



London Ambulance Service

Appendix B



NHS Trust

Annual Quality Account 2015/16



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Introduction

What is a Quality Account?

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

There are four main aims:

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

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

Engagement with clinicians and patients: the priorities and metrics included in the Quality Account must be relevant and public. Broad engagement in the development of quality reports is needed to meet these requirements.

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

In order to give a more comprehensive oversight of quality we have made the decision to report beyond the minimum requirements. In addition, where possible we have also reported comparative data from other Ambulance Trusts in England. The Quality Account is required to follow a template and report on a set of mandatory items. We have followed this format and for ease of reading we have divided our Quality Account into three distinct sections.

- Section 1 contains a statement on quality from the Chief Executive and an introduction to the report.
- Section 2 details the new priorities for improvement identified for 2016/17 and reports progress made against the priorities we identified for quality improvement in the 2015/16 Quality Account. This section also includes a review of the year and a range of statements of assurance from the Trust Board.
- Section 3 Provides evidence of external assurance and written feedback we have received on the 2015/16 Quality Account

Commissioners

The relationship with our commissioners continues to strengthen. The new operational structure has been embedded across 2015/16 reflecting seven distinct sectors supporting local engagement and health improvements. We have continued to focus on being more responsive to local needs with roles such as the Stakeholder Engagement Managers proving pivotal in ensuring a consistent senior presence at a local level.



This has been demonstrated throughout 2015/16 through closer working relationships with not only commissioners but a range of key partner agencies such as our acute Trust colleagues, frequent caller forums and safeguarding boards to ensure patients receive high quality, integrated care across the capital.

We continue to work with our commissioners to agree commissioning intentions. Once agreed these will influence the final contract, the key performance indicators and the final projects identified within the Commissioning for Quality and Innovation Framework (CQUIN).

The Trust Board

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

- Nominating the Director of Nursing and Quality as being responsible for bringing quality issues to the attention of the Trust Board and acting as the custodian for quality issues.
- Nominating the Medical Director as being responsible for bringing safety issues to the attention of the Trust Board, acting as the custodian for safety issues and accountable officer for controlled drugs and Caldecott Guardian.
- Prioritising quality on the agenda by ensuring, wherever possible, quality issues are placed at the top of the agenda.
- Inviting a patient, or member of staff, to every Trust Board to meet the Trust Board and present their experience of the London Ambulance Service NHS Trust as either a service user or a provider.
- Having a Board level committee nominated to focus on quality that has the same status as the audit and finance committees.
- Monitoring the quality of care provided across all our services and routinely measuring and benchmarking services internally and externally where this information is available.
- Proactively looking at any risks to quality and taking prompt mitigating action.
- Challenging poor performance or variation in quality and recognising quality improvement.
- Building a quality culture across the organisation.
- Working to ensure our workforce is valued and motivated and able to deliver high quality care.
- Promoting a culture of openness with respect to incident reporting.

The Expectations of our Regulators

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

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

The NHS Trust Development Authority is the body who oversees the transition of NHS Trusts to NHS Foundation Trust status. As a NHS Trust the London Ambulance Service has



a relationship with this body. We are required to undertake monthly integrated delivery meetings with the NHS Trust Development Authority to provide oversight and assurance.

Monitoring Quality in 2015/16

Trust Quality Governance Committee is the accountable forum for overseeing quality across the Trust supported by the internal quality dashboard and 3 core committees:

- **Clinical safety and Standards Safety** – chaired by the Medical Director
- **Clinical and Professional Development** – chaired by the Director of Paramedic Education & Development
- **Improving Patient Experience** – chaired by Director of Nursing and Quality

The quality dashboard has developed throughout 2015/16 to ensure quantitative information is shared in a consistent format at the committees enabling a single source of data related to quality measures. Feedback from key stakeholders has been essential in the on-going refinement and format of the dashboard to ensure data is accessible and reflects the key indices to provide assurance on the quality of care the Trust delivers. The committees have met bi-monthly producing a summary report for the Quality Governance committee highlighting key assurances, issues and concerns. These committees review relevant risks in the Board Assurance Framework (BAF), the Trust risk register and local risk registers at their meetings and include areas of concern and action plans in their reports.

The dashboard and associated papers are shared with Commissioners at the monthly Clinical Quality Review Group (CQRG) meeting and the Trust Development Authority (TDA) at the Integrated Delivery meeting ensuring external scrutiny and challenge.



Statement on quality from the Chief Executive

This is the seventh Quality Account published by the London Ambulance NHS Trust. It acts as a written review for the public of our quality of service during 2015-16 and identifies quality improvement priorities for 2016/17.

It is a huge privilege to have been asked to lead the Trust in January 2015, to have been appointed substantively to the post of Chief Executive in July 2015 and to have the opportunity to lead the Trust through a pivotal period of improvement and development.

The Care Quality Commission (CQC) carried out a planned inspection in June 2015 and their report into the Service was published at the end of November 2015. While it gave the organisation a 'good' rating for the care of patients, it highlighted a number of areas of concern and judged the Service to be 'inadequate' overall, and recommended that we were placed 'in special measures'.

The report is constructive and I am extremely pleased that the CQC recognised that patients in London receive good clinical care, that our staff are caring and compassionate and that our paramedics and nurses in the control room give good advice to frontline staff while our intelligence conveyance system prevents overload of ambulances at any one hospital. We have taken immediate action for our most pressing issues and the Board are committed to ensuring delivery of the improvements required.

We take being placed in special measures very seriously. We recognise that this will assist in accelerating our progress and we are working with the Trust Development Authority, NHS England, Defence Medical Services and our other partners to address the concerns raised in the report.

We held our Quality Summit with key stakeholders in December 2015 and submitted our Quality Improvement Plan (QIP) to the CQC in January 2016. At its heart, this plan is about delivering better care for patients and making the London Ambulance Service a better place to work for all our staff. In order to achieve this, we need to fundamentally transform the Service. As part of the plan, we highlighted the action we have already taken since the inspection and detailed the five work streams for action each with an identified Executive lead. They are:-

- Making the London Ambulance Service a great place to work
- Achieving good governance
- Improving the patient experience
- Improving the environment and resources
- Taking pride and responsibility

I had the pleasure of meeting over 900 staff through a series of road shows during the autumn of 2015 and the discussion and feedback from these sessions has helped shaped the projects within our plan.

There is still work to do in each area and this is described later in this document in an overview of the Quality Improvement Plan, but it is important to emphasise the progress that has already been made to deliver better care for patients and provide a supportive working environment for our staff. At the Quality Summit and our stakeholders and in particular our Clinical Commissioning Group lead commissioners, NHS England (London) and the Trust



Development Authority acknowledged the progress made since the CQC inspection in June 2015.

As the new CEO, with new operational management leadership teams – I am focused on leading, developing and supporting our staff to deliver the improvement plan.

While challenges such as improving vehicle preparation, recruiting more frontline staff, increasing our ethnic diversity, and our systems and processes generally need centralised leadership, we also recognise that local leadership and personal ownership are very important around issues such as improving our drugs records and ensuring we have a culture where incidents are always reported and any inappropriate behaviour is challenged.

Much of the action we have to take needs to be led by local managers, however we also need the discipline of being able to check and monitor ourselves to make sure these changes to behaviour and practice are happening, and 'at pace'.

Managers and clinical team leaders from across the Service attended a series of briefing sessions at the end of February to update them on progress made since publication of the CQC inspection report and help develop local action plans around the five work streams.

In 2015/16, we again experienced an unprecedented increase in demand across London, concern about increased terrorist activity in Europe, and the busiest winter on record in the absence of significant periods of adverse weather or public health concerns such as flu or noro-virus. Ensuring quality of care is maintained and evidenced under such activity pressures continues to be the paramount focus for the organisation. One of the most significant challenges we face to providing safe, sustainable care is the high number of patients who are delayed in handover to acute hospitals and we have continued to work with NHS England and our acute Trust colleagues to address this issue.

After the tragic events in Paris and Brussels we have been working to ensure our Service and our specialist teams are ready to respond if we did face this type of situation in London. The Major Incident Plan has been revised and approved by Trust Board, Major Incident training is now incorporated into the Core Skills Refresher (CSR) training for all frontline staff and in response to the CQC recommendations we have recruited to the required level of Hazardous Area Response Team (HART) paramedics to meet the National Ambulance Resilience Unit (NARU) specification. We also participated in Exercise Unified Response earlier this year, a large scale major incident exercise run on behalf of the London Resilience Partnership. The exercise saw the participation of local, national and international agencies and sought to test London's resilience at the operational, tactical and strategic levels. Staff from across the organisation participated in the exercise which was planned on a scale never before seen in the UK.

One of my priorities as Chief Executive is to continue to reduce pressure on staff so we can improve morale, our response and the quality of care we deliver to all our patients.

2015/16 has seen the introduction of a number of initiatives to support this.

We were slow to respond to our staffing issues and this was highlighted by the CQC report however we have successfully accelerated recruitment and retention to ensure sufficient frontline paramedic and other staff to meet patient safety and operational standards. To date we have recruited 711 people since April 2015. We are now scheduled to have 2,926 staff fully operational by the end of March 2016. This is equivalent to 92 per cent of the 3,169 establishment figure (allowing for 35 leavers a month) and with a further 217 still in training.

We have continued to replace our fleet with 104 new ambulances on the road and a further 140 purchased. We have invested in 60 new fast response units, with plans for a further 60 each year, on-going.



We are fully committed to the role of clinical team leaders to provide support and feedback to those on the frontline. We have ensured they now spend 50 per cent of their time being clinical and 50 per cent supporting operational colleagues.

The LAS Academy launched in January 2016 to offer existing non-registered staff the opportunity to train as paramedics and we are working with universities to create more graduate paramedic places. We have also continued to develop a clinical career structure with Advanced Practice Paramedics, extending the number to 24 operating from three sites across London.

We have launched our new intranet so staff can access information and communicate more easily and have again delivered great things in control around the clinical hub. I am proud that the VIP Awards have become embedded this year, allowing us to celebrate our staff – their achievements and enthusiasm. The first LAS app was launched with significant developments on-going and mental health nurses are now embedded in the clinical hub, supporting the care we give to some of our most vulnerable patients.

The results of the 2015 NHS staff survey were published in February 2016 and the findings show improvements in a number of areas compared to last year's survey, whilst also reflecting the pressure the organisation has faced and staff concerns on key issues. The results include an improved level of overall staff engagement compared to both 2013 and 2014, and indicate that people feel more motivated at work, prepared to recommend the organisation as a place to work or receive treatment, satisfied with their level of responsibility and involvement, able to contribute towards improvements at work, satisfied with communication between senior management and staff.

However, there was also an increase in the percentage of staff saying they had experienced bullying or harassment in the previous 12 months. We appointed a Bullying and Harassment Advisor in November 2015 and a Non-Executive Director to lead a comprehensive programme of work across the Trust in relation to bullying and harassment to ensure staff are trained, know how to identify bullying and harassment, know how to report incidents and are supported in doing so. We have completed around 18 workshops and completed regular updates to staff, with over 250 having attended workshops and we are on target to train an additional 350 by summer 2016. It is encouraging that there are better results in some important areas and it is clear that we are continuing to make improvements for staff and patients. We are addressing our key issues through our quality improvement plan in response to the CQC report.

While there is no quick fix to making this the organisation all we want it to be, there is significant forward momentum, we have a very clear plan and everyone has a role to play in helping us to get there.

Dr Fiona Moore MBE, Chief Executive



Our Purpose and Values

The London Ambulance Service NHS Trust is one of 10 Ambulance Trusts (and Ambulance Foundation Trusts) in England, responding to over 1.9 million calls and attending over 1 million incidents each year. We provide emergency medical services to the whole of Greater London, which has a population of around 8.9 million people. We are the busiest emergency ambulance service in the UK. The Service employs over 4,600 whole time equivalent (WTE) staff, who work across a wide range of roles based in over 70 ambulance stations and support centres.

Our Purpose, Goal & Values:

The **purpose** of the London Ambulance Service is to care for people in London: saving lives; providing care; and making sure they get the help they need

Our **goal** is to deliver safe, high quality care that meets the needs of our patients and commissioners, and that make our staff proud

Our purpose is supported by the following values:

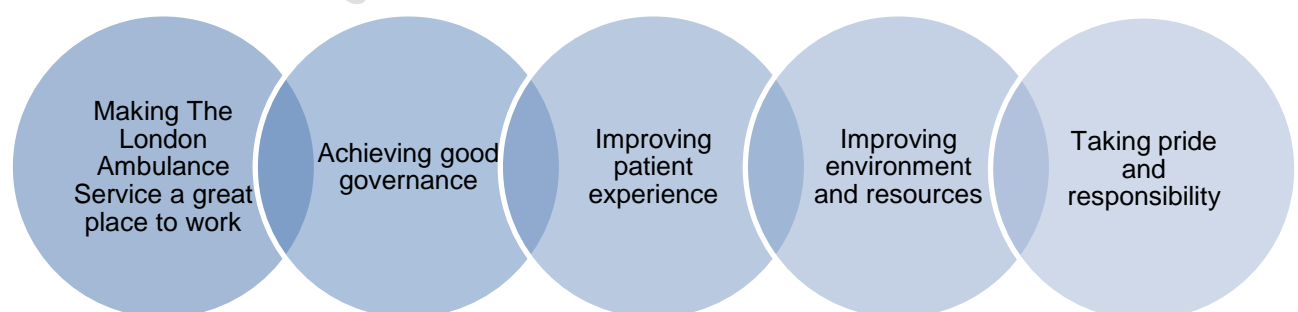
In everything we do we will provide:

Clinical excellence: giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Care: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation.

Commitment: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement.

Our key corporate objectives for the year ahead form the basis of our Quality Improvement Programme which is our roadmap to improving our care to patients, the experience of our staff and our overall CQC rating when we are re-inspected in 2016/17 to ensure we come out of special measures as quickly as possible. The five objectives are:



2016/17 Quality Priorities

It is proposed this year should continue to focus on the areas of:-

- Patient Safety
- Patient Experience
- Clinical Effectiveness & Audit.

For each of these core areas specific elements have been identified.

1/ Patient Safety

Sign up to Safety campaign

The Trust enrolled on the Sign up to Safety programme in 2015-2016 and will continue to progress this work throughout 2016/17.

The ambition is to apply the approach demonstrated in Maternity across 2015/16, where comprehensive risk meetings with multi-disciplinary teams to discuss complaints, serious incidents, Patient Advice and Liaison Service (PALS), claims and inquests has used the Sign up to Safety pledges to help inform its agenda. Work continues to improve the safety of the service we provide by effective engagement with staff involved in incidents and providing proactive training on Maternity risks to clinical staff. Learning points are also shared at a London-wide Heads of Midwifery meeting. We will expand this methodology to other high risk areas of our activity such as paediatrics and mental health.

In addition to this we have commenced the publication of a quarterly 'Trust Learning From Experience' report, identifying themes from across serious incidents, complaints, inquests, incidents and claims. This report is shared at the Quality Governance Committee and with our commissioners. We will continue to develop these reports, ensuring we are drawing on all sources of quality data available and invite feedback through transparent sharing of these with external stakeholders and staff.

We are working extensively to integrate the Duty of Candour into the culture of the organisation and those staff involved in Serious Incidents are offered support through the process. Family Liaison Officers are also allocated to each case to engage and support family members. This work will continue to be progressed and reported against as part of our commitment to the Sign up to Safety pledge.

Medicines Management

The Trust is committed to supporting a system of processes and behaviours that optimise medicines management and ensure safe and effective administration of all therapeutic interventions for all patients. The CQC identified medicines management as a specific area of concern to the Trust.

Significant improvement has been made during 2015-16 including the recruitment of a Medicines Safety Officer and the appointment of a board director with responsibility for oversight of medicines management. A medicines management communication campaign has also commenced entitled 'Shut it, Lock it, Prove it' in order to improve security of drugs and medical gases. The implementation of the new Trust operational management structure has supported a system of additional medicines management checks by Clinical Team Leaders supported by Incident Response Officers and other local managers.



The Medicines Management Group continues to meet regularly with the Trust Pharmacist and reports controlled drugs incidents and associated learning via the Local Intelligence Network.

Medicines management events have been held with local medicines management leads and feedback from these events used to guide and inform future medicines management developments within the Trust.

Medicines management has been identified as a core area of focus in 2016/17. During 2016-17 the Trust will seek to build upon the improvements seen in 2015-16 through further refinement and development of medicines managements systems and processes. Specifically our priorities will include:

- The review of a new drug distribution system looking to incorporate barcode technology and condition-based modularised drug packs for frontline staff. This will improve the availability and traceability of medicines.
- A programme of work with our Management Information department to improve reporting of drug usage data and further investigate additional technological solutions to support supply and administration of medicines.
- Medicines management training will be provided for all clinical staff via the Trust Core Skills Refresher programme throughout 2016-17.

Infection Control

The Quality Improvement Plan highlights a number of key areas associated with infection prevention and control that the Trust will focus on throughout 2016/17.

This will include a review of current guidance on bare-below-the-elbow, protective clothing, and local monitoring for infection control.

A review will be undertaken of all stations to understand the scope of works required to achieve infection control standards, and review cleaning contracts to meet requirements.

There is also a commitment to recognise that re-use of blankets for patients is always unacceptable and poses a cross-infection risk. Effective solutions will be implemented to include a review of provision, distribution, numbers and quality of blankets to ensure staff have access to adequate blanket supplies to support single usage for every patient.

2/ Patient Experience

Mental Health

Dementia

The Trust is committed to increasing its focus on the care of patients with dementia, which includes the training of staff and working with organisations that specialise in dementia care. A number of focus groups were held in 2015/16 with dementia patients and their carers. They described their experience of the London Ambulance Service and gave their suggestions to ensure the care we deliver to this group of patients and their carers is of a consistently high quality, recognising their specific needs. Four key themes emerged:-

- education & training
- managing delays
- support for carers



- providing feedback

The learning obtained from the focus groups has been integrated into the Trust Mental Health Action Plan for 2016/17 with specific objectives identified against each element. A key objective is to increase training in dementia care for staff at all levels of the organisation and to improve partnership arrangements with third sector organisations. This will include the development of bespoke training videos for staff focussed on dementia and taking forward

Delivery of the action plan will be monitored through the Trust Mental Health Committee

Patients detained under Section 136

It is recognised the Trust has continued to face challenges in meeting our agreed target response time of within 30 minutes to all patients detained under section 136.

As part of the Quality Improvement Programme a review of all mental health act guidance issued to staff is being undertaken ensuring that this is well understood and disseminated, There will be a specific focus on the guidance associated with section 136 in partnership with our police colleagues including the Metropolitan, British Transport and City Police services. Ensuring our policies and protocols are consistent and that these are reflected in our shared Memorandum Of Understanding is a priority in order to ensure consistent information is passed, received and appropriately triaged to enable a timely, safe and effective response.

Detailed data analysis will be undertaken to understand any variances in response times and triage allocation in order to amend procedures or review training programmes with staff.

The current Trust e-learning package for Mental Health will be reviewed and built upon during 2016/17 to ensure timely access to education and support for all staff.

We will also strengthen the training we provide to staff on the Mental Capacity Act and put in place a support network for staff to ensure they are confident in carrying out mental capacity assessments and able to seek clarification and guidance easily where required.

Bariatric Care

“Bariatrics” is the science of providing healthcare for those who have extreme obesity. Both a patient's weight and the distribution of this weight throughout the body are involved in determining whether a patient is “bariatric”. The care and transportation of bariatric patients in emergency situations from their home to hospital can be complex and challenging for the patient and clinical staff. An analysis of LAS calls would suggest that we are dealing with at least one bariatric patient per 24 hours. Appropriate procedures and equipment must always be available.

The Trust will ensure operational plans are in place to respond appropriately to the growing bariatric population in London and that care is delivered in a way that maintains the privacy and dignity of this group of patients. This will a working group to oversee effective training of all front line staff in assessment of patients, the use of specialist manual handling and clinical equipment during their care and treatment and patient involvement. The appropriate number of vehicles to accommodate bariatric patients in safety and comfort will be a primary focus as will service user feedback on care received.



End of Life Care

End of Life care presents specific quality challenges to the London Ambulance Service in order to ensure patients, their relatives and carers are supported appropriately to meet their individual needs and wishes. End of Life care calls are often associated with extended on scene times and are reported by staff as being some of the most emotionally challenging cases they attend. A clinical audit conducted in 2012 identified staff felt they had low levels of confidence and limited knowledge in relation to End of Life care.

The London Ambulance End of Life Care Steering Group was convened in June 2015 chaired by the Deputy Director of Nursing and Quality, This is a monthly forum which includes a multi-professional group, external partners and patient representatives and shares specialist knowledge, experience and skills to improve care for these patients. The group also oversees and advises on those elements of the service that have a specific focus on improving the quality of care delivered to patients requiring End of Life support including staff education, clinical audit, care pathways and patient involvement. It is also a forum for departments within the LAS and external agencies to report any issues relating to End of Life Care.

The Trust will continue to focus on this important area of care across 2016/17 reviewing End of Life pathways, education programmes and service developments to assess impact on patient and staff experience; making recommendations as required and producing evidence based oral updates and written reports to internal and external stakeholders. Identifying, reviewing and escalating any incidents relating to End of Life Care ensuring lessons learned are shared and adopted by all key stakeholders and further embedding our partnership with Coordinate My Care will be key objectives.

To date a range of significant pieces of work including have been undertaken including

- Development of the End of Life Core Skills Refresher (CSR) training package which commenced delivery in December 2015
- Funding to support and End of Life conference in North West London on the 27th January 2016
- The successful implementation and on-going evaluation of appropriate care pathways with partner agencies supporting the rapid referral of patients identified as requiring End of Life support

The End of Life Steering Group reports to the Improving Patient Experience Committee and onward to the Quality Committee. This allows areas of innovation, learning and on-going challenges to be escalated effectively through the quality governance structure.

3/ Clinical Effectiveness and Audit

Exercise Unified Response (EUR) 2016

LAS participated in Exercise Unified Response in February 2016 - a large scale major incident exercise run on behalf of the London Resilience Partnership. This clinical audit has been triggered by an external request from the London Resilience Partnership and feedback from the Care Quality Commission and the Coroner following the inquest into 7/7. Furthermore, at the end of 2015 the LAS Incident Response Procedures were revised and the requirement for clinical documentation has not yet been assessed. The clinical audit will include all 'patients' that were assessed and/or treated by the LAS during a major incident training exercise, covering a range of clinical conditions including: fractures, wounds, head injuries, respiratory conditions, chest injuries, amputations, abdominal trauma and spinal injuries. The documented triage, assessments, medication administration and management



of these 'patients' will be assessed for compliance with clinical practice guidelines and incident response procedures.

Continuous Re-contact

In 2015-16 we reviewed the decision not to convey patients by Paramedics on the Clinical Hub and clinicians on the road. We looked at patients who re-contacted the LAS within 24 hours following a referral to 111, a hear & treat or a see & treat incident where on second attendance the patient was conveyed to hospital with a pre-alert or died unexpectedly. This contributed to the LAS's mortality review and as a result in the first six months seven cases were escalated for review by the Serious Incident Group. The value of this project was considered so great that it will be continued in 2016-17.

Sickle Cell Crisis

In response to a request by the LAS Patient's Forum to review the care provided to sickle cell patients we will undertake a re-audit of the care provided to patients who contact the LAS during a sickle cell crisis. The re-audit will focus on initial telephone triage and ambulance response as well as pain assessment and management, medication administration and conveyance decision. In addition, this re-audit will seek to understand the patient's experience. We hope to send these patients a questionnaire asking them how they feel about how quickly the ambulance arrived, the treatment they received and the attitude of the clinicians who attended. The results will help to develop a specific training package for our mandatory Core Skills Refresher Training in 2016.

Hypovolaemic Shock

Following a patient safety incident and revised internal guidance we aim to assess LAS management of hypovolaemic shock. Working backwards from Emergency Department diagnosis of a medical conditions which may cause catastrophic fluid loss (for example gastrointestinal bleed, obstetric haemorrhage, ruptured ectopic pregnancy, abdominal aortic aneurism (AAA), recurrent vomiting and profound diarrhoea) this clinical audit seeks to examine the recognition, assessment and medication administration to patients with hypovolaemic shock.

Mental Capacity Act

The Care Quality Commission found that many staff lacked confidence working within the Mental Capacity Act 2005. Therefore, following a programme of training on the Mental Capacity Act assessment, this documentation audit will examine appropriateness of completion of the LAS Capacity Tool (documentation for the treatment of patients who are unable to consent).

Continued from 2015-16

Paediatric Conveyance Review

In 2010, following a baseline clinical audit and in response to advice from the Royal College of Paediatrics and Child Health the LAS reviewed our management of paediatric patients and a new policy was introduced. This resulted in all patients under the age of two years being conveyed to hospital with further strong recommendations for patients twelve years and under. Anecdotal concern from hospitals and staff regarding unnecessary conveyance/ referrals have prompted a further review of any patients twelve years and younger who are not conveyed to hospital, with a focus on those less than two years old. The audit will examine the assessment undertaken and appropriateness of conveyance and referral decisions.



Heart Failure

There is a perception of an overuse of nitrates as a medication in the management of acute heart failure within the LAS. This clinical audit will review the identification, assessment and medication administration to patients where acute heart failure is suspected in the pre-hospital setting or diagnosed at hospital.

Statements of assurance from the Board

Statements mandated by NHS England

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

Data Review

During 2015/16 the London Ambulance Service NHS Trust provided three NHS Services and has reviewed the data available to them on the quality of care in these services.

Income

The income generated by the NHS services reviewed in 2015/16 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Services NHS Trust for 2015/16.

Clinical Effectiveness and Audit

Every month the Trust submits data to NHS England for the Ambulance Quality Indicators. The data is collated and updated on their website every 3-4 months to reflect the collated monthly submissions from all ambulance trusts. The clinical outcome measures within these look at the quality of clinical care that we provide to patients who have had a cardiac arrest, heart attack or stroke. We also contribute to the ambulance services' National Clinical Performance Indicators programme that benchmarks the care we provide to patients who have had a febrile convulsion, older people who have had a fall, those with a single limb fracture, those who have self-harmed, and those suffering asthma. This year, based on feedback from staff, we investigated different immobilisation and splinting options for the management of patients with a single limb fracture. As a result it has been agreed by the Clinical Equipment Working Group to procure alternative equipment.

We also submit data relating to our cardiac patients to the National Out-of-Hospital Cardiac Outcomes project, which is national registry of cardiac arrests in England. This registry is currently in its validation stages and the aim is that the information contained within it will shortly be used to look at variations in outcomes of cardiac arrest nationally, providing information to help inform treatment and improve survival for this patient group. During 2015/16 we provided 8,367 cases to the registry.

In 2016-17 we will focus on improving care to nine different patient groups that we have identified as requiring attention: cardiac, stroke, trauma and asthma patients; those with a



ruptured abdominal aortic aneurysm, in sickle cell crisis or hypovolaemic shock; those requiring care under the mental capacity act, and those left at scene.

Clinical audit

During 2015/16, two national clinical audits and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was eligible to participate in during 2015/16 are as follows:-

NHS England Ambulance Quality Indicators: Clinical Outcome measures covering:

Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)

- Outcome from cardiac arrest – Survival to discharge
- Outcome from acute ST-elevation myocardial infarction (STEMI)
- Outcome from stroke

National Clinical Performance Indicators (CPI) programme covering:

- Asthma
- Single limb fracture (trauma)
- Febrile convulsion
- Elderly falls
- Self-harm (mental health)

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
NHS England AQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 2399 b) 306	a) 2399 b) 306	100%
NHS England AQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 2362 b) 297	a) 2362 b) 297	100%
NHS England AQI: Outcome from acute STEMI b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	b) 804 c) 1767	b) 804 c) 1767	100%
NHS England AQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 4269 b) 7428	a) 4269 b) 7428	100%
National CPI: Asthma a) Respiratory rate recorded b) PEFr recorded (before treatment) c) SpO ₂ recorded (before treatment)	600	600	100%



d) Beta-2 agonist recorded e) Oxygen administered f) Care bundle			
National CPI: Single leg fracture (trauma) a) Two pain scores recorded b) Analgesia administered c) SpO ₂ recorded (before treatment) d) Oxygen administered e) Immobilisation of limb recorded f) Assessment of circulation distal to fracture recorded g) Care bundle	600	600	100%
National CPI: Febrile convulsion a) Blood glucose recorded (before treatment) b) Temperature recorded (before treatment) c) SpO ₂ recorded (before treatment) d) Oxygen administered e) Anti convulsant administered f) Temperature management g) Appropriate discharge pathway recorded h) Care bundle	453	453	100%
National CPI: Elderly Falls a) Primary observations recorded b) Recorded assessment of the cause of the fall c) Recent history of falls documented d) 12 Lead ECG assessment e) Recorded assessment of mobility f) Direct referral to an appropriate health professional g) Care bundle	600	600	100%
National CPI: Self-harm a) Mental state of patient is recorded b) Evidence of use of drugs and/or alcohol is recorded c) Exact nature of injury recorded d) Has a clinical assessment been completed? e) History of events leading to today's self harm episode recorded f) Has there been an assessment of mental capacity? g) Has information relating to social/family support network or NOK been recorded	300	300	100%

The reports of the above national clinical audits were reviewed by the London Ambulance Service NHS Trust in 2015/16 and the following actions have been taken to improve the quality of healthcare provided:

- Continued clinical education provided to staff through training updates, and reminders in bulletins and newsletters.
- Introduction of a Clinical Information and Support Overview tool to allow discussions to take place directly with frontline staff in relation to their illness coding and time spent on scene to improve learning.

The reports of **six local clinical audits** were reviewed by the London Ambulance Service NHS Trust in 2015/16 and the Trust intends to take the following actions to improve the quality of healthcare provided against each as detailed below.

Recognition and Management of Paediatric Severe Sepsis

- Create a video tutorial on paediatric sepsis to ensure crews are aware of: the importance of undertaking core observations; how to undertake a comprehensive review of systems; key indicators of severe sepsis, and the treatment and management of severe sepsis, including



spending as little amount of time as possible on scene with critically ill patients

- Consider the introduction of a Paediatric Sepsis Clinical Performance Indicator to continuously manage the care provided to this patient group
- Investigate why certain equipment was described as missing, specifically paediatric oxygen saturation probes and blood pressure cuffs

Management of Patients Detained Under the Mental Health Act

- Explore the possibility of a trial where Non-Emergency Transport crews convey patients under Section 136 who do not need medical attention
- Review processes to ensure LAS management are informed when an LAS clinician accompanies a patient in a police vehicle
- Amend the Memorandum of Understanding with the Metropolitan Police Service to detail the information required from the police for Section 136 calls and ask the MPS to ensure receipt of any cancellations is confirmed
- Notify the British Transport Police and City of London Police of all of the above

Administration of Ketamine and Midazolam by Advanced Paramedic Practitioners

- Amend the Patient Group Direction to reflect intraosseous and subcutaneous as appropriate routes of administration for midazolam, increase the permissible dose for midazolam and ketamine, and remove the requirement to give patients leaflets
- Provide feedback to individual Advanced Paramedic Practitioners regarding possible areas for improvement

Paediatric Respiratory Assessment

- Distribute posters to all ambulance stations congratulating clinicians on improvement and reiterating that two respiratory rates should still be measured for all patients
- Write a Clinical Update article to ensure that the importance of an accurate respiratory rate is reinforced

Administration of IV Paracetamol

- Recommend to the Association of Ambulance Chief Executives that there should be a clearer distinction between oral and IV paracetamol in the national guidelines
- Remind clinicians to use a step-wise approach to pain management and to consider whether their patient has self-administered medication containing paracetamol
- Revise the pain assessment tool to include IV paracetamol

Inter-hospital Transfers

- Provide hospitals with further guidance on requesting inter-hospital transfers, including the use of the HCP line and the importance of providing an escort where needed
- Instruct call-takers to refer to immediate transfers as “immediate within one/two hours” when talking to hospital staff in order to avoid confusion



- Consider recommending the introduction of an alternative MPDS card to separate the coding of inter-hospital transfers and HCP admissions in Command Point

The London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to six patient groups(cardiac arrest, difficulty in breathing, glycaemic emergencies, mental health, sepsis and patients that were discharged on scene) and quality assures the documentation on 2.5% of all clinical records completed.

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

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Clinical research ensures our clinical staff keep up to date with the latest possible treatment options and their active participation leads to improved patient outcomes. The number of patients receiving relevant health services provided or sub-contracted by the London Ambulance Service NHS Trust in the first 3 quarters of 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 4635. These patients were recruited into a range of interventional and observational studies. These studies were:

PARAMEDIC-2: A pre-hospital double blind randomised controlled trial exploring the effectiveness of adrenaline administration on patient outcomes following cardiac arrest

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

Aneurysm-FILTR: An observational study to prospectively validate the diagnostic accuracy of an aneurysm scoring system developed by St George's Vascular Institute and the LAS available as an App for smartphones. Patient care and destination are not altered

VAN: A mixed methods study design which explores national variation in non-conveyance to emergency departments by identifying determinants of non-conveyance, studying variations in hear and treat and identifying the causes of potentially inappropriate non-conveyance

A Study of Major System Reconfiguration in Stroke Services: A mixed methods design study to support and analyse reconfiguration of stroke services in England. The study aims to identify lessons that will guide future reconfiguration work in other services

In 2015/16 686 members of clinical staff received protocol training to enable them to participate in interventional and observational research at the London Ambulance Service NHS Trust.



CQUINS

A proportion of London Ambulance Service NHS Trusts income in 2015/16 was conditional on achieving quality improvement goals agreed between the lead Commissioner, Brent CCG on behalf of the pan London CCGs agreement for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 are detailed below;

Goal No.	Goal Name	Description of goal	Expected financial value of goal (£)
1	Integrated Care: Improving reporting and use of patient information.	Review the functionality of current patient information available to support the overarching ambition to improve decision making and patient care Identify & address areas to improve access to patient information within LAS process and technical ability	£744,423.68
2	Integrated Care: Promoting Use of ACPs	Review the impact of the Pathfinder training already rolled out as part of the 14/15 winter resilience initiative to ensure it is still fit for purpose and aligned to LAS requirements. Implement Pathfinder training across all eligible staff Scope opportunities to develop an appropriate / suitable 'feedback' mechanism on ACPs	£1,353,497.60
3	Sepsis Management	Improving the management of patients with sepsis in the pre hospital setting via a developed sepsis pathway, management toolkit.	£744,423.68
4	Staff Development & Retention: Development of Clinical Team Leaders	Develop leadership capabilities in clinical team leaders to ensure the robust management of, and support to frontline staff	£812,098.56
5	Mental Health: Improving Mental Health Outcomes	Review the LAS Mental Health Risk Awareness Tool 'Proof of Concept' previously undertaken, to transition into a pilot project that will include 4 partner CCGs pan-London (North, South, East & West)	£676,748.80
6	Mental Health: Dementia & Delirium	Undertake a pilot project to identify key areas of improvement in the experience of Dementia patients (and their carers) when using the service	£135,349.76
7	Improving Patient Care: Frequently calling patients	Develop and agree a project plan for the identification and management of complicated frequent callers.	£812,098.56
8	Improving Patient Care: HCP Pilot	Delivery of a pilot project for a dedicated Health Care Professional (HCP) line and provision of data on GP usage within CCGs.	£1,353,497.60
9	ED Conveyance: Reducing unnecessary ED Conveyance (National CQUIN Requirement)	Reduce rate of ambulance transportations to type 1 and type 2 A&E per 100,000 populations	£135,349.76



Agreed 2016-17 CQUIN themes

Goal No.	Goal Name
1	E-solution 1: Preparing the roadmap for LAS digital integration with London wide U&E care
2	E-solution 2: Supporting a mobile workforce through identification of benefits of the e-Ambulance digital healthcare initiative
3	E-learning development: Supporting the move to a total workforce information approach with a review to identify a comprehensive learning management system
4	Improving focus on special patient groups: Bariatric, Mental Health & Sickle Cell
5	Improving LAS Emergency Operations Centre: Supporting consistent delivery of patient care, safety, experience and outcomes and strengthening governance and quality assurance processes, improving clinically appropriate and timely response and experience for patients
6	National: 1a Introduction of health and wellbeing initiatives (two options, only one to be selected)
	1b Healthy food for NHS staff, visitors and patients
	1c Improving the uptake of flu vaccinations for front line staff within Providers

Patient Safety Incidents

Serious Incidents (SIs)

In total across 2015/16 out of 396 cases reviewed 62 incidents were deemed to meet the criteria to be declared as serious to NHS England (London). The number of serious incidents declared equates to a 41% increase compared to 2014-15. Each declared Serious Incident (SI) is then subject to a full investigation using Root Cause Analysis (RCA) methodology with SMART recommendations put in place to mitigate the likelihood of repeat occurrences.

For the third year in a row the numbers declared have increased significantly (18 in 2012/13 and 39 in 2013-14, 44 in 2014-15). This continues to demonstrate a better understanding and use of the internal incident reporting process and a firm organisational commitment to improve the channel for identifying Serious Incidents. It also reflects a more open reporting culture in a time of increasing demand on the Trust.

As in previous years, the number of ambulance delay related SIs has remained high, although in 2015-16 we have seen a wider range of incidents declared including HR related issues, Information Governance issues and medicines management. This wider range of incidents raised by members of staff that are then declared further demonstrates the increasing confidence of our staff in the purpose and benefit of reporting errors and incidents.



Process and Governance

The SI group membership includes 4 executives and meets weekly. Following a review of the Terms of Reference this year the membership has expanded to include more subject matter experts. This has resulted in more informed decision making. We have hosted a variety of observers at the meeting, both external in the form of commissioners and the NHS Trust Development Authority and internal, with an increasing number of staff with a Quality or Governance focus to their roles demonstrating an interest in the discussion and decision-making process for SIs. The purpose of the meeting is to provide an open and challenging discussion to incidents raised, and this has been reflected in feedback from our external stakeholders. We have also seen a continuing number of Inquests and complaints raised to the group for evaluation and decision.

Each SI has executive and senior management leads who review and sign off the report before it is submitted; we also involve our legal services team and seek external legal advice as required. Ensuring the Duty of Candour is complied with is essential and this now forms an integral part of the discussion for responsibilities as when a patient safety SI with moderate or severe harm is declared and a Family Liaison Officer is appointed.

We expect that 2016/17 we will see further increases in the number of incidents reported and declared as DatixWeb a mechanism for reporting incidents on-line, is introduced making incident reporting more accessible to our staff and managers. Those which meet the threshold for an SI will be considered by the SI group.

Learning from experience

Please see below some examples of where the LAS have improved its service as a result of SIs;

1. In August 2015 an incident was declared where a patient went into cardiac arrest at the Olympic velodrome and there was a subsequent delay in reaching the patient due to the E20 Olympic Park not displaying on the Sat Nav system. In response mapping books were updated detailing the Olympic Park and E20 area and subsequent updates in November 2015 to the Garmin system now detail the area and road network.
2. Following a number of incidents where PRFs (Patient Report Forms) were lost on vehicles in 2015-16 the Trust has designed a new self-sealing LA1 form replacing the existing form. This will enable used PRFs to be stored more secure during a shift and will also ensure a record of statutory vehicle checks will be recorded every shift. If the new LA1 envelope is lost there is a 24/7 contact number to enable it to be returned to the service. This has been piloted with a view to roll out to the rest of the service.
3. In September 2015 the LAS responded to patient who had suffered a fall from height a number of times over a four day period with the patient losing all power in their lower limbs. As a result a greater awareness of the subtleties of the various presentations of cord injuries and the significance of patients re-presenting to healthcare for the same problem is required for ambulance clinicians in London. This issue was covered in a clinical update with associated case study. The complexities



of such cases will also be covered in Core Skills Refresher training programme for 2016-17

Future developments

Although the numbers of SIs declared by the Trust are lower than some of our peers, this could be seen as a measure of the safety of the service rather than a poor process for capturing errors and incidents. There is also significant variation in what different ambulance services report. Some declare ambulance handover delays, whereas the arrangements in London are for these to be declared by the Acute Trust responsible. LAS are taking part in an ambulance service initiative to share the details of SIs declared to allow for better learning and comparison across Trusts using the Proclus/Zeal system. It is important that in 2016-17 we continue to work on reducing the length of time it can take to investigate an SI and the level of quality of the report that is produced. As such approximately 30 members of staff have undertaken Root Cause Analysis training in the latter part of 2015/16 to help ensure this is done. In addition to this there are now clear channels for escalation of overdue SIs to both Senior and Executive management.

How we are implementing Duty of Candour

The LAS have taken a multifaceted approach to implementing and embedding the Duty of Candour into the culture of the organisation. In addition to the appointment of Family Liaison Officers in Serious Incidents, there have been several classroom-based Family Liaison Officer training sessions for clinical managers to help explain the purpose of the Duty of Candour and what is required to fulfil that duty. In addition to this a dedicated Duty of Candour session has been included on Core Skills Refresher training 2015.3 for all clinical staff. In 2016-17 Duty of Candour will be included as a mandatory training module for all staff with an attached multiple choice competency test and it will be included on Trust induction for all new staff. These initiatives have run alongside a continuing internal communications programme.

CQC

The Care Quality Commission (CQC) Chief Inspector of Hospitals inspection of The London Ambulance Service NHS Trust took place between 1st and 5th June 2015, and 17th and 18th June 2015, with further unannounced inspections on 12th, 17th and 19th June 2015. This inspection was carried out as part of the CQC's comprehensive inspection programme.

Four core services were inspected:

- Emergency Operations Centres
- Urgent and Emergency Care
- Patient Transport Services
- Resilience planning including the Hazardous Area Response Team

The CQC inspection report was published on 27th November 2015. Overall, the trust was rated by the CQC as 'Inadequate'.

Of the five CQC domains: Safe was rated as 'Inadequate', Effective was rated as 'Requires Improvement', Caring was rated as 'Good', Responsive was rated as 'Requires Improvement', and Well-led was rated as 'Inadequate'.



We are pleased the CQC recognised:

- That patients in London receive good clinical care
- Our staff are caring and compassionate
- Paramedics and nurses in our control room give good advice to frontline staff while our intelligence conveyance system prevents overload of ambulances at any one hospital



	Safe	Effective	Caring	Responsive	Well led	Overall
Emergency operations centre (EOC)	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Resilience	Inadequate	Requires improvement	Not rated	Not rated	Requires improvement	Inadequate
Patient transport services (PTS)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Emergency and urgent care	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate



Following the CQC inspection, the LAS had developed a Quality Improvement Programme (QIP) which is the single overarching plan addressing quality improvement in the Trust. We have established a clear programme of delivery, accountability and governance, led by the Director of Transformation, Strategy & Workforce and supported by a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our Quality Improvement Programme. A Quality Improvement Group has been implemented, chaired by the Chief Executive, which will meet monthly to review progress against the whole plan and each of the five work streams, assessing risks and directing interventions to ensure delivery. The table below identifies the key CQC “must dos” which were identified and the actions that have already been taken to address them as well as any further mitigating actions.

What the CQC said	Our actions and plans (completed and further actions as of April 2016)
Recruit the required number of Hazardous Area Response Paramedics	<p>We have already recruited to all of the 84 posts, all of whom have completed the national HART training. We have also revised our policies and protocols relating to HART and designed our Core Skills Refresher (CSR) to ensure that all frontline staff receive major incident training.</p> <p>Further actions: Monthly monitoring of our HART service to ensure that it continues to meet the national specification requirements and all HART staff are fully trained.</p>
Improve medicines management	<p>We have already appointed a Medicines Safety Officer and begun a review of the journey of a drug from arrival at the service to when it is administered. We have already implemented audits at key points during this journey. We are also working with the TDA and CQC to review and update the guidance for administering drugs by paramedics in the UK</p> <p>Further actions: Our Medicines Management Project will assess how medicines management facilities and compliance at our sites can be strengthened. We are also working with NHSE and TDA to clarify national policy on Patient Group Directives for oral Morphine and rectal Diazepam.</p>
Improve the system of governance and risk management	<p>We have already carried out a baseline audit of all local risk registers and designed a training programme for all managers which will be complete by 31 March 2016. We are beginning to see evidence of the application of Duty of Candour following the training that has been underway since the end of 2015. We have also worked to increase incident reporting including having the relevant reporting forms readily accessible on all vehicles.</p> <p>Further actions: Launch Datix Web to simplify and improve incident reporting</p>
Tackle bullying & harassment & perceived culture of fear in some parts	<p>We have already appointed a bullying and harassment specialist, carried out awareness training for all Senior Managers and have had a telephone advisory service in place since July 2015.</p> <p>Further Actions: roll out training for all staff and launch a far reaching publicity campaign to highlight bullying & harassment key messages. We will also re-launch the policy which will include KPIs and an emphasis on mediation and conciliation.</p>
Recruit sufficient frontline staff	<p>We have already recruited an additional 284 frontline staff between June and December 2015 with a further 177 in training and supervision. We will have another 297 to join by the end of March 2016. Our retention initiatives have also decreased turnover from 15.1% to 12.6% in the same time.</p> <p>Further actions: Progressing our 2016/17 recruitment and retention plan to ensure the Trust maintains its staffing levels.</p>



Governance

London Ambulance Service NHS Trust Information Governance Assessment Report overall score for 2015/16 reached 83% satisfactory, Level 2 for all requirements.

Reporting

London Ambulance Service NHS Trust did not submit records during 2015/16 to the secondary users service for inclusion in the Hospital Episode Statistics.

London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Reporting on core indicators

As a Trust we are required to report performance against those core set of indicators relevant to an ambulance provider.

1/ The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.

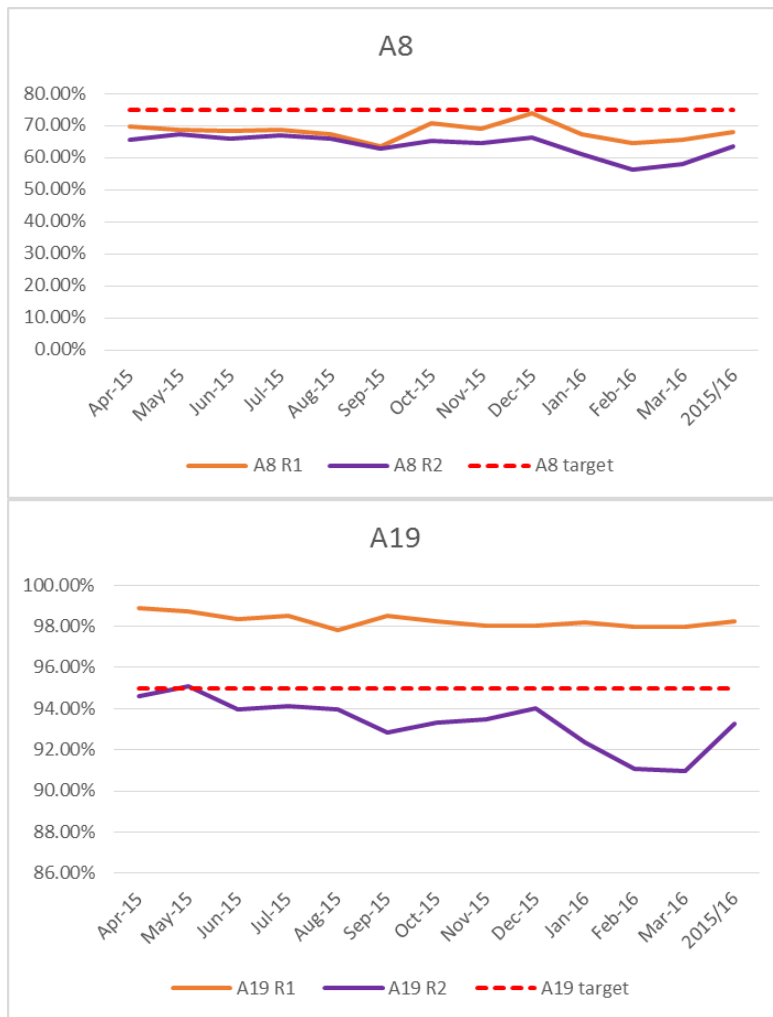
2/ The percentage of Category A telephone calls resulting in an emergency response by the Trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.

**March 2016 data for all indicators is still being processed and validated and will change*

Date range: 01/04/15 to 31/03/16

Month	A8			A19		
	R1	R2	A	R1	R2	A
Apr-15	69.84%	65.45%	65.57%	98.89%	94.59%	94.72%
May-15	68.68%	67.29%	67.32%	98.75%	95.10%	95.20%
Jun-15	68.19%	66.00%	66.07%	98.36%	93.97%	94.10%
Jul-15	68.68%	66.94%	66.99%	98.49%	94.11%	94.23%
Aug-15	67.36%	65.84%	65.88%	97.82%	93.94%	94.05%
Sep-15	63.53%	62.81%	62.83%	98.51%	92.84%	92.99%
Oct-15	70.73%	65.40%	65.54%	98.22%	93.33%	93.46%
Nov-15	69.04%	64.39%	64.52%	98.03%	93.47%	93.60%
Dec-15	73.83%	66.41%	66.63%	98.05%	94.02%	94.13%
Jan-16	67.29%	60.94%	61.13%	98.20%	92.37%	92.55%
Feb-16	64.52%	56.39%	56.62%	97.98%	91.09%	91.29%
Mar-16	65.57%	57.93%	58.16%	98.00%	90.95%	91.16%
2015/16	68.10%	63.68%	63.80%	98.26%	93.26%	93.40%





3 & 4/ The London Ambulance Service NHS Trust submitted the following information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2015/16 and 2014/15.

	2015-16 *		2014-15	
	LAS average	National average (Range)	LAS average	National average (Range)
STEMI patients	70.3	78.3 (65.4 – 87.4)	72.6	80.7 (70.6 – 89.5)
Stroke patients	97.3	97.6 (96.1 – 99.6)	96.7	97.1 (93.5 – 99.4)

*At the point of preparation of this Quality Account, NHS England reported data for April to October 2015.

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



Review of the Year 2015/16

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

Quality Priorities identified for 2015/16

Patient Safety

1/ Sign up to Safety Campaign

In 2015-16 the Trust enrolled on to the Sign up to Safety campaign in order to contribute to the system-wide ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This meant signing up to 5 specific pledges:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learning.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

We have seen significant progress in Maternity where a 6 weekly “Risk Summit” set up to discuss complaints, serious incidents, PALS, claims and inquests has used the Sign up to Safety pledges to help inform its agenda. Work continues to improve the safety of the service we provide by effective engagement with staff involved in incidents and providing proactive training on Maternity risks to clinical staff. Learning points are also shared at a London-wide Heads of Midwifery meeting.

The introduction of structured executive walk-rounds in February 2016 supports the aims and objectives of the Sign up to Safety campaign, promotes an open, responsive and supportive safety culture, ensuring visibility of the Executive Leadership Team (ELT) and engagement from staff across all areas of the organisation. Each member of the ELT has an allocated sector and are committed to spending time each month either on a ride out or a locality visit such as a training centre, annexes or stations. A structured programme of feedback and learning has been instigated which will feed into the monthly Trust quality



report to inform strategic and operational planning with appropriate actions identified as required.

The Trust now publishes a quarterly 'Learning From Experience' report, picking up a number of themes from across Serious Incidents, Complaints, Inquests, incidents and claims. This report is shared at the Quality Governance Committee and with our commissioners.

In regards to "Being Honest" we have worked extensively to integrate the Duty of Candour in to the culture of the organisation and staff involved in Serious Incidents are offered support through the process including staff welfare, evidencing our commitment to being supportive.

2/ Maternity

Following the successful appointment of a Consultant Midwife 3 days a week, maternity care was identified as a key quality priority for 2015/16 with an associated workplan.

In 2015 the London Ambulance Service was proactive in delivering a range of opportunities for staff to improve skills and knowledge around the care of pregnant and newly delivered women. The experience of the staff attending has evidenced the need to continue to develop joint training with an ethos of "those that work together should train together"

Key Successes 2015:



- Celebration of International Day of Midwifery (5.5.2015) and Launch of Maternity Mannikin.
- Clinical Safety – Establishment of 6 week Maternity Risk Summit
- Establishment of Joint Maternity Training for the Pre- Hospital Setting led by LAS and local Maternity Units – 100 Ambulance Staff trained with midwives across London.
- Delivery of Maternity "Mouthfuls" training for staff working within the Emergency Operations Centre to reinforce the advice given over the telephones
- Responsive changes to the triage system used within the LAS reviewed and submitted to improve care – Cord Prolapse, Water birth, Cardiac Arrest and Skin to Skin care for new-borns.
- Stork Awards initiated to celebrate the work of Emergency Medical Dispatchers in management of telephone support to women who give birth prior to the arrival of the ambulance service



Progressing Maternity into 2016:

With the publication of the National Maternity Review (2016), there is a clear direction toward promoting home birth, and births taking place within stand-alone birth centres. Whilst we are active in engaging with our local maternity units the maternity work programme must reflect the needs of women balanced with the needs to develop the emergency services response to maternity care provision.

The inception of the maternity risk multidisciplinary meeting enables a strategic group to provide an overview of the complaints, incidents and risk within the ambulance service and enable a rapid response to learning and provision of feedback when staff evidence excellence in clinical practice. This forms the basis of our commitment to the “Sign up to Safety” campaign.



Whilst the stork awards are aimed in recognising and celebrating the work of the Emergency Medical Dispatchers in supporting couples birthing at home, the feedback from women and those using the service is an area to proactively review toward ensuring the maternity care is safe, responsive, and provides a positive experience largely under emergency conditions.

Maternity Work plan 2016/17:

Objective	Measurable	Associated Documentation
Strengthening Risk and Promoting Safety and a Positive Experience of Care	6 weekly – Maternity risk multidisciplinary meeting Sign up to Safety in Maternity Launch Establish feedback process for maternity “Walking in their shoes” – Capturing the user and staff experience of care - Workshop	Morecambe Bay Investigation 2015 Kirkup Report 2015 The National Maternity Review 2016
Deliver Maternity Education Programme	Delivering of Joint Maternity Training Including Masterclass in response to local incidents Maternity Webinars	Obstetric Policy Training Needs



	Update Training Needs Analysis	Analysis
Reviewing BBA's attended by LAS	Work with CARU to quantify BBAs and plan an audit to review preventable and non-preventable incidents Work alongside commissioners to develop a responsive ambulance services response to improvements to the delivery of birth in the pre hospital setting.	High Quality Maternity Care 2014 The National Maternity Review 2016
Maternity Advice – A Joint Triage Model with Maternity Services	Integration of dual registered nurse/midwives into the clinical hub. Pilot of “Rapid Response Midwife” project with Lewisham Maternity Services to impact on ambulance and maternity outcomes.	High Quality Maternity Care 2014
Launch of the Maternity Pre-Hospital Screening Card	Maternity card Webinair Maternity card available: On LAS App In maternity packs Personal copy Staff feedback and audit to evaluate effectiveness	
National Maternity Pack	Development and implementation of a standardised maternity pack Exemplar shared nationally Launch of the pack with Webinair	

3/ Frequent Callers

The Trust identified the systematic review of the processes, pathways and resources allocated to supporting the identification of frequent callers and subsequent management as a quality priority for 2015/16. The Trust was successful in securing a Darzi Fellowship to support this work, focussing on reviewing the current processes, quantifying the problems posed to the service, understanding the different cohorts of patients who make up this group of patients and evaluating intervention methodologies to assess effectiveness.

This was also identified as a CQUIN, in partnership with our commissioners, and quarterly reporting has demonstrated significant improvement across a range of aspects with a detailed project review and recommendations for future practice developed.

Supporting the integration of health and social care, or the provision of community and local care. A specific focus was the review of the impact, efficacy and sustainability of integrated approaches to case management and personalised care planning for frequent callers. It was evidenced that effectively escalating individual entrenched Frequent Callers has been demonstrated to inspire greater engagement from the wider health and social care



community and facilitated a more robust management of clinical risk. Accessible LAS data indicated a reduction in crisis frequency and duration for patients who are managed by locally owned Frequent Caller Forums.

Breaking down barriers between care provision, staff groups, and disease areas.

Ambulance services are in a unique position to act as coordinators and to map current systems and pathways. This project has focussed on some of London's most vulnerable, resource intensive patients requiring whole system communication and engagement to positively affect how they use services and subsequent quality of care. A review of the various approaches currently in place was undertaken identifying a range of multi-disciplinary and multi-professional teams for example falls services utilising paramedics and district nurses, mental health teams applying street triage models with direct access to psychiatrists and specialist nurses and palliative care networks supported by shared records and specialist nurses working within the call centre.

Developing innovative and radical care delivery options, or investing in new health technologies. An assessment was conducted of the varying methodologies available across the health and social care such as access to summary care records utilising innovative IT systems, data sharing agreements and hardware options to highlight where innovation is impacting positively on patient care.

Increasing the potential for better efficiency/demand savings and explores viable options for sustaining and improving the NHS. Quantification of the associated costs to the Trust and the wider NHS was undertaken with annual figures detailing the organisation accommodates 1,622 Frequent Callers annually generating 49,534 incidents and incurring associated costs of approximately £4.4 million to LAS with a wider cost to the London health care economy of approximately £18.8 million annually. This does not take into account other services accessed and provider input into the management of their care. A review of current reporting methodologies was undertaken and a new process initiated allowing greater granularity and more focussed care planning at a local level.

Patient Experience

1/ Safeguarding processes

Continued improvement to safeguarding processes was identified as a quality priority for 2015/16 specifically a focus on training, supervision, partnership working and the implementation of the new Care Act and associated reviews. A detailed work programme has been undertaken and significant progress made.

The Trust delivered a wide range of safeguarding training across the Trust on inductions, level 1, level 2 and level 3 during 2015-16, 91% of staff completed level one and 93% completed level three training.

The Trust engaged in a considerable amount of partnership working during 2015-16 with over 250 meetings attended locally, with the new operational structure enabling a senior member of staff to attend safeguarding board meetings where invited. We have also



attended a number of pan London meetings for both children and adults during the year. LAS partnership working has directly resulted in children and vulnerable adults being protected in the past year. The Trust is progressing recommendations from the Savile report on DBS checks and this forms part of the work plan for 2016/17. The Safeguarding governance arrangements within the Trust are working well and providing assurance to the Board.

Types of Abuse

Physical (hitting, slapping, misuse of medication, restraint)

Domestic Violence (Incidents or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse. By someone who is or has been an intimate partner or family member regardless of gender or sexuality)

Sexual Abuse (rape, indecent exposure, subjecting to pornography, not consented or pressured to consent)

Psychological abuse (emotional abuse, threat of harm or abandonment, blaming, humiliation, isolation)

Financial or Material Abuse (internet scamming, will issues, inheritance, financial transactions)

Modern Slavery (human trafficking, forced labour, domestic servitude, coercion, deceive and force individual into life of abuse)

Discriminatory abuse (sturs issues of race, gender, disability etc.)

Organisational abuse (neglect or poor practice within an institution or care setting. Neglect or poor professional practice as a result of policies, processes)

Neglect and acts of omission (ignoring medical, emotional or physical care needs. Failure to provide access to appropriate health care)

Self-neglect (wide ranging, neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding).

Incident can be one off or multiple and affect one person or more.

Changes with effect from 1st April

- Staff must (where safe) have a discussion with the adult at risk about their safeguarding concerns.
- Adult at risk must consent to a safeguarding concern being raised by LAS.
- Staff must state consent obtained or reason why it was not in all safeguarding concerns.
- Concerns can be raised if patient lacks capacity, however a capacity assessment and best interests assessment should be completed to evidence this.
- If patient has capacity concern can only be raised if actions are impacting on other (public interest) or you believe patient is being coerced.
- Staff should also ask the adult what outcome they would like from them raising the concern and record this appropriately.
- Where possible a vulnerable adult should be advised to contact the local authority themselves for care and support when there is no safeguarding concerns. The Service should only perform this role when adult is unable to raise need.
- Welfare concerns **WILL ONLY** be sent to the local authority if the adult consents to welfare concern being raised.
- If you do not have consent to raise a welfare concern. Record lack of consent on FRF.
- EBS staff will ask staff for consent and outcome information. If this is not provided the concern cannot be raised with the local authority. Staff will be notified of reason it cannot be progressed.
- This will apply to concerns raised via the phone or fax.

Changes to Safeguarding Adult Practice

With effect from the 1st April 2015 the way adults are safeguarded will change.

Service practice will also change

This is a result of the Care Act 2014 which provides the statutory and legal requirements to safeguard adults and brings it into line with child safeguarding.

The Care Act puts adults and their wishes and experience at the centre of safeguarding and is a move away from the process-led culture to a person centred approach which achieves outcomes that people want.

There is a change in terminology with a safeguarding referral now being called a safeguarding concern and Serious Case Review (SCR) will be called Safeguarding Adult Reviews (SAR)

Safeguarding

Children, young people and adults at risk

The second annual Safeguarding and Mental Health Conference was held in April 2015 for 110 staff and national partners covering a range of topics including child sexual exploitation, female genital mutilation, hoarding, homelessness and mental health. A third conference took place in March 2016 covering Domestic Abuse, Frequent Callers, Elderly & Loneliness, Mental health initiatives and Children in Gangs. Speakers with personal experience of the issues were used which has a significant impact on those attending and feedback from both conferences has been extremely positive.

We have also produced a number of materials to support safeguarding activity such as:-

- 2nd Safeguarding Pocketbook
- A pen that contains a flowchart on the Mental Capacity Act and Care Act information.
- A leaflet on the Care Act safeguarding requirements for staff

2/ Mental Health

An on-going focus on Mental Health was agreed as a quality priority for 2015/16.

Dementia care

Building upon initiatives from 14/15, dementia was identified as a CQUIN in partnership with our commissioners. We engaged with voluntary organisations including the Alzheimer's Society, Dementia Concern and Camden Dementia Carers Service to initiate a number of focus groups with dementia patients and their carers. People taking part in the focus groups provided a range of helpful responses and ideas with the aim of helping the Trust improve the way it provides care to people living with dementia. A report was developed highlighting

key findings and recommendations which will be used to inform our mental health work plan for 2016/17.

The Trust has focused on raising dementia awareness across staff. A communications initiative was put in place to encourage dementia friend's uptake. We also secured face to face dementia training sessions delivered by University College London (UCL) Partners who were awarded funding by Health Education North Central London (HENCEL) to lead a cultural change in dementia care across NHS organisations. We delivered train the trainer sessions for our clinical tutors, enabling them to become dementia champions, with the ability to cascade their learning across the organisation. Dementia awareness sessions were also delivered for Emergency Operations Centre staff.

Training and Education

The Trust has focused on delivering face to face mental health training updates to our Clinical Team Leaders and Advanced Paramedic Practitioners with sessions including the national section 136 protocol and updates in mental health policy and practice. A gap analysis was conducted in respect to our international recruits to ensure that appropriate training on mental health legislation was delivered to this cohort of staff.

The introduction **of mental health nurses** in our Emergency Operations Centre has also supported improved knowledge and confidence of our staff working in the control centre with this workforce model receiving recognition from NHS England as an innovative new model of working. The LAS identified that demand from mental health callers was growing and that mental health specific training within the paramedic curriculum was limited. In 2015 we made a commitment to create six full time mental health clinical advisor posts to supplement existing clinical advisor roles and support the service's hear and treat model. The introduction of mental health experts within our control room has gone some way in fulfilling the parity agenda. By introducing a hear and treat pathway for mental health patients, this has ensured that patients who may get a low priority response still receive a full mental health assessment and more importantly a risk assessment in a timely manner allowing for appropriate advice to be given and for people to be referred on and linked into the most appropriate service the first time. The work of the mental health nurses is broadly divided into three elements:





- Hear and treat service –providing a full mental health assessment and signposting appropriately, upgrading and deciding on the most appropriate course of action, advising patients over the phone.
- Warm transfers-assisting call handlers and fellow clinical advisors with the management of difficult mental health calls.
- Providing advice to frontline crews around mental health legislation and accessing mental health services.

An initial evaluation of the mental health nurse role has shown that mental health clinicians have been a source of mental health knowledge and expertise and have been able to provide support to clinical hub staff and crew staff on the road in their day to day management of mental health patients as well as assist call handlers with challenging mental health calls when appropriate. Between March 2015 and March 2016, mental health nurses have responded to 5961 calls with 15.9% of all calls closed with a hear and treat function. There have been no complaints or incidents reported. Their quality assurance reports have been excellent with nurses achieving an average compliance of 99.6% on their individual performance reviews. The accepted compliance level for clinical hub staff is 95%. The LAS will continue to audit and evaluate the role at regular intervals. As well as the collection of activity and outcome data, there are plans to include staff perceptions and quality of interaction with the post holders through semi structured interviews and through an anonymised questionnaire administered through a tool such as survey monkey. Although this has not yet commenced, informal feedback suggests that the mental health nurses have been very well received and are now a well embedded and popular resource within the service.

A further initiative was the roll out of the **mental health risk awareness tool** (LA383) across the service. This tool was developed as a result of a pilot conducted in the Hillingdon area between March and November 2012 and was rolled out as part of our CQUIN initiatives in 2015/16. The LA383 is being used as an aid to crews' assessment of patients presenting with mental health issues. In conjunction with the crews' clinical training and holistic view of the patient, the tool supports decision making. Formal evaluation is currently taking place but initial indications suggest that the LA383 has been well received by both LAS staff and our partners.

A full review of the mental health **Core Performance Indicators** (CPI) was undertaken this year by the Clinical Audit and Research Unit (CARU) in August 2015 detailing progress since its inception in 2012. This audit showed that we have seen overall improvements in the level of care provided to patients with a diagnosed psychiatric problem. Some aspects of care were consistently well recorded, whilst documentation of other aspects of care has



improved over the three-year period although it requires further attention to achieve the same high standard as the other CPIs. Initiatives to support this improvement have included Clinical Team Leaders updates and educational sessions focusing on risk awareness and the mental health risk awareness tool. An initial increase has been noted since roll out of the LA383; however we acknowledge that more needs to be done to ensure this group of patients receive the high standard of care provided to other patient groups audited via the CPIs.

Parity of esteem

The importance of treating mental health as equal to physical health and focusing on the needs and safety of people with mental illness have been highlighted within the 2014 Mental Health Crisis Care Concordat and Five Year Forward View for Mental Health. The introduction of mental health experts within our control room has supported the parity agenda supporting patients with a low priority response to still receive a full mental health assessment and more importantly a risk assessment in a timely manner allowing for appropriate advice to be given and for people to be referred onto the most appropriate service as required.

A continued focus on the review of **Appropriate Care Pathways** (ACPs) for mental health is vital in ensuring parity between physical and mental health and we now have established ACPs with all the nine Mental Health Trusts although there is some variability. We have focused our efforts this year on ensuring that mental health pathways available to our staff are accessible and available 24/7 providing both advice and referral pathways for our staff. Of the nine mental health trusts, three now have a single point of access for LAS staff and similar pathways are currently being developed with the remaining Trusts. LAS is also now included in the two street triage initiatives in London (South London and Maudsley NHS Foundation Trust and North East London Foundation Trust) which has fostered excellent responses and partnership working.

Care of patients detained under the mental health act (1983)

The service responds to two types patients detained under the mental health act (1983), emergency detention which constitutes section 136 MHA (1983) and planned mental health act assessments.

Planned Mental Health Act Assessments

Since March 2012, LAS has had a section conveyance protocol in place offering a response time of between 8 minutes - 60 minute dependent on presentation. Given the increasing demand for LAS resources there is recognition that there have been consistent difficulties in providing transport to this specific group of service users within the protocol specifications. Further concerns were also expressed by service users, carers and a wide range of agencies about the current transport arrangements which led to a review of our responses to people who have been detained under the mental health act. We have now completed this review led by NHSE and Brent CCG with a recommendation to move planned mental health act assessments to our Non-Emergency Transport Service (NETS). In partnership with Social Care Leads it is recognised that a significant proportion of planned mental health act assessments can be safely dealt with by NETS. We are currently piloting this service within the Camden and Islington area with a view to rolling it out across London from April 2016.



NETS uses a pre-bookable scheduling system to maximise effectiveness with a performance target of 90% of all pre-planned journeys receiving a vehicle before or at the time stated and 100% of bookings achieved within 30 minutes after the booked time. This initiative will also support the parity of esteem agenda.

Section 136 MHA (1983)

A national section 136 protocol directly informed by the Mental Health Crisis Care Concordat was introduced and implemented across the Trust in April 2014 recommending a response time of 30 minutes to all persons detained under the MHA (1983). The service continues to face challenges in our ability to respond to all section 136 incidents in the specified time frames.

The service has concentrated efforts this year on a detailed review of section 136 responses specifically how these are triaged and how the service meets the response times allocated to these calls. This data is triangulated with Metropolitan Police Service (MPS) data. A section 136 audit was completed by CARU in December 2015 and this has allowed the identification of key issues that can result in ambulances not being dispatched within the concordat specifications. Performance monitoring information shared with the Mental Health Partnership Board details that LAS are now responding to 58% of Section 136 incidents within the concordat specifications.

Issues highlighted include:

- Insufficient information supplied by MPS to LAS which results in the patient not being identified as being detained under a section 136 resulting in the correct triage category not being applied.
- Internal awareness of some staff in relation to the guidance and policies relating to mental health act response times.

Mar 2015- Feb 2016 Total 871

Time of response	SECTION 136	Avg Response (min)	Shortest Response	Longest Response
1 - Within 8 mins	168	4.36	0.00	8.0
2 - Between 8 and 30 mins	337	16.84	8.0	28.4
3 - Between 30 and 60 mins	210	42.45	30.0	57.5
4 - 60+	156	96.50	60.15	265.3

Mental health and wellbeing of LAS staff

The Five Year Forward View Mental Health Task Force findings 2015 emphasised the importance of responding to the health and well-being needs of NHS and social care staff themselves, and the need to improve morale and the psycho-social working environment, especially given the ever increasing pressures. There was an expressed view that it was critical to recognise that environment and working practices could have an impact on the wellbeing of the workforce



In a departure from previous reports, mental health and wellbeing of LAS staff has been captured within the mental health annual report given that good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, and our work and to achieving our potential.

The Service has signed the Blue Light Time to Change pledge, offering dedicated wellbeing support to our staff as they work round the clock to keep patients safe. Our Practice Learning Manager Control Services has done some extensive work with Mind, the Mental Health charity, and provided significant and inspirational training to the majority of our EOC staff which enhances the previous work with some manager/supervisory specific awareness

We have had over 300 LAS staff speak to Hear Us, another mental health charity we have been working closely with since 2013. 232 staff has so far attended the one day MIND courses. Several publications have been shared in the organisation; over 800 booklets/leaflets have been read/taken by staff.

3/ Complaints and PALS

Timeliness of complaint responses was agreed as a key area for focus during 2015-16.

It was identified that whilst complaint responses were comprehensive the time taken to respond to complainants significantly breached the 35 day standard response time. In May 2015 a local review of the complaints backlog, systems and processes was commissioned.

The Patient Experiences staff were enthused and engaged in the process with some systems implemented prior to the review to support improved turnaround for complaint responses. These included the use of templates for clinical opinion and crew statements to better direct staff to the salient points raised in the complaint to ensure these were answered in full. Whilst some activities within the team can be reduced or eliminated the majority of the time taken to respond to complains is due to influences outside of the Patient Experiences Department.

The time required to receive Quality Assurance reports to inform complaint responses was identified as the main contributory cause however additional themes also emerged as areas for developing action which included:-

- Process and system for managing statements from crews
- Process and system for managing Clinical opinions form the medical directorate
- Process and system for managing throughput in the Executive office
- Process and system for managing complaints from Health Care Professionals

A comprehensive action plan was developed which has been integrated into the Quality Improvement Plan and significant improvements in turn around and an on-going reduction of the backlog has been evidenced. A trajectory or improvement identifies complaints to be managed within the 35 days' timeframe by the end of August 2016.



Workforce

1/ Recruitment

We said that as part of our ‘no ordinary challenge’ campaign, between the end of 2014/15 and 2015/16 we would recruit around 850 additional frontline staff.

Workforce planning in 2015/16 has focussed on building a clear and sustainable pipeline to increase the number of staff working operationally within the Trust. This has been focussed on three core groups:

1. Overseas paramedics: 360 whole time equivalents(wte) have been engaged
2. UK Graduate paramedics: 105 wte have been engaged from UK universities
3. Emergency Ambulance Crew: 252 wte have been employed

In total we have brought 711 additional frontline staff in 2015/16. At the same time we have significantly reduced the number of staff leaving the organisation resulting in not needing to bring in as many additional frontline staff as included in last year’s Quality Account.

We said that we would increase the number of training posts in the UK resulting in more UK Paramedics entering the service in the future.

We have worked closely with Health Education England (HEE) locally and nationally. We worked closely with HEE when they developed their Workforce Plan 2015/16 to acknowledge the shortage of paramedics and the need to increase the pipeline of future paramedics. The HEE investment plan demonstrated their intention to increase paramedic training by over 87% by 2017/18. This clearly aligns with our workforce needs as we look to increase the number of UK staff we recruit each year.

We also work closely with Universities to ensure that they train the right number of paramedics so that they provide a strong workforce pipeline for the future. Last year, locally, we increased the number of Paramedics in training with our 4 main Universities from 150 to 590 training places

We said that to ensure we have sufficient staff immediately we would recruit in Australia and Ireland.

As detailed above, we have recruited over 550 WTE paramedics in 2015/16 to increase our frontline capacity. We have undertaken three separate recruitment trips to Australia and have learned lessons from each one so we now target graduates from specific universities to ensure we recruit the most suitable candidates. We have a fourth recruitment trip to Australia planned in Q1 2016/17.

During 2015/16 we also undertook a trip to Ireland where we recruited a small number of Clinicians.

We said that we would use local advertising to seek to attract recruits from across London so that the Trust better represents the communities we serve.

As of January 2016, 11.7% of our workforce identified themselves as being from a BME community, compared 10.6% of the workforce in 2014. This compares to 39.3% BME representation in the London working age population so much remains for us to do in this area in order for the LAS to be representative of the communities we serve.

Our recruitment and community involvement teams attend a large number of local community events, particularly in schools and colleges where we promote working for the



LAS. Going forward we will design local recruitment campaigns in order to encourage staff from the local area to the vacancy to apply.

In addition, during the last year we have worked with Health Education England locally to ensure our Universities recruit from more diverse communities. We are encouraged to see that In December 2015, 21% of new starters were from BME background.

2/ Retention

We said that we would introduce a number of non-pay benefits including lease cars, cycle to work scheme and child-care vouchers.

As part of our retention strategy we have launched a number of non-pay benefits. All London Ambulance Service staff are now eligible for our cycle and car salary sacrifice schemes. In 2015/16 80 staff have used the car sacrifice scheme and 238 have used the cycle lease scheme.

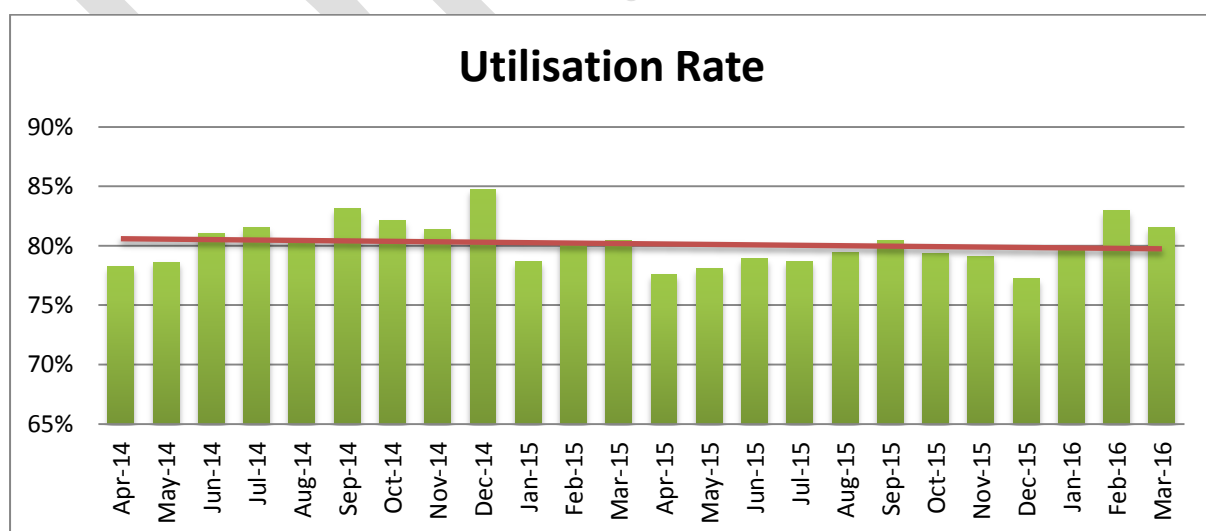
Staff are also able to make use of the Trust's childcare voucher scheme which helps working parents to save up to £933 per year on their registered childcare costs.

Additionally, the LAS actively promotes a number of other discounts and offers that are available to our staff including: phone contracts; gym membership; and Microsoft Office packages.

We also said that we would work to reduce our utilisation rate.

By recruiting more staff we have sought to reduce the utilisation rate for our frontline staff. However, demand for our services has risen again this year making it difficult to have a significant impact on utilisation rates and this will be a continued focus in 2016/17.

The chart below shows the monthly utilisation rate for 2014/15 and 2015/16. There has been a slow but steady decrease in utilisation with the average utilisation rate falling from 80.9% in 2014/15 to 79.3% in 2015/16



We said that we would invest in leadership and management development and education and training bursaries.

171 Clinical Team Leaders have received management development in the form of a two day bespoke management course developed and delivered by Cranfield University with 14 to be trained imminently. The 2 days have also been embedded in to future team leader courses. Clinical Team Leaders have also received an human resources master class on managing attendance, disciplinary and grievances.

During the year, we established a Leadership Forum for our most senior managers to hear about best practice management and leadership development.

Last year, HEE provided £1.6m additional funding to support training and development of our staff . As a result of this investment we were able to provide bursaries to 336 members of staff. The bursaries are allocated in conjunction with our 4 partner universities (St Georges, The University of Hertfordshire, Anglia Ruskin and The University of Greenwich) and were focused on clinical development.

We said that we would improve appraisal rates in the Trust.

We acknowledge that in recent years appraisals have not been as commonplace in the LAS as we would like them to be and so in 2015/16 we have engaged with our staff to determine what appraisals should look like in our organisation and re-launch them.

An appraisal workshop was held on 23rd February 2016 with a number of Clinical Team Leaders, Group Station Managers and Sector Delivery Managers, looking at the current appraisal process as well as discussing the purpose of the appraisal process. The workshop identified that going forward LAS appraisals should focus on Personal Development Reviews (PDR), with specific emphasis on development needs and the Trust values.

The workshop also identified what the LAS appraisal process should look like which included designing new appraisal documentation. This new documentation includes guidance for managers and staff outlining what the purpose of the appraisal is and how to get the most out of it to support staff development.

Looking forward to 2016/17 we will formally launch the new appraisal process for all staff, both frontline and corporate, and set expectations across the organisation that they are completed. In 2016/17 we expect to see a dramatic increase in appraisal rates as well as improved reporting so we know which staff have and have not received their appraisals.

Uptake against appraisal in 2016/17 will be reported to the Trust Board.

We said that we would restructure the HR function.

In November 2015 we appointed an Interim Director of HR & Workforce to lead the restructure of the department to ensure that it was fit for purpose and would provide a high quality service to LAS. The first phase of the restructure consisted of undertaking a diagnostic exercise to identify which elements of the department needed to change. This involved speaking to all members of the directorate as well as key stakeholders from across the organisation. The Executive team will review the findings and recommendations and will consider next steps to work with the service.



3/ Engagement

We said that the Trust would develop an annual plan of staff engagement activities to better connect with our staff.

We have engaged with our staff in a number of ways this year, trying to meet with more people, discuss what is going on in the organisation and to hear their ideas:

- Routine Information Bulletin; we continue to publish the RIB every week to ensure important information is cascaded to all staff throughout the organisation.
- Team Talk; having been launched at the end of 2014/15 we have now embedded Team Talk within the organisation. Team Talk enables key organisational messages to be cascaded from ELT to all staff via their direct line managers. Team Talk also encourages teams to feedback their thoughts on these messages and what they think should be included in future editions.
- Chief Executive Roadshow; In November 2016 we ran a series of roadshows where our Chief Executive and other senior managers met face to face with over 900 staff at sites across London.
- LAS News; Based on feedback from staff we re-launched LAS News to make sure that all staff can find out about what is going on in the organisation and publicise the great work that they do to others
- Quality Improvement Plan (QIP) Launch Events; to launch the QIP we held sessions with over 350 managers. These sessions enabled us to discuss the content of the QIP and spend some of each session asking managers to contribute to a refresh of the organisation's values. We plan to hold further such events every six weeks.
- VIP Awards; The first annual VIP awards evening was held this year and was highly successful. The awards allow staff to nominate their colleagues who they think are deserving of an award with all nominees invited to attend the awards ceremony.
- New Intranet; we have launched a new Intranet to provide a clearer and more intuitive portal for staff to access important information and news about what is happening in the organisation.
- Chief Executive Video Messages; Our Chief Executive has recorded a number of video messages about key issues to provide staff with another way of finding out about important information and changes in the organisation. This also enables all staff to hear these messages straight from the Chief Executive.
- Facebook Listening in Action (LiA); Facebook LiA continues to provide our staff with an open forum to discuss any work related topics that interest them. Senior managers are also active on the site ensuring that good ideas are picked up and important questions are answered.

4/ Establishment

We said that in 2015/16 our workforce numbers would increase comprising of:

- **The creation of a new Non-Emergency Transport Service with 150 band 3 staff**
- **A net increase of 158 frontline staff (paramedics and Emergency Ambulance Crew)**



In 2015/16 the Non-Emergency Transport Service (NETS) was set up in order to provide a response to less acutely ill patients. In 2015/16, 106 staff were recruited which is fewer than the 150 outlined in the Quality Account. This variance is due to NETS not requiring as many staff as first thought to match the demand for the service which is lower than initially modelled due to other internal and external initiatives helping to manage some lower acuity demand.

Over 2015/16, we have increased the number of frontline staff working for the London Ambulance Service by 314 wte.

5/ Training and Development

We said that training and development would remain a priority over the period of the plan to ensure staff have the appropriate clinical, operational and managerial skills.

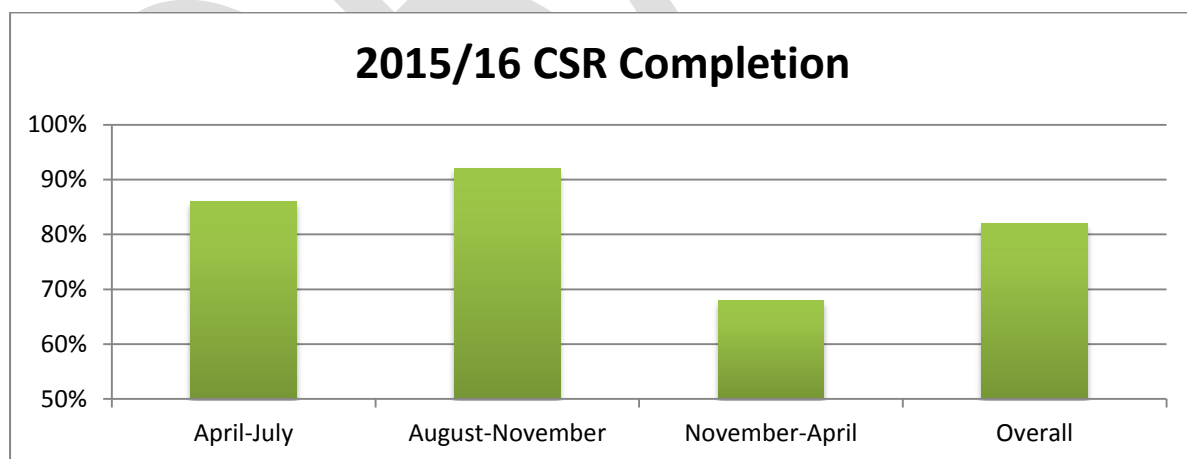
The LAS has a number of ways in which it trains and develops our staff. This includes; induction; clinical supervision; Core Skills Refresher for all clinical staff; Leadership and management skills; as well as e-learning.

Induction and clinical supervision.

Over the past year the Trust has welcomed in excess of 900 new staff to the front line. Each of these members of staff have undertaken induction training as well as a period of clinical supervision dependent upon their role and experience. This ensures all new staff are supported to do their jobs as quickly and safely as possible.

Core Skills Refresher (CSR).

Over 12 months each of our clinicians is required to attend three CSR sessions. The table below shows the attendance during the 2015/16 against a target attendance rate of 85%.



As the chart demonstrates over the first two CSR periods (April-July and August-November) we exceeded the target by reaching 86% and 92% respectively. However due to losing four weeks to winter pressures the third CSR period only reached 68% which reduced the overall 2015/16 completion rate to 82%, slightly below the target.



Leadership and management.

As mentioned in the retention section, all our 185 Clinical Team Leaders have received management development in the form of a two day bespoke management course developed and delivered by Cranfield University. The 2 days have also been embedded in to future team leader courses. Clinical Team Leaders have also received an HR master class on managing attendance, disciplinary and grievances.

During the year, we established a Leadership Forum for our most Senior Managers to hear about best practice management and leadership development.

E-Learning.

We are launching the NHS IT Skills Pathway to support the learning need for staff requiring development of their IT skills on the Microsoft Office product suite. This is a recognised route of learning for the whole of the NHS workforce and staff are able to access eLearning from home as well as on Trust premises.

The eLearning team are also continuing to develop our own bespoke eLearning for our eLearning site LASLive which includes new modules on PREVENT, Health and Safety, Information Governance and Infection Prevention and Control.

Strengthening training and development.

The organisation has invested in a number of ways to ensure that training and development remains an organisational priority. We have restructured our Organisational Development (OD) Team and have brought in an OD expert to spearhead some of the improvements that we want to see.

We said that we would work with Local Education and Training Boards (LETB) to increase the training and development opportunities for our staff.

We have submitted a bid to Health Education England to support the training and development of our clinical staff and have agreed with commissioners and Local Education and Training Boards bursary funding for graduates training in London if they then agree to take up a role at The London Ambulance Service in qualifying

Last year, HEE provided £1.6m additional funding to support training and development of our staff. As a result of this investment we were able to provide bursaries to 336 members of staff. The bursaries are allocated in conjunction with our 4 partner universities (St Georges, The University of Hertfordshire, Anglia Ruskin, and The University of Greenwich) and were focused on clinical development.

We said that we would develop a more robust system to identify who is compliant or non-compliant with mandatory safeguarding training.

This area has not progressed as far as we would have hoped in 2015/16 and has therefore been included as a priority in our Quality Improvement Programme (QIP). In order to make it easier for staff to complete their mandatory training we will roll-out Individual Learning Accounts for all staff and improve our e-learning system to ensure that all training undertaken can be accurately recorded and monitored.

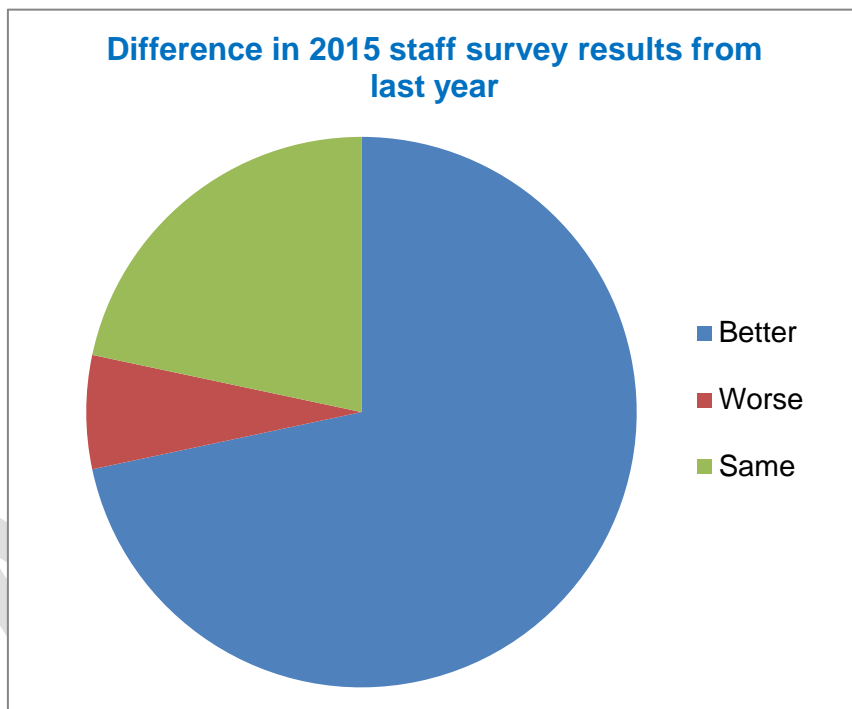
We are also redesigning our corporate induction programme and redesigning the core skills training programme to ensure all staff complete their statutory safeguarding training.



NHS Staff Survey Results

The results of the 2015 ambulance staff survey were released in February 2016. Out of the 60 questions that were asked in both the 2014 and 2015 surveys we scored significantly better in 2015 in 43 of them, around the same in 13 of them and significantly worse in 4. We are pleased with some of the significant improvements that we have seen including in:

- Acting upon concerns raised by patients and service users
- Managers taking a positive interest in the health and well-being of their staff
- Staff looking forward to going to work
- Happiness with the standard of care provided by the organisation



However, two of the areas that have seen a worsening position are detailed below with the actions that we are taking to address them as part of the Quality Improvement Programme.

KF 26 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

2014	31%
2015	38%
2015 national average	30%
Best ambulance trust	15%

The 2015 staff survey shows a worsening in this indicator from 31% in 2014 to 38% in 2015. Whilst this is disappointing it should be noted that the 2015 staff survey was undertaken at the start of our journey to tackle this issue in our organisation. Bullying & Harassment is a key part of our Quality Improvement Programme and the QIP outlines the actions that we have already taken to make significant improvements in this area:

- Awareness training in bullying & harassment has been completed for the Executive Leadership Team and Senior Leadership Team
- An independent Telephone Advisory Service has been in place since July 2015
- In November 2015 we appointed a Bullying & Harassment Lead
- We commissioned independent investigators to lead on any bullying allegations within the Service.
- We have designed and launched simple easy-to-follow guidance for staff to understand and report bullying and harassment
- We appointed an Organisational Development Specialist in November 2015 to support our work on changing the culture within the service



- We have designed a training course for all staff on bullying and harassment which is currently being tested with key staff groups
 - We have appointed a Non-Executive Director to lead on bullying and harassment.
- We would expect these actions to have a positive impact on this key indicator in future years' staff surveys.

KF 21 – Percentage believing that trust provides equal opportunities for career progression or promotion

2014	63%
2015	60%
2015 national average	71%
Best ambulance trust	76%

Whilst the result of this indicator has remained largely static, falling slightly from 63% to 60%, we still remain below the national average. Equality & Diversity is another key aspect of our Quality Improvement Programme.

Through the Equality & Diversity Quality Improvement Project we will review our recruitment processes, particularly in relation to internal promotion opportunities. We also have a number of actions within our Quality Improvement Programme contained in the work stream looking at reviewing development opportunities for staff. These include:

- Redesign the corporate induction programme so that staff are inspired and excited about working in LAS, and that they have all the information they need to start their new job well
- Launch the LAS Academy, to ensure that LAS has the ability to internally train its paramedics for the future
- Complete a training needs analysis to determine the training needs for all our staff
- Roll out individual learning accounts to protect learning time for all staff
- Develop and implement a new training records system.

Complaints and Patient Advice & Liaison (PALS)

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

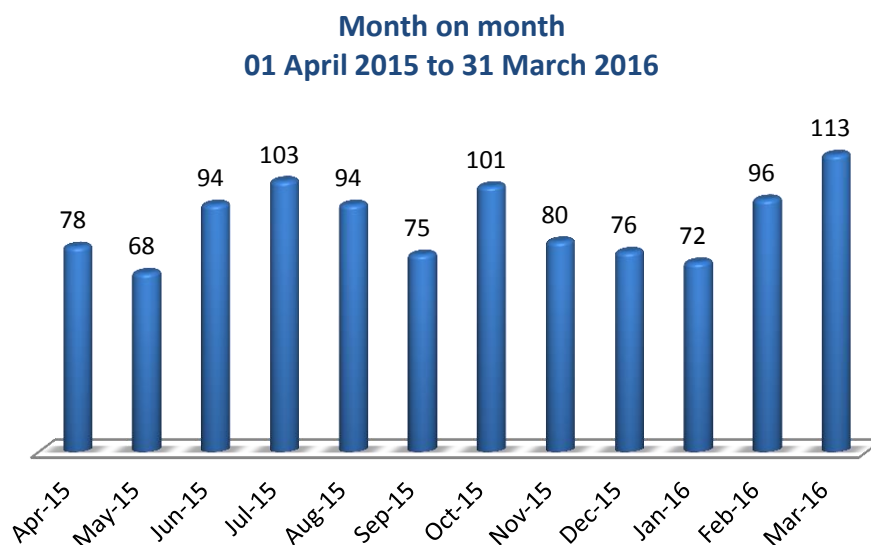
Patient and service user feedback is captured by our Patient Experiences team who identify and report on emerging themes through the Trust's governance structure.

Activity

The volume of complaints dropped this year, totalling 1050 against 1403 in 2015/16. Enquires to PALS continue to increase, 3862 being received this year. This activity was against the background of the Resourcing Escalatory Action Plan (REAP) remaining at Level 4 for the entire year, followed by persistent periods of high 999 demand. Our internal surge escalation processes were being appropriately implemented to maintain clinical safety as call rates continued to be unexpectedly higher than average.



Graph showing numbers of complaints by month 2015/2016:



Themes

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

An emerging trend is that of complaints about patients being referred to alternative care pathways by the attending ambulance staff, a policy and practice change which is often interpreted as the staff not treating the patient's symptoms seriously or their unwilling to take the patient to hospital.

Performance

A deep dive review of the complaints function was undertaken and an analysis of outstanding cases completed to identify obstacles.

We put in place measures to ensure that update letters are sent to complainants where the 35 day target will not be met and regularly review those cases where we are awaiting further information, escalating these to senior managers where appropriate. We have also agreed target response times with other departments whose input is necessary to respond to the complaint, reduced the volume of QA requests and made extensive headway in dealing with the backlog that had accrued..

Based on current demand, it is anticipated that by September 2016 we should be fully achieving the 35 day target. External factors can also influence performance, for example there is a risk that by improving access complaint volumes could increase.

Improvements made arising from patient feedback

Some of the changes we have made include the following:

- Amending the *elderly fallers' protocol* which automatically prompts an upgrade to the level of emergency priority when there is a delay exceeding 60 minutes in an ambulance response. This now takes account of elderly patients who have sustained a suspected injury as a result of the fall but have been helped up from the floor.



- Asking the International Academy to review the way patients with diabetic problems are assessed to take account of ketone levels within the triage protocol
- Reviewing the way we assess children who have swallowed a foreign object to make sure we know that their airway is clear (this is because retching can suggest a potential blockage)
- Reviewing how we assess patients with deep wounds given the risk of infection where there is a delay in an ambulance response
- Reviewing how we assess patients with lower limb injuries who are unable to weight bear
- Referring a case to NHS England where there is a discrepancy in assessment between NHS 111 and 999. This followed an incident involving a referral from NHS 111 about a patient who had taken an overdose. NHS 111 coded the target response at a lower priority than would have been the case if the call had been made directly to 999. This meant that the patient would have been noted as a 'vulnerable patient' and as such the call would have been monitored by the Clinical Hub so that an upgrade could be made as necessary with welfare and re-assessment callbacks being made in the event of a delay.

Examples of learning

Treatment

Complaint that it was recorded that the patient refused treatment at hospital against advice. Clinical opinion supported the view that the patient's symptoms were not generally sufficient to warrant assessment at A&E in favour of referral to her GP. However, the crew misrepresented the patient's position about declining being taken to hospital.

Outcome: A group has been set up in conjunction with Med Directorate to review use of this provision, as it cannot indicate any evidence of whether the patient has been able to make an informed decision or influenced by other forces, including by pressure from the attending staff.

Service Provision

A complaint was received from the family of a young rugby player concerning the care he received in relation to his injuries.

Outcome: Clinical findings identified that the patient would have benefited from neck immobilisation. An article relating to this scenario will be placed in a Clinical Update to widen learning across the Trust

Call management

A complaint was received about the delay in dispatch which also highlighted concerns that the patient was instructed by the EMD to leave the door open pending the arrival of ambulance staff. The complainant was concerned that there was a risk to vulnerable people in doing this.

Outcome: Control Services governance group have again been asked to review the wording of the instruction.

Delay

Complaint due to the delay in an ambulance attending a patient in a public place. Common causality of demand outstripped resourcing. We apologised for the delay but similarly



acknowledged the compassion shown by the 999 caller who remained with the patient and eventually took the patient home themselves.
Outcome: The complainant has been invited to share their experience with the Trust Board.

Conduct

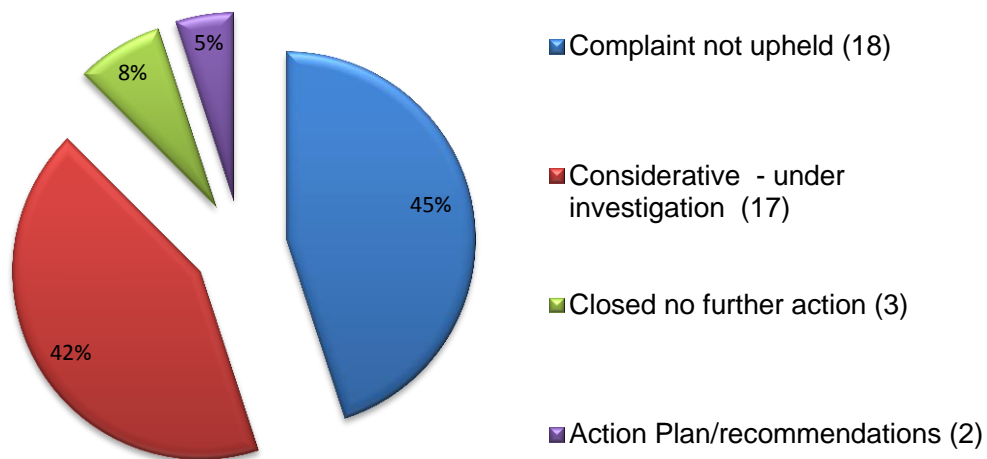
A patient called 999 for advice and felt she needed to be on a drip, having experienced symptoms of diarrhoea and weakness for 3 days. The call handler explained that we could refer the patient to another service but the patient was insistent that she needed an ambulance as she could not get to see her GP. Fast Responder was sent to a patient who complained that an ambulance had not been sent. The patient further complained about the care provided and that the Fast Responder did not have any sterile wipes after taking a blood sugar reading.

Outcome: An explanation was provided against each head of complaint with feedback being given to the Fast Responder highlighting the patient perspective in seeking help from the NHS.

Ombudsman cases

The Ombudsman continues to investigate a higher number of complaints across all NHS Trusts. During 2015/16 we were approached by the Ombudsman for 40 case files of which 17 remain under investigation due to complexity.

Ombudsman cases 2015/16



One of the Ombudsman's key findings supported our view about the 999 triage in that "*the purpose ... is not to diagnose the patient's problem nor to decide on treatment plans. ... Assessments are based on the immediate situation not how things might deteriorate*"

PATIENT ENGAGEMENT

The Trust remains committed to supporting a wide range of Patient engagement and education events with LAS presence requested at 874 events in 2015. Of these we were able to attend 597, 68% of all requests made.

This is due to the ongoing support of over 1,000 staff on our database with 276 individuals taking part in multiple events largely in their own time.

The range of events we attend is extensive including Basic Life Support and cardiac awareness training, Careers events, Job Fairs, Junior Citizenship, Knife Crime awareness, First Aid (Brownies, Cubs groups), road safety initiatives, Mental health events, deaf awareness training, Older peoples groups, Learning disability groups, Patient and Public Involvement events.

Patient Representative Reference Group

The London Ambulance Service invites patient representative organisations from across London to attend specific meetings and focus groups to share ideas and help inform our future plans.

We held three Patient Representative Reference Groups in 2015 with the most recent held on the 8th October 2015 to discuss the topic: how to keep London healthy this winter. The session included presentations on key issues of relevance to the communities and patient groups the representatives support, as well as the opportunity to discuss how we could work with them together to ensure that Londoners stayed healthy that winter.

Our next Patient Representative Reference Group to be held in April 2016 will focus on the Care Quality Commission findings; outline our plans for improving our service, and to hear views and ideas about how other organisations may be able to support us while we make the changes required.

Mental Health Focus Groups

Seven Mental Health focus groups were completed in 2015/16 including representatives from the following organisations:

- Oxleas Mental Health Trust
- South London & Maudsley
- Hear Us
- SW London & St. George's NHS Trust
- LAS staff group
- Healthwatch Waltham Forest
- Enfield Mental Health User Group

The report from our external facilitator was presented to the Mental Health Committee and the Trust Board with recommendations included in the Mental Health work plan for 2016/17.

Dementia Focus Groups

Four Dementia Focus Groups have been completed and the report from our external facilitator was presented to the Mental Health Committee in March 2016. As with the Mental Health focus groups, recommendation have been included in the mental Health work plan for 2016/17 and Dementia care has been identified as a quality priority for the Trust fro 2016/17.

Friends and FamilyTest (FFT)



From April 2015 ambulance trusts were required to make the Friends and Family Test (FFT) available to Patient Transport Service patients and “See and Treat” patients - those who were assessed at home but not conveyed to hospital. The LAS had implemented FFT in October 2014 as part of the 2014-15 CQUIN programme. Leaflets for each group of patients were produced and distributed for staff to give out to their patients, and the FFT questionnaire was also made available on the website. Lead staff were identified on each ambulance station complex, to maintain stocks and remind staff to take the leaflets on duty with them, and within the PTS management team. Articles about the reasons for implementing the FFT, and the benefits of receiving this feedback, were published several times throughout the year in the Trust’s Routine Information Bulletin, which goes out to all staff, and regular emails were distributed to the FFT leads across the Service, with updates, feedback and reminders. Posters advertising the FFT have also been produced and distributed across the Service.

Despite this, numbers of responses to the FFT question were low; the total number received in the year 2015-16 was 158. Almost all patients who responded to the question said they would either be “extremely likely” or “likely” to recommend their friends and family to the LAS if they needed similar care or treatment.

The reasons for the low response rate have been considered and explored in detail with our findings are consistent with those of other ambulance services in England, all of whom have also had significant challenges in implementing FFT. The challenges in implementing FFT within ambulance services have been reported to NHS England, and this is likely to lead to a change in guidance during the coming year.

Taxi Usage (patient survey)

A survey has been designed to complete with a selection of patients conveyed to hospital in a taxi as an alternative response vehicle to assess their satisfaction with the service against the circumstances of their call and condition.

The survey will hopefully elicit useful feedback from patients that can be used to evidence satisfaction levels in the future as required.

We are currently completing the consent process for applicable service users to enable this.

Feedback from events

Knife crime talk Birnham Wood

“Thanks again for today. The talk he gave us was very informative and interesting, and I hope that he has managed to deter some of the children away from carrying knives on them for protection.”

Oasis Academy South Bank

“It was wonderful! The students really enjoyed the session: it was interactive, fun, and engaging.”

Coleville Primary School,

“All paramedics were extremely passionate about their job and their presentations to the children were really engaging and fun. All the children were very excited and many said that they wanted to be a paramedic when they are older. The children had a chance to try on some equipment during the session and they really enjoyed this. The added bonus of activity books and stickers was a real treat for the children. The children definitely have a better understanding of how paramedics can help them. The session was perfect, Thank you very much for taking the time to visit the children at Colville. They really enjoyed meeting the paramedics and learning about how they help us.



Other services - Patient and Non-Emergency Transport

Patient transport is commissioned by tender process' with individual healthcare Trusts across London and delivers patients to access their on-going medical appointments.

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

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

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

Over the past year we have recruited (90) new operational staff who have completed 4 weeks classroom based training. This has then been supported by three weeks post course mentoring operationally in the field.

All existing staff have undertaken statutory and mandatory training topics such as Infection Prevention & Control, Safeguarding and Manual Handling.

What have we done to update our equipment?

To support the NETs start-up we have commissioned 57 new stretcher capable vehicles which has seen a revamp of our ambulance fleet.

How have we communicated with stakeholders?

Prior to the introduction of NETs and our healthcare professional direct access line we worked with our commissioners and Local Medical Committees to get General Practitioner input into the proposals. The roll out was then supported with a detailed letter to partners and posters.

How have we responded to patients?

PTS has continued to provide patients with a "What do you think of our service" questionnaire after each and every journey. This includes the friends and family test question.

Of the responses received, 96.6% of patients stated that they were either extremely likely (82.4%) or likely (14.2%) to recommend our service.

Service users were also asked about whether they arrived on time for their appointment, staff were polite, caring and considerate, and whether our vehicles were clean, tidy and comfortable.



The results are shown in the following table.

	Arrived on Time	Polite, Caring and Considerate	Vehicle Clean, Tidy and Comfortable
Yes	91.5%	100%	98.3%
No	1.7%	0%	0%
Blank	6.7%	0%	1.7%

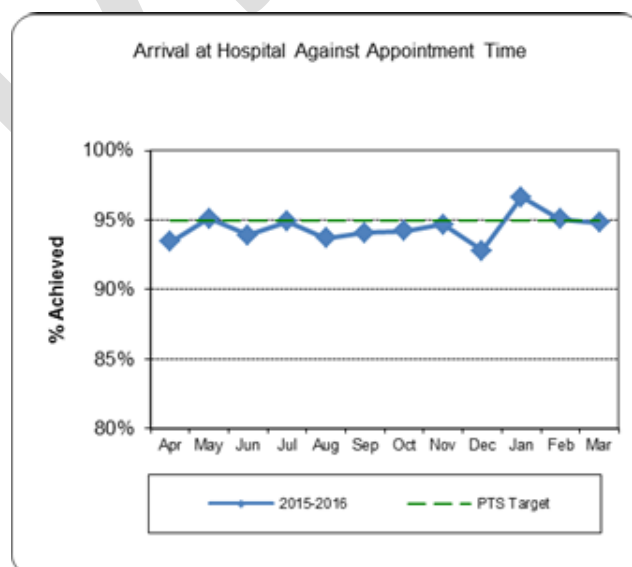
Patients were finally asked to score or service on a scale of 1 to 6, with 1 being unsatisfactory and 6 very satisfactory. 96.6% of respondents scored us as 5 or 6 for overall quality of service.



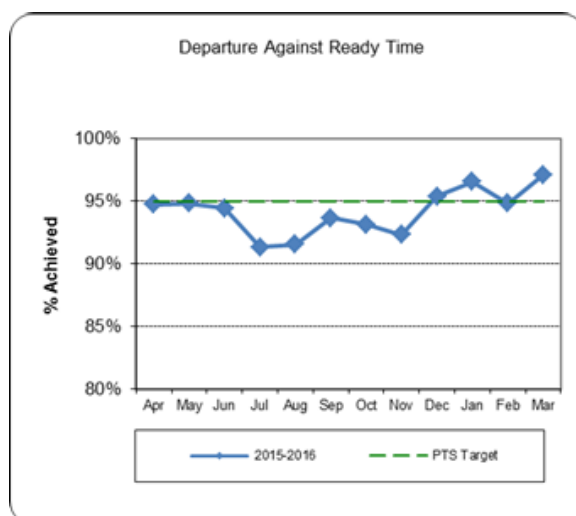
How have we performed against our contracted quality standards?

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

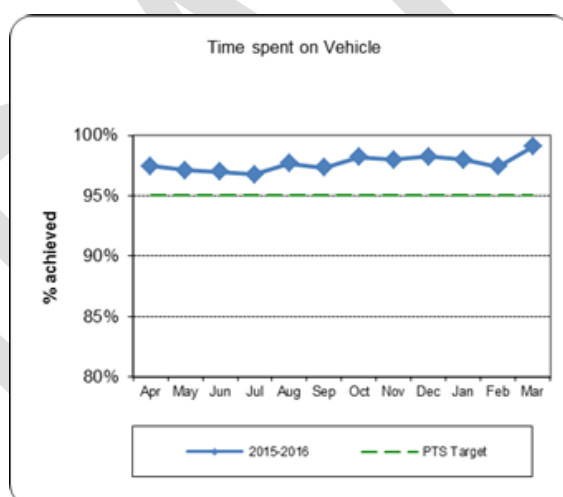
Appointment Time: This is the arrival of a patient for their appointment within a time window as specified by the commissioning Trust.



Departure Time: This is the collection of a patient after their appointment within a time window specified by the commissioning Trust



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



Across the year performance against these measures has been improved and remains above 90%. Although there has continued to be a loss of contracts throughout 2015/16 which increases pressure on maintaining standards as the operational workforce is spread across a wider geographical area; there has continued to be a focus on delivering better standards for patients. This is shown in the table below:

Quality Standard	Appointment Time	Departure Time	Time on Vehicle
2011/2012	91.72%	92.69%	95.27%
2012/2013	92.49%	93.62%	96.89%
2013/2014	93.37%	92.85%	97.92%
2014/2015	92.46%	92.41%	96.24%
2015/2016	94.45%	94.18%	97.69%



Other services - South East London 111



2015/16

This report has been prepared to review the activity within LAS 111 South East London (SEL) for 2015/16 and has been broken down into six key areas.

- Incidents, complaints and feedback
- Call Quality and monitoring
- Safeguarding
- Patient Experience
- General governance activity
- Other information

Incidents, complaints and feedback

Type	Mar 16	Feb 16	Jan 16	Dec 15	Nov 15	Oct 15	Sep 15	Aug 15	July 15	Jun 15	May 15	Apr 15
Serious incidents	0	0	0	0	0	1	1	0	0	0	0	0
Incidents	64	59	55	47	37	38	26	13	9	23	17	14
Complaints (formal)	5	3	3	1	1	3	2	1	0	1	1	2
HCP feedback	1	1	5	5	3	3	3	2	3	2	1	2
Compliments	3	2	1	0	2	1	1	4	0	0	1	2
Authorised confidentiality breaches	21	19	18	12	19	14	14	16	28	18	12	16

Incident details

Incidents relate to a range of issues at LAS 111. The majority over the last year have been relating to staff errors concerning mistakes or misinterpretations in use of procedures and policies. The errors are varied, and do not suggest specific trends. Once identified issues are dealt with individually and used to identify wider learning and training needs.

The occurrence of incorrect or disputed out of hours (OOHs) service referrals has continued and a lot of work has been done on communications with the OOHs services, identifying pressure points and resolving issues around boundaries and OOHs' responsibilities. The process for dealing with these incidents within the service has also been streamlined.

As part of the investigation for two serious incidents there has been a focus on the automated links between 111 and the GP out of hours (cancelled referrals) and the auto-link between 111 999 services. Trends and causes for this have been identified and work is going ahead with partner agencies and pan-London to ensure safe referrals.



Internally updates to all staff re-affirming correct procedure and ensuring safe onward referral. Technical issues are addressed and resolved as they occur.

Feedback from Health Care Professionals

The main services /departments that we receive feedback from are the LAS crews and the GP Out of Hours (OOH) providers. The majority was related to the perceived inappropriateness of the referral and whilst several have been upheld, many have resulted due to a lack of understanding of the 111 system. Considerable effort has been put into improving understanding and communication channels between the 111 and 999 services; and also into improving understanding between the 111 service and OOHs services, e.g. including them in End to End reviews and engaging in joint work on entering and viewing Special Patient Notes.

Feedback to Health Care Professionals

Staff are encouraged to raise issues where the actions of other healthcare providers have resulted in a delay in patient care. In the main the feedback given has been to GP OOH Providers as a result of failure to accept patient referrals due to patient location, or disputes causing delay to patient care., eg. a refusal by some OOHs services to accept referrals regarding repeat prescriptions once the possibility of a Pharmacy Repeat Urgent Medication Service (PURM) referral has been exhausted. The SEL Clinical lead has worked with SEL GP OOH providers, PURM and NHSEngland to resolve these issues. A 24/7 on call system for senior management advice is also now in place to advise on difficult issues at any time.

Authorised confidentiality breaches

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

Compliments

Compliments have been received relating to both the service and individuals undertaking patient contact duties.



Call quality and monitoring

Call Audit Data	Mar 16	Feb 16	Jan 16	Dec 15	Nov 15	Oct 15	Sep 15	Aug 15	Jul 15	Jun 15	May 15	Apr 15
Calls answered at 111	29,586	25,935	26,573	24,963	23,219	22,305	20,697	22,442	21,794	21,939	25,812	25,648
% Call audits (target >1%)	1.4%	1.5%	1.7%	1.8%	1.8%	1.7%	1.65%	1.43%	1.05%	1.38%	1.1%	1.3%
No. Call audits	422	385	462	452	421	385	342	323	231	303	282	338
No. Call Handler audits	206	188	228	229	213	247	198	183	80	148	136	164
No. Clinical Advisor audits	216	197	234	223	208	138	144	140	151	155	146	174
% Compliance (target >86%)	88.3%	89.4%	86.6%	89.8%	87.6%	85.5%	88.6%	91%	82.3%	91.4%	89.7%	89.6%

We have continued to exceed the required standard for 1% of call audits every month including the winter months where demands on the service increased. Each staff member has a minimum of 3 calls audited each month. Where performance issues are identified the level of audit is increased.

The compliance percentage has been achieved in all but two months. Consistency workshops are run regularly for auditors and an audit of a random selection of audits undertaken is completed monthly to ensure consistency.

End to End call audits

Monthly end to end call audits are undertaken at LAS111. The audits are attended by the clinical leads for the service (LAS –Dr. Fenella Wrigley and South East London –Dr. Patrick Harborow). The subjects that have been reviewed include:

- Calls involving a safeguarding referral
- Advice given by clinical quality advisors
- Referral to ED
- Frequent Callers
- Referral to OOH Service

The end to end audits have all highlighted areas of good practice but also areas that require some improvement and we have been working consistently on them.



Safeguarding

Safeguarding referrals have remained fairly static for both adults and children. The LAS 111 service has referred 335 people in total to Social Services which equates to circa 0.13%.

Of referrals made circa 52% were for adults and 48% for children. Referrals for adults were predominantly for welfare concerns and for children for safeguarding issues.

Patient Experience

Patient satisfaction survey

The 111 patient surveys are sent each month to around 200 patients.

82% of those who responded reported being fully or fairly satisfied with the 111 service, with the large majority fully satisfied. Patient concern /complaint level has remained low.

Language line

Complaints regarding Language Line's response times have reduced in number. The system is working well, and showing some increase in the number of calls benefitting from the service. There are an average of 79 calls per month and a use of 27 different languages, with Spanish being the most frequently requested language.

Training

All staff have undertaken mandatory training relating to changes made to the 111 call management system Pathways with a change to Version 10 was successfully implemented in December 2015. New safeguarding training at Level 2 is in the process of being rolled out to all staff. Agency staff are included in all staff-wide training. Statutory and Mandatory training is up to requirement.

Pilots and Innovation

LAS 111 has been actively involved in a number of pilots throughout the year including

- Taxi Bookings for patients requiring transport to Emergency Departments and to avoid ambulances being sent to the lowest acuity calls
- Direct bookings in to GP hubs in Lambeth and Bromley
- Working with NHS England to introduce referrals to dental triage service
- Working with NHS England for the introduction of the Patient Relationship Manager which provides enhanced telephony routing of calls to the most appropriate provider and for patients with a Coordinate my care record directly to a Clinical Advisor.
- Developing and introduction a range of Management Information support tools to enhance support for staff and analysis of clinical data

Additionally we have focused on embedding good practice from previous pilots into our day to day delivery model including

- Enhanced clinical assessment for green (low acuity) ambulance calls. Circa 80% of calls reaching a Green ambulance outcome at the Call Handler stage being passed to a clinician for further Assessment and circa 70% of these achieving an alternative disposition of which 3% will be upgraded to a red response.
- Referrals to pharmacy for repeat prescriptions



Other Information - Key clinical call information

We have performed strongly and consistently across the Clinical Indicators throughout the year.

- 70% of calls queued for clinical call back are achieved in less than 10 minutes
- 7.7% of calls end in an ambulance dispositions which is regularly the lowest in referral rate nationally and remains the lowest in London month on month

Feedback

Comments from our partners and stakeholders

We are obligated to give stakeholders the opportunity to comment on our Quality Account and to then publish their comments in full. This year we invited the following organisations/groups to respond.

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

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

Statement of Directors responsibilities

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

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

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2015 to March 2016
 - papers relating to quality reported to the board over the period April 2015 – March 2016
 - feedback from commissioners dated **xxxxxxx**
 - feedback from local Healthwatch organisations dated...



- feedback from Overview and Scrutiny Committee dated xxxxxx
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated..
 - the 2015 national staff survey
 - the Head of Internal Audit's annual opinion over the trust's control environment dated xxxxxx
- The quality report presents a balanced picture of the NHS trust's performance over the period covered
 - The performance information reported in the quality report is reliable and accurate
 - There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
 - The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

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

By order of the BoardChairmanDate

.....Chief ExecutiveDate

