and engagement
- further service development work.

However, the context of this work has changed significantly since the action plan was developed and we wish to extend the learning across a wider group of patients. Therefore, the group recently produced a new paper highlighting how proposed

changes within the NHS will affect category C patients.

The proposals for consideration include reviewing the impact on patients of current changes both within the service and across the wider health and social care system. Also, engaging more consistently with external networks and stakeholders, and ensuring that the education and skills of our staff meet the needs of category C patients.

The paper is in its final stages of preparation and will be considered by the Trust's Quality Committee.

How are we engaging with the wider community?

Again, this features within our Integrated Business Plan. We have started to engage more widely than just with service users. We have held a number of events with our Trust membership. Most recently we held a stroke event for our members and other stakeholders. This is part of a series of free events designed to allow the public to find out about what we do. The stroke event was well attended and received very positively. At the event a patient shared their experience of using our service and we explained what further improvements we intend to make to our stroke service.

There was also the opportunity for those attending to question clinical staff and members of the Trust Board on stroke care.

Section 4. Stakeholder contributions

Stakeholders

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

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

We wanted to be extensive in our engagement and made the decision to ask all of the London LINK groups and a number of non NHS stakeholders. Hillingdon's Scrutiny Committee asked us to present our Quality Account to a committee meeting. This was well received and both the Hillingdon Scrutiny Committee and the Hillingdon LINK took up the opportunity to provide written feedback.

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

Organisations receiving a draft report

Commissioners

Director of London Ambulance Commissioning
NHS North West London Sector
GP Commissioning

LINKS

Barking & Dagenham
Barnet
Bexley
Brent
Bromley
Camden
City of London
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith & Fulham

Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington & Chelsea
Kingston Upon Thames
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond Upon Thames
Southwark
Sutton
Tower Hamlets
Waltham Forrest
Wandsworth
Westminster

Partner Organisations

Metropolitan Police
City Police
London Fire Brigade
British Telecom
Greater London Authority
London Assembly
NHS Direct

Other Organisations

London Ambulance Patient Forum
Hillingdon Overview and Scrutiny Committee
Westminster Overview and Scrutiny Committee
London Trauma Office

Feedback Received from Hillingdon External Services Scrutiny Committee

LONDON AMBULANCE SERVICE NHS TRUST

Consultation on the Trust's Quality Account - 2010/2011

Response on behalf of the External Services Scrutiny Committee at the London Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2010/2011 Quality Account and acknowledges the Trust's commitment to attend its meetings when requested.

In its 2010/2011 QA report, the Service had identified five priority areas which included cardiac care. It is noted that, despite there having been an 11% increase in the total number of patients, the Service has significantly improved cardiac care and survival rates have increased from 4.2% to more than 25%. The Committee notes this improvement and hopes that these improvements will continue in the following year.

The Committee notes that there has been significant successes with the improvements to stroke care following the recent review. Improvements have also been made to freeing up ambulances.

The target to reduce the percentage of patients going to Accident & Emergency has not been met, and the Committee has been advised that the target will be rolled into 2011/2012. It is also noted that the Department of Health standard of meeting less urgent patients has not been met; the Service achieved 85% against its target of 95%. The Committee has requested that it receive an update on how these targets will be/have been met in the following year.

The Service has identified four priority areas for 2011/2012:

1. Improving mental health care – 8 different work streams
2. Improving end of life care
3. Improving the care for patients who have fallen – improvements are needed with regard to communication with patients' GPs after a fall
4. Developing a quality dashboard – to include the monitoring of how well body temperature and pain are controlled

The Committee notes that, as there is a move towards lone working, the Service will need to give consideration to how the work of these staff will be quality assessed.

Members have expressed their satisfaction at the measured targets changing to reflect what is more suitable. There have been some positive changes with regard to how targets are being measured - with time and quality of service both being measured. 'Quickest to sickest' is still being measured, with a target time of reaching those in critical need within 8 minutes. For less serious cases, the time based measurements have been removed and the quality of the service is being measured.

Committee Members acknowledge that Hillingdon Ambulance staff levels have increased by 30% to meet the increase in demand for the service and that a new roster has been introduced to reflect the change in meeting this demand. Figures have shown that the need for this change was self-evident. Members are pleased that staffing levels and changes in the roster have changed to meet the demands of the service.

Members are also pleased to note that ambulance staff are stationed and are reassured that they are not being rushed. This ensures that the care provided can be of the best quality possible.

The Committee would like to congratulate the Service on the quality improvements that have been made in the emergency operations centre, as well as for being achieving "Control Room of the year" in this year's Emergency Services Awards.

Members recognise that:

- Hillingdon has been rated 4th in London for good performance in terms of life dependency (Category A);
- St Mary's Hospital will be going 24/7 for Trauma patients;
- the Stroke Unit in the Borough is now operational; and
- morbidity has reduced and the initial indicators are very positive.

The Committee notes that the Trust invited patient groups to help identify quality priorities for 2011/12. This idea is welcomed by Committee and Members agree that quality indicators will be more meaningful to the public and those that use the service.

As discussed at an External Services Scrutiny Committee meeting, Members note that consideration needs to be given to closer working relationships between CNWL and the LAS with regard to mental health to ensure that the service is more joined up. The Committee believes that this closer working will bring a range of benefits.

Overall, the Committee is pleased with the continued progress that the Trust has made over the last year and looks forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

Feedback Received from Havering LINK

Response to London Ambulance Service NHS Trust Quality Account: 2010 - 2011 Havering Local Involvement Network

Havering Local Involvement Network (LINK) welcome the opportunity to comment on London Ambulance Service NHS Trust Quality Account for 2010 - 2011.

Havering LINK are always mindful of the particular needs of the population of Havering and will continue to work closely with the Trust in order to be a stronger voice in how local health and social care services are delivered.

Priorities for 2011 - 2012

Havering LINK supports the seven critical values and in particular would commend on clinical excellence.

We are pleased to see that the Trust intends to improve mental health care and acknowledges that this is an area which is neglected. We would suggest that as well as NHS Trusts the London Ambulance Service should look to work with the voluntary sector specialised in mental health care.

Conclusion

The LINK believes that the Quality Account is representative and provides a comprehensive statement of services provided by London Ambulance Service NHS Trust.

Med Buck

Chair Havering LINK

Feedback Received from the Patient Forum (London Ambulance Service)

LAS Quality Account – June 1st 2011

Public Involvement

We welcome the LAS's strong and continuing commitment to public involvement in service improvement and development.

Sickle Cell Crisis

We are concerned about the recent death of a woman in Barking who was suffering from a sickle cell crisis. We are also concerned about statements made by members of the Sickle Cell Society about the poor care they sometime receive when they are in crisis. We welcome LAS's approach to working with the Sickle Cell Society on this issue to seek service improvements. We would like to see evidence on a continuing process of education and training for all front line staff on the care and treatment of people in a sickle cell crisis.

Shift Work

The Forum is concerned about the impact of 12 hours shift on staff and the consequent impact on patient care. We would like to LAS to carry out a study of the impact of long shifts on the care of patients and health of staff.

Diversity of the LAS workforce

The Forum has raised on many occasions the fact that about 94% of front line staff are white. We are concerned about the lack of data about disabilities of LAS staff. We would like to see evidence that the LAS is committed to diversity and inclusion amongst all of its staff. We recommend that the LAS seeks expert advice from the CHRE and other specialist sources, to address this problem and initiate a programme of work to transform the ethnic composition of staff and Board members. The LAS should be seen as an employer and organisation of choice by all communities in London.

Staffing levels

Reports that staffing levels will be cut in the LAS concern the Forum. We would like assurance that services to patients will not be cut and that in line with the contract with the commissioners for 2011-12 that the quality of services will be enhanced.

Patients Safety and Patients Complaints

We recommend a better process for combining RCA reports for incidents, with work on complaints investigations. The HSC statement 'Driving improvement and learning from NHS complaints information' provides a bridge for learning from incidents, accidents and complaints. Evidence of outcomes and enduring improvement is essential and must be placed in the public arena.

The Mid-Staffs Test

We would also like to see the introduction of a 'Mid-Staffs assurance test' demonstrating to the public that the LAS is a safe organisation. This will be important before and after the Mid Staff Inquiry publishes its report.

Patient Safety Alerts

We congratulate the LAS on completion and implementation of all Patient Safety Alerts.

Being Open

We would like to initiate a joint project with the LAS to demonstrate evidence that people are informed when something has gone wrong with their treatment or care.

Quality standards for Patient Transport

We would like to work the LAS to improve the quality of PTS through the adoption of our patient led 'quality standards for patient transport'. These include waiting times, quality of care, training of staff and appropriateness of vehicles.

Collaboration Mental Health Services

We are concerned that patients with a mental health crisis should receive adequate and appropriate care. We recommend that the LAS carries out an audit of the effectiveness of services provided to patients with acute mental health conditions. and invites users of mental health services, their community mental health teams and GPs, to regularly comment on the quality of and access to care provided by the LAS. We welcome the setting up of a mental health committee in the LAS.

Joint clinical meetings with A&E departments

We recommend that front-line LAS staff regularly attend meetings with A&E clinical staff to review the outcomes of the clinical care they have provided to acutely ill patients who are admitted through A&E departments.

Public Involvement and Joining the Foundation Trust as a Member

We would like much more collaborative work between the LAS, Patients Forum and LINKs on user involvement and encouraging service users to recommend improvement to services. We recommend a campaign to ensure that local people know why is it worth joining the LAS FT as a member in terms of enhancing patient care. It is not clear at the moment to many people what the value is of joining an FT.

Joseph Healy
Chair
Patients Forum LAS

Feedback Received from the City of London Police

Thank you for sending on to the City of London Police your Quality Account (Consultation Version 2) document.

We have no comment to make on the document.

Feedback Received from LINK Southwark

LINK Southwark would like to thank you for sending the draft consultation 2010/11 quality account. However, due to the limited resources within LINK Southwark and our priority to comment on local hospitals' we are unable to provide a comment this year.

Feedback Received from Barnet LINK

We will include it in our Barnet LINK e-newsletter and hope our members want to respond. I am also sending it to relevant steering committee members and our Chair.

Feedback Received from NHS North West London (Commissioners)

7th June 2011

RE: LAS quality Account 2010/11

Thank you for the opportunity to review the London Ambulance NHS Trust's (LAS) Quality Account for 2010/11. This response is made on behalf of NHS North West London as Lead Commissioner.

As a commissioner, we strive to ensure that the services provided for Londoners are of the highest quality, and we recognise the developing systems and processes in place within the LAS to drive up the quality of the ambulance service. We welcome this second quality account from the LAS, and its improved format, including case studies, aiming to make it more meaningful for the public.

Looking Back 2010/11

As Lead Commissioner's we receive regular performance reports, serious incident reports and patient complaints data and use these as the basis of our regular meetings at clinical and strategic level to discuss the quality of services provided. We also meet regularly with clinicians and managers, looking at clinical pathways, performance and service redesign. As a consequence we believe the information presented in this report, is broadly representative of the quality of service and developments in 2010/11, however the LAS' performance against the national mandatory indicators, is under represented.

The performance of the quality indicator for timely response within 8 minutes for 75% of life threatened Category A calls was a significant cause of concern with fluctuations in performance and regularly missing agreed trajectories during the year, indicating a lack of resilience and a requirement for significant recovery action. We acknowledge that actions did result in final year end achievement. We expect that in 2011/12 the LAS will strengthen their resilience, and deliver consistent timely responses, ensuring that resources are matched to the varying demands, both in terms of volume and geography, that the service faces during the year.

The performance of the quality indicator for timely response to urgent Category B calls was also disappointing, missing the agreed trajectory and falling substantially below the 95% target, in part due to the focus in the final six months on recovering the Category A indicator. Whilst we acknowledge that this particular indicator has been replaced by a range of ambulance outcome indicators in 2011/12, it is an essential requirement that the LAS deliver to the levels of performance commissioned

For the final version of the Quality Account, we have asked the LAS to explain how you have demonstrated in year improvement in both Infection Control and Safeguarding, which are priorities for Londoners and have been discussed with the Patients Forum. We also have asked for more emphasis on Patient Experience, including the work done with non-life threatening patients. Currently the Quality Account does not reference patient compliments or complaints, or how information gained from these sources is used as part of the quality assurance assessment.

We do recognise the significant improvements, and lead role that the LAS has had, in Cardiac, Stroke and Trauma care over the past year in partnership with the NHS in London. We recognise that the LAS performs well nationally for patients with emergency specialist needs and we look for the LAS to improve similarly in 2011/12, with the increasing focus on their urgent care work, such as mental health care.

Looking forward 2011/12

We welcome the quality priorities for 2011/12 on improved pathways for Mental Health, End of Life Care and Elderly Fallers, which are fully in line with our commissioning intentions and we have incentivised by the Commissioning for Quality and Innovation (CQUIN) payment framework. These priorities have been supported by the new Clinical Quality Group, which has GP representation from across London, and clinical representation from the LAS. The rationale for these shared priorities is that over 60% of all the LAS workload is for non-life threatening calls. The LAS have a significant role in improving their role as a mobile healthcare provider, and supporting the improved care of Londoner's closer to their home, in line with the wider NHS strategy.

In terms of information on quality, we expect the early development and sharing of the Quality Dashboard, which was a 2010/11 commitment, and would want clear SMART (Specific, Measurable, Achievable, Realistic and Time) indicators for this, to demonstrate the quality improvement for the public and commissioners. This will be supported with the new national ambulance Clinical Performance Indicators, which will enable an improved quality comparison with other ambulance services on clinical outcomes, rather than just the timely response.

We support the increasing commitment to openness and transparency, as demonstrated by the public board reporting of an infection control dashboard, which indicated areas of concern, and demonstrated over a few months the significant improvements made. Providing publicly available information, including highlighting areas of concern, are an essential component of improving safety and patient care, and will help prevent quality failures, such as those experienced at Mid Staffordshire NHS Foundation Trust. The Clinical Quality Group, with GP commissioning leaders from across London, will play a critical role in both monitoring quality and supporting service developments to improve the quality of healthcare for Londoners.

I hope the LAS will find these comments helpful and we welcome the evolution of this report in future years to reflect greater patient involvement in the quality agenda and continuing evidence of increases in the quality of care for Londoner's.

Yours sincerely

Anne Rainsberry
Chief Executive

Feedback Received from Hillingdon LINK

Hillingdon Link Response to the London Ambulance Service Quality Accounts 2010-11

Hillingdon LINKs welcomes the opportunity to respond to the London Ambulance Service Quality Accounts 2010-2011. Quality Accounts are intended as documents for the public and therefore as part of our responses we include comments on "readability".

The main focus of our response is on the identified priorities for 2011-2012.

It was useful to have a description of the selection process of the priority areas at the outset. There seems to be a good balance between national and local priorities in determining the four specific areas of quality improvements for 2011-2012. The active involvement of patient groups in determining the priorities is commendable. However it is disappointed that the LINKs were not involved.

Overall the document is accessible in terms of the layout and the language. It was easy to read. The case

studies clearly illustrate the positive outcomes of the service for the patient and carers.

The idea of developing a quality dashboard as an area of quality improvement does not seem to be appropriate. The dashboard should be viewed as a monitoring tool to measure, gather evidence and assess the progress made against the indicators for the different quality priorities, and not a quality priority in itself. Furthermore, seeking patient views and learning from their experience should be a quality priority rather than a measure on the dashboard.

We cannot comment on how effective and accessible the dashboard will be since the document does not contain an example of what it will look like. It is hard to comment if it will be user friendly and understood by the patients and the general public. Placing so much emphasis on the dashboard without providing one detracts from the document.

None of the four quality areas have clear indicators of how these will be measured and evaluated. Each area of quality improvement outlines a set of actions that will be undertaken to improve performance, but there are no clear targets or indicators of performance against individual statements or for the specific quality area. If the data is available the presentation would benefit from showing last years, and the English average.

Some of the action statements seem abstract and vague. We are not clear how these will be implemented or measured. For example, under further improvements in the End of Life Care section it says „understand the challenges associated with the end of life care for people with dementia“. This does not tell us how it will be implemented and evaluated.

The document did not have a summary. We would have liked to look at the summary as we feel this is the section most likely to be read by the patients and the general public.

We understand that no LINKs responded last year including Hillingdon. We recommend that the London Ambulance service approaches the London Region of NALM our national body to ensure a better response.

Feedback Received from a member of the public

Quality Account Report 2010-2011

This is a good, well presented and very interesting report.

The easy read with clearly understood terminology and pictorial addition has made this a pleasurable presentation for all levels of readers.

The inclusion of case study and patient experience is to be commended.

The evidence of change and improvements implemented has shown positive outcomes for patients and staff.

The facts and figures are clear and precise and the complexities faced by the LAS highlighted the various skills and training required to meet the criteria.

I attend several committees and network related meetings and it is good to see issues submitted for attention have been included in the LAS Quality Management teams programmes.

The Mental Health Strategy has a difficult task and the 'Improvements' listed are commendable in this increasing areas of demand for the LAS.

The many changes that have to be implemented by Response staff at HQ as well as the Ambulance and Paramedic crews are of some concern.

All staff work in a highly pressurised work scenario and the ability to take on board and perform to high standards all these changes must cause a tremendous burden and take just as tremendous toll on their strength and stress levels.

I am sure training programmes are efficient and well managed but management must take these detrimental effects to account in the welfare of their staff.

There is only so much learning staff can take on board at any one time and continue the high performance standards required and expected of them – a stressful work load at the best of times.

The awards you have detailed must be the reflection of the quality of your service and the Quality of all operatives.

Well Done.

Name & address supplied



Summary

This Quality Account has identified a number of quality priorities that are consistent with our vision and values and directed by the NHS Operating Framework, commissioning intentions and our own service priorities. The quality priorities for 2011/12 are supported by patient groups and other stakeholders.

This final section provides a summary of all the quality priorities in one section to allow for ease of monitoring in year and for the reporting of progress in the Quality Account for 2012/13.

Improvements to our quality processes

1. We need to embed the quality dashboard
2. We need to improve the way we structure and use feedback from patients
3. We need to improve the way we learn and share the learning from serious incidents

Improving mental health care

4. Improve the skill and competence of our clinical staff
5. Participate in whole system transformation work with partner organisations
6. Improve the advice and support available to our clinical staff
7. Improve the actual clinical intervention we provide to mental health patients
8. Improve our governance and safeguarding arrangements with mental health patients
9. Improve the care of patients with dementia
10. Consider how we can use health promotion work with mental health patients
11. Improve the management of alcohol related harm

Improving end of life care

12. Improve the skill and competence of our clinical staff
13. Hold and share the information about a patient's current care preferences
14. Clarify how we obtain clinical support from local providers

15. Improve the confidence in the systems so we can handover care
16. Have the knowledge to take appropriate action if the agreed care provision breaks down
17. Improve the knowledge in the dying process
18. Improve the ability of clinical staff to make an examination and assessment
19. Improve the knowledge of drug use in and out of hospital end of life care
20. Understand the challenges associated with end of life care for people with dementia

Improving the care for patients who have fallen

21. We will further develop the tool to assist our clinicians in decision making and make this more widely available to staff
22. We will implement training so that staff are familiar with the developed tool
23. We will improve our monthly referral rates following agreed falls protocol (back to GP) for uninjured people who have fallen.

Implementing a quality dashboard

24. Implement the use of the dashboard through our quality governance structure
25. The implementation of the additional quality measures identified within our quality strategy
26. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success

Improving cardiac care

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

Improving trauma care

29. In conjunction with the London trauma office work is ongoing to develop a triage tool suitable for paediatric patients
30. Evidence suggests that the major trauma field decision tree is currently over sensitive and may be taking more patients than necessary to major trauma centres. This needs reviewing in 2011/12

Progressing alternative & appropriate care pathways

31. There are further opportunities to develop the care pathways and this has been identified as a specific priority for 2011/12
32. We will continue to explore opportunities within urgent care centres
33. We will look for ways to obtain patient feedback on how the pathways benefit patients

Improving stroke care

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

Ambulance Availability

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

37. We will look at the times that mechanical or equipment repair result in lost vehicle availability
38. We will continue to drive down the length of unnecessary delay during the transfer of care between ourselves and other Trusts

Emergency Operations Centre

39. Implement and embed the new computer system
40. Embed new ways of working in dispatch
41. Understand impact of the new Department of Health code changes
42. Focus on developing our hear and treat activities to optimise response to certain categories of calls
43. Introduce a new system for supporting our clinical telephone advice
44. Move to dual control rooms
45. Support the re-launch of our clinical response model
46. Continue to plan for the Olympics and Paralympic Games

Patient transport services

47. Continuing to lower the age of the fleet to a projected 1.2 years old by the end of 2011
48. We will see enhancements to the equipment carried on our bariatric vehicles as well as the introduction of a bariatric support vehicle. This will provide additional specialist equipment such as a hoist, lifting cushions and a variety of ramps for the most challenging situations

Emergency bed services

49. Roll out the incident reporting and critical care pilot work
50. Introduce a falls referrals support service
51. Implement call voice recording for safeguarding referrals

For further information on the quality improvements contact

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