London Ambulance Service Headquarters

Inspection report

220 Waterloo Road
London
SE1 8SD
Tel: 02079215100
www.londonambulance.nhs.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Overall summary

We carried out this unrated focused inspection as a result of receiving several pieces of information from individuals concerning a range of matters. This included concerns about staff levels, the skills and competencies of some staff, and the visibility and oversight of managers. We were also told that figures essential for monitoring the efficiency of the service were not being reported correctly.

This report covers the inspection of the London Ambulance Service's (LAS) 111 Integrated Urgent Care Clinical Assessment Services in north east London (NEL).

This service was previously inspected on 2 September 2019 and again on 6 and 13 September 2019. The overall rating for the service was good. This rating applied to the safe, caring, responsive and well-led domains. The effective domain was rated requires improvement.

You can find the reports of our previous inspections by selecting the 'all reports' link for London Ambulance Service Headquarters on our website at www.cqc.org.uk.

This report comprises information from a combination of:

- What we found when we inspected the service
- Information from our ongoing monitoring of data about the service and information from the provider, patients, staff, the public and other organisations.

Our key findings:

- Staff said the NHS 111 service was a good place to work, although acknowledged this had been stressful recently due to issues with staff recruitment.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. However, the service had not been able to assure itself that information had been read by all relevant staff.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided.

The areas where the provider **should** make improvements are:

- Continue with efforts to achieve the service's staff rota fill targets.
- Assess the use of the service's escalation plan triggers to ensure key factors are being considered.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector who was accompanied by a CQC inspection manager and a service manager specialist adviser.

Background to London Ambulance Service Headquarters

The London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing services and became an NHS Trust on 1 April 1996. The main role of the LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year.

LAS was awarded, through open tender, the contract to deliver the Integrated Urgent Care (IUC) Clinical Assessment Service (CAS) for the boroughs of Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest, which commenced on 1 August 2018. This north east London (NEL) service is based at Maritime House, Barking.

In line with the national specification, the new LAS IUC CAS has a multidisciplinary team of GPs, Advanced Practitioners, Pharmacists, Nurses, Paramedics, Health & Service Advisors providing expert advice over the phone and working closely with other urgent care services in the area as part of the overall integrated urgent care system.

The model for an IUC CAS requires access to urgent care via NHS 111, either on a free-to-call telephone number or online. The service provides:

- Triage by a Health Advisor;
- Consultation with a clinician using a clinical decision support system or an agreed clinical protocol to complete the episode on the telephone where possible;
- Direct booking post clinical assessment into a face-to-face service where necessary;
- Electronic prescription;
- Self-help information delivered to the patient.
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Are services safe?

Staffing

We had received several anonymous notifications about the staffing levels and use of agency staff in this location. We considered a range of information about the staffing of the department to understand if there had been any changes since the previous inspection.

Analysis and forecasting of activity were undertaken locally; however, staff planning was completed by a central team off-site. This may have created a lack of understanding and knowledge of what was locally required due to local practices and issues.

In our discussion with the clinical operations manager we were told there had been staffing issues and where staffing levels were down in the day, this impacted on the evening. To help manage this the clinical navigators, who were on duty 24-hours a day, had oversight of the queue, assessing and prioritising from a safety perspective. On weekends there were two clinical navigators with staggered start times, which helped in managing and overseeing activities.

The service had an hourly log for activity, and at times when activity built, the demand management policy (DMP) was enacted. The DMP's escalation trigger matrix showed that one or more of the three triggers within the policy might apply depending on the escalation level. The clinical operations manager told us that only one trigger used by the service (a threshold of less than 120 unallocated cases). It was clear to our expert advisor that the trigger was not suitable to manage risk. Due to the current call volumes and the clinician resource available to handle the demand, this was considered potentially dangerous.

Our specialist advisor stated that this method (opting for the number of cases in the clinical queue as a measure for escalation) was too limited and a more holistic approach such as looking at key factors should be considered. For example, the ratio of cases per clinician; evaluating the collective risk rating of the cases (speaking to a GP immediately about high risk cases contrary to low risk cases; the number of breaches in the clinical queue at that time and the skill-mix of the clinical team working the queue (GPs, advanced nurse practitioners, pharmacists and NHS P clinicians)) as this would indicate whether they have the right skill mix present to mitigate the clinical risk presented by the queue at that time.

We were told there were clinical and non-clinical floor walkers in the call centre at the weekend. These staff were able to respond to questions according to category, thus avoiding non-clinical questions taking up the time of clinical staff.

The clinical operations manager told us that senior managers were carrying out a 'deep dive' with respect to staffing, having the right number of staff at the right time. There was also an on-call senior manager who could make decisions about cancelling activities, such as coaching, to meet the demands of the service.

We were told the health advisor roles were now fully established. Two clinical advisors' posts had been advertised and eight people had been shortlisted. The GPs were currently all self-employed or working via an agency.

Although the level of activity had increased at the service, we were told and saw that staffing had improved over the last six months. We saw that the forecasting and planning team had streamlined and staggered the rota so that staff were rotated to different times in the day depending on the forecasted demand, which had eased pressure.

There had been four call handler training programmes since the last inspection, each having 12 attendees. A further course was due to start at the end of January 2020. The use of Bank staff had increased in quarter four of the year and agency staff usage continued, running parallel to the training programme.

We looked at performance for the previous three months and asked how the service had managed to do well in January after two months of poor performance in some areas. We were told that a group of twelve staff had recently completed their NHS Pathway (NHS P) training and were added to the workforce during that period. Another twelve new starters were scheduled to start their training on 27 January 2020.

We saw from information provided to us that in November 2019 the service experienced 20% more calls than they had been contracted to provide. The centre manager informed us that an 80% target for responding to incoming calls had been agreed with the commissioner until February 2020. This was confirmed within our discussion with the clinical commissioner after our visit.

We were told non-clinical service advisors (who are not NHS P trained) did comfort calls to people awaiting a call

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from GPs (where the service had breached the call back time). The calls were not re-triaged (re-assessed) at this time but remained in the queue. As a result of the comfort call, the patient may be escalated upwards and therefore moved up the queue, which was confirmed by the clinical commissioner in our discussion following our visit. Post inspection, the provider told us this was not limited to patients waiting for a call from a GP, but included all patients in the CAS queue, regardless of which clinical skill set was responding to their query.

We looked at staffing rotas and found the health advisor call handler rotas had gaps and were not consistent during quarter three of 2019/20; however, there was an improvement in quarter four, and this was likely to lead to a more consistent and better level of call answering performance in this period. This was driven by a reduction in call demand (seen nationally) and an increase in call handlers because of the recent recruitment drive.

The GP rotas were still not completely full. It was clear looking at the rotas, clinical breaches and lack of audit and 1:1's that not having a GP lead on-site in quarter three of 2019/20 had put additional pressure on the already challenged leadership of NEL IUC. We were told a new GP Lead had just started and it was expected this person would make a difference to the management of the GP service.

Our review of rotas suggested availability of advanced practitioners (Band 7, non-NHS P clinicians) was looking good and improving throughout the whole of quarter four. The rotas for NHS P clinicians (Band 6) showed gaps throughout quarter three, and despite a recent recruitment drive, did not look like they would improve to the 100% level any time soon. (These roles are harder to fill via agency clinicians because of the specific NHS P training and license accreditation requirement). We did see that there were significant staffing shortfalls throughout quarter four for NHS P clinicians (Band 6) and because of the exacting requirements for this role with respect to training, mentoring and auditing, it was likely to take time to bring these positions up to required levels. The organisation understood what the problems were around recruitment and continued to work to address this.

Are services effective?

Appraisal and training, staff performance:

We spoke with the governance and assurance manager about the process of appraisal. They told us new staff received a review at intervals of three and six months and an annual performance review a year after their start date and annually thereafter. We saw one-to-one forms were completed for staff, and that the discussion also included a summary of audits of their response to and handling of calls into the centre. Information recorded by team leaders included the individuals' productive time and duration of calls. It was noted that those less experienced may have taken longer on a call whilst they were developing their confidence and competence.

There was no head of training on site, although training was delivered at the location. A lead accredited trainer was responsible for arranging and delivering training, and this was based on NHS P. They were supported by pathway trainers, of which there were at least eight on site. Training included a mixture of e-learning and classroom training, plus on-the-job activities, with direct supervision. A training needs analysis had not been undertaken, although it was recognised some sessions needed to increase in availability to enable staff to access.

Call handler training started with a distance learning pack, which was provided prior to a two-week classroom programme. The latter included scenarios, group exercises, signs and symptoms of various conditions and two written assessments. This was followed by two to three weeks direct coaching in the call centre, sitting next to an experienced member of staff and having to carry out five calls appropriately before being signed-off as competent to take calls without supervision. The centre manager explained that trainees' responses to calls were evaluated through direct supervision and several audits, the latter of which they had to pass before signed off as competent. Once signed off, the staff members were still subject to five audits per month, reducing to three audits per month after three months. Line managers were responsible for undertaking the audits of staff competence. Feedback was given via one-to-one meetings and emails. Leaders were open that positive audit feedback was not always communicated to staff due to service constraints. Where required, additional coaching sessions were provided.

We were shown individual files for staff who were undergoing NHS Pathways training, which would enable them to respond to incoming calls from members of the public. Detailed information had been recorded in the files and there was evidence of the support processes used between the staff member being trained and their colleagues.

We were shown the IT system for recording training and saw at the time of inspection mandatory training was up to 84% within the Ambulance Trust as a whole, and in the IUC was 85%.

Before the inspection, we received information about a clinician not taking calls which they were meant to. During the inspection, a member of staff confirmed that at times this had happened, but they raised it with the clinical floor walker who instructed the clinician to take the call. The matter had been resolved following this.

We listened into four call handler calls taken by staff who had been with the service between six months and approximately one year. We found the staff responded in a competent and professional manner whilst following the required NHS Pathway. Where clinical input was required as part of the initial triage, the call was picked up and responded to by one of the circulating navigators.

Audit:

A full Clinical Assessment System (non-NHS Pathways (P)) audit tracker had been provided on a month by month basis for the past six months. The team used the same model, tier one (three audits) and tier two (five audits) as the NHS P audit governance framework. The management team did acknowledge that there had been a significant drop in the amount of audit undertaken in quarter three because of service demands; however, they also confirmed that no formal approval had been given for this reduction by either NHS Digital (who are responsible for NHS P) or the commissioners, as per the required NHS P license requirements and guidelines.

The governance and assurance manager spoke with us about the audit process, which included a tracking sheet for NHS P and where calls were referred to the clinical navigator for relevant advice. On the electronic system we were able to see how audits could be filtered by quality; for example, we saw that in October 2019, all the required 493 audits of NHS Pathways were completed. Of these the pass rate was 91% (450 audits). The compliance target was above 86%.

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We asked if themes were captured from the audit results and were told factors included inappropriate dispositions. Work was said to be in progress to develop sub-categories within the audit. This was expected to give more insight into themes. In terms of improving staff competencies and skills, line managers were said to identify trends by individuals. However, we did not see any evidence that team leaders came together to discuss these themes, which would have allowed oversight of the extent of recurring problems. We were not reasonably assured that collective learning was being shared more widely with a view to improving practices.

We explored how safe the clinical queue was and what assurances the team had about breaches. The service did not carry out any analysis of the clinical case breaches that resulted from cases in the clinical queue not being responded to within the disposition time frame. Further, no audit had been undertaken to assess the impact of the large number of clinical breaches and the potential impact on patient care. We could not be reasonably assured that the service was fully aware of its issues and what was being done to address these.

The staff we spoke with said their calls were regularly audited and results fed back via email if they were positive and verbally if there were any concerns. Incident reports were also emailed, and a paper copy placed in a folder on the side of each desk. We were told by three members of staff that the provider did not check if they had read the reports. One member of staff felt the volume of emails (policies, incidents, audit feedback) was unsustainable and staff should be given time to have reflective sessions to digest the information, audit results, and themes. We were also told that the minutes from the daily morning 'Huddle' meetings, which last took place in early November 2019, were not circulated.

Following the inspection, the provider told us, the quality governance and assurance manager and the director of integrated patient care had discussed and agreed to introduce a protected daily educational break. This was shared with the wider team on 28 January 2020. The staffing profile was reviewed in light of agreeing to this protected learning time.

Are services responsive to people's needs?

Learning from incidents:

Information related to learning from incidents was compiled by the clinical operations manager, with sharing of information via emails and directly to staff in the call centre. One-to-one meetings were expected to be held monthly, which would include the sharing of learning from incidents and other important information. However, these meetings did not always happen due to work pressures. Staff confirmed that one-to-one meetings did not always occur but said that live observations had been introduced as a support mechanism by their team leaders. Some staff who only worked one twelve-hour shift per week agreed to have their one-to-one review less frequently and we saw evidence of this in the data management system used.

Incidents were reported through the trust's designated IT system and considered within the investigative process. They were discussed at the Clinical Quality and Risk Group. We were informed that there had not been any escalations for the previous two-months.

We were also informed that the provider had initiated a daily report which highlights the longest waiting patients in each priority for the previous day. This was started on 17 February 2020 and the process for maximising the use of this data is being worked through and will be written into their clinical governance and assurance frameworks.

Are services well-led?

Visibility of leaders:

We spoke with the clinical operations manager about visibility of leaders and staff awareness of who was available. They were concerned to hear that there was a view that leaders were not visible, as they had worked hard to increase access and visibility within the service. The staff we spoke to confirmed that leaders were always on-site, this included on weekends.

The arrangements were different at NEL from SEL. The latter had six senior managers, whilst NEL had five managers who shared responsibilities. This included floor walking and facilitating an open-door approach as part of their rota. The clinical operations manager said they even came in on days off and had come in early to see the night staff. Management surgeries and drop in sessions were advertised in various places for staff to see. A restructure commenced in 2019 to align both services however due to executive leadership changes had not been finalised at the time of inspection.

A suggestion box was available for staff to put comments in, and we saw this was in the kitchen area. The box was opened weekly and the information considered as part of 'you said, we did'. Information arising from the comments in the box was shared via posters and monthly newsletters. We saw noticeboards contained information aimed at sharing updates with staff.

Team managers had been increased from four to nine, which meant that team sizes had reduced to 20 in each. This helped to facilitate greater oversight and increased contact, including active assessment of calls made by team members. We found these arrangements had contributed to increased access to and visibility of line managers.

The medical director had visited NEL and there were other leadership meetings including monthly contracts meetings, senior management meetings and weekly operations meetings. These were beneficial to the understanding of the service demands, but also in increasing awareness of difficulties staff experienced.

Data management:

We had been told that figures required to measure the responsiveness of the service were being manipulated to suggest better performance. We asked the clinical operations manager about this and they told us data was recorded but to see specifics they would need to see the business information team. We could not identify any electronic database systems which could be manipulated in the department. We also had confirmation from NHS Digital that they had not identified any concerns. Further, the clinical commissioner who spoke with us told us they reviewed data on a weekly basis, and they had not seen any figures to suggest alteration. Therefore, we did not find any evidence to corroborate what had been reported to us about inaccurate data.