London Ambulance Service NHS Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

London Ambulance Service NHS Trust covers the capital city of the United Kingdom, over an area covering approximately 620 square miles. The service is provided to a population of around 8.6 million people, and over 30 million annual visitors. 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 trust provides an emergency and urgent care (EUC) service to respond to 999 calls, which are received and managed by the trusts emergency operations centre (EOC). Staff working in EOC provide clinical advice over the telephone, and dispatch emergency vehicles where required. The LAS also provides resilience and hazardous area response teams (HART), which all NHS organisations have been required to have since April 2013. LAS plays a crucial role in the national arrangements for emergency preparedness, resilience and response,(EPRR), contributing to a co-ordinated and planned response to major incidents through the local health resilience partnerships (LHRPs). There are two LAS Hazardous Area Response Team (HART), one based in Hounslow and the other in Tower Hamlets. In addition, LAS provides a patient transport services (PTS).

Services are managed from the trust's main headquarters in Waterloo, and annexes in Bow and Pocock Street .

The trust also offers the following services: First Aid Training to organisations and the public, and Community First Responders (volunteers trained by LAS to provide life-saving treatment).

The trust uses a command and control Computer Aided Dispatch (CAD) system to manage all calls into the Emergency Operations Centre. In the year 2015-2016, LAS received 1.86 million 999 calls into its two operations centres.

The trust had previously been inspected in June 2015, where we rated Emergency and Urgent Care (EUC) and Resilience Planning as inadequate. The Emergency Operations Centre was rated as requires improvement. A follow up inspection undertaken in August 2016 found progress had been made with regard to the requirements we had set out in a warning notice issued as a result of the June 2015 inspection. We did not rate the August 2016 inspection because we did not consider all of the key lines of enquiry due to the focused approach of the inspection.

We inspected LAS as part of our planned, comprehensive inspection programme. Our inspection took place on 7, 8 & 9 February 2017, with unannounced visits on 17,24 & 25 February 2017. We looked at three core services: access via Emergency Operations Centres (EOC), EUC, and the Emergency Preparedness, Resilience and Response (EPRR), which included its two hazardous area response teams (HART). The 111 service provided by the trust had been inspected recently, and we did not inspect the patient transport services on this occasion. The commercial training services were not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

During the inspection we visited ambulance premises as well as hospital locations in order to speak to patients and staff about the ambulance service.

Overall, we rated this trust as requires improvement.

We rated the trust as being good for providing care which was effective and responsive to the needs of the population it serves. We rated safety and the well-led domain as requires improvement.

People reported and we observed staff go the extra mile. There were examples when people reported the care they received exceeded their expectations.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff was strong, caring and supportive. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account. For these reasons, we rated the trust outstanding for the caring domain.

Our key findings were as follows:

Safety:

Summary of findings

- Whilst there had been improved mechanisms for identifying, reporting and investigating incidents, there remained a level of inconsistency in staffs perception of what constituted an incident and the reporting of such in all three services. As a result the trust was not always able to capture important data, which could identify trends and common themes across the organisation.
- Learning from incidents had improved but, was happening in an ad-hoc way, and as a result was not not yet fully embedded in practice across all areas of the service. Whilst the executive team had clear methods for communicating learning, staff reported they did not always have time to read updates.
- Mandatory safety training for non-clinical staff was not meeting the trusts own targets, and as a result, there was a risk of staff not being updated with regard to the latest safety practices.
- The systems and processes for safeguarding people who were vulnerable as a result of their circumstances were clearly set out, and staff we spoke with were aware of safeguarding and how to recognise and report abuse or neglect.
- Infection prevention and control measures had been established. Despite this, standards of compliance with protocols varied across the organisation. This was compounded further by the lack of staff awareness of standards, possibly attributed to non-completion of required training, and a lack of basic essential items to support practices.
- A number of ambulance vehicles needed internal repair, which prevented a good level of cleanliness from being achieved.
- There was some inconsistency in undertaking the required safety checks of vehicles and equipment, some of which was attributed to time factors at the start of shifts.
- Significant improvement in medicine management had been achieved over the past few months. There remained an issue related to the tracking and tracing of medicines, which was still not sufficiently robust with regard to safe storage and tracking.
- Whilst significant work had been undertaken to increase front-line ambulance staff, we were not assured all ambulance crew were allocated to response vehicles appropriately. Inexperienced crew were sometimes paired together and solo first responders were not always paramedics. As a result patient care and treatment was delayed when backup support was required.
- Patient records provided detailed information to support handover at local hospitals, as well as an audit trail from call handler on-wards. Records were accurately kept and stored securely.

Effective:

- Significant improvements had been made in Emergency Preparedness Resilience and Response, demonstrated through staff adherence with its agreed formal framework, and compliance with national standards. Response times to incidents classified as a HART response had been met.
- Staff ensured patients consented to treatment and care where able, and recognised where the best interests of the patient had to be considered where the situation indicated a response from staff without formal consent.
- Staff had good induction procedures and access to training. The trust was supporting staff to enhance their roles through additional responsibilities and expanded roles, such as clinical team leader and advanced paramedic practitioner. The introduction of the in-house academy provided an opportunity for staff to progress to the paramedic role.
- Staff were supported to access training and development opportunities, and had their skills and competencies assessed. The performance review of staff through an annual appraisal levels had improved, although the completion rates did not yet meet the trust target.
- Staff used evidence-based guidance to ensure patients were appropriately assessed, risks were identified and managed. The provision of care, advice and treatment reflected national clinical and medical guidance standards. For example, there were pathways of care to assess and respond to deteriorating patients. These included suspected stroke, chest pain, and trauma.

However,

- The trust was not meeting the national performance targets for highest priority calls attended to by emergency and urgent care crew. Although outside

Summary of findings

factors of handover delays at emergency departments, and increased activity contributed towards this, patient safety was at risk due to delayed treatment and non-conveyancing to hospital.

- The EUC ambulance crews experienced significant problems with handover delays at hospitals, resulting in stacked ambulances and crew being unable to attend emergency calls.
- Many staff did not have a clear understanding of the Mental Health Act. Although this had improved for staff working in emergency 999 services.

Caring:

- Staff across all services were caring, compassionate and treated patients with dignity and respect the majority of time.
- Patients who spoke with us were very positive about the service they received and the way they were treated by staff. Formal written information from patients to the trust demonstrated high levels of satisfaction.
- The emotional needs of patients and their relatives were addressed by staff providing information, treatment and care. Staff used a range of skills to provide empathy, support and reassurance when dealing with patients who were anxious or distressed.
- Ambulance staff explained treatment and care options in a way which patients were able to understand, and involved them and their relatives in decisions about whether it was appropriate to take them to hospital or not.
- Call handlers took their time to provide information and advice in a manner which was understood. They were patient, respectful and kind.
- Patients could receive advice from experts and clinicians in order to manage their own health. Clinicians provided information to patients about managing worsening symptoms and were able to advise patients of alternative services, such as non-emergency services, their GP or local urgent care centres.
- A small number of ambulance crew who were waiting with patients to hand them over to nursing staff in emergency departments did not on occasion demonstrate considered attention to the patient.

Responsive:

- There was effective and collaborative working between emergency operations centres, ambulance crews and the resilience staff, as well as external agencies. The services were co-ordinated to support seamless care, admission avoidance and alternative care pathways.
- The service was able to cope with different levels of demand, and was accessible via a number of routes. Systems for reporting to the National Ambulance Resilience Unit (NARU) and NHS England about the Hazardous Area Response Teams capacity had improved; formal arrangements were in place to report staffing on a shift by shift basis to NARU.
- Patients with complex needs could be met by the staff, and they had access to an interpretation service when required.

However,

- Attendance rates for equality, diversity and human rights training was relatively low.
- There was more work to do in relation to developing a comprehensive business continuity plan, which would include all aspects of service delivery, including control services demand management systems, and rolling out the business impact assessment procedure to all part of the service. It was estimated this would be completed within 12-24 months.
- The complaints process was clearly defined and the process for responding to complaints was robust. There was however, limited evidence of learning from complaints and concerns.

Well-led:

- The governance arrangements were much stronger and organised in a manner which enabled better scrutiny and oversight. There was greater recognition, management and recording of risks at departmental level and information was communicated via various committees upwards to the trust board. There remained deviation from local trust policies in how

Summary of findings

risks migrated to the trust-wide risk register. Further, developments were required in terms of understanding and operating of the board assurance framework.

- The trust had a clinical strategy, which took into account growing demand and increased activity. This was linked to quality plans, designed to improve clinical outcomes.
- There was a clear governance structure with accountable roles for staff and managers in each area of the service. This included the use of a framework to manage risks and provide quality assurance. Managers and their staff were more familiar with local risk registers, and generally knew the key risks to the service.
- Service quality was measured through monthly staff key performance indicators (KPI), management meetings, and reports to the board. Work was also in progress on a comprehensive review the trust's major incident processes and IT systems.
- There had been a shift in the culture across all areas, and generally staff were positive about working for LAS, although there was recognition that work still needing to be done to develop this further and maintain momentum.
- Staff morale in both Waterloo and Bow EOCs had significantly improved since the trust's previous inspection in June 2015. There remained variations in staff morale in ambulance stations, which was linked to varied leadership styles.
- The trust recognised more work needed to be done to reduce the disconnect between the executive team and frontline staff. Staff reported not feeling fully engaged with the trust's strategy, vision, and core values. Further, they were unsettled with the constant changes within the executive team, and were seeking more stability.
- Staff did not feel fully consulted and engaged in the trust change agenda and reported the trust leadership as having a top down managerial approach. Remoteness of ambulance stations further added to the feeling of disconnection.
- Staff reported rarely receiving a rest break. This meant they could work 12 hour shifts without having adequate rest. The lack of sufficient rest breaks posed a health and safety risk to staff, which had been recognised by the executive team.
- Although the trust were in the process of reviewing current rosters and breaks, the current system was a contentious issues among staff. Staff told us there was an inconsistent and inflexible approach across the organisation and this was a source of frustration with them. Additionally, there was variation in how sickness absence was managed at departmental level, which caused a degree of unrest.
- The trust had placed a great deal of emphasis on tackling bullying and harassment, despite this there remained a perception from some staff of issues remaining of this nature, and of discrimination. The variation in the local management of stations was linked to this.

We saw several areas of outstanding practice including:

- We observed staff behaviours and heard staff interactions, which demonstrated outstanding care and treatment to patients, and their relatives. Staff were committed to the provision of a compassionate and caring service towards patients, and treated patients and callers on line and at the scene with dignity and respect.
- The trust had employed mental health nurses at their clinical hub to provide expert opinion and assistance to frontline staff when they treated patients with mental health concerns.
- A maternity education programme and maternity pre-screening tools and action plans had ensured staff were able to respond to and support maternity patients.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such training must be more efficient and subject to scrutiny.

In addition the trust should:

Summary of findings

- Continue to develop a culture which empowers staff to recognise and report incidents. This should include reporting of low harm and near-miss incidents.
- The trust needs to do more to ensure they meet the national performance targets for highest priority calls.
- Improve the oversight and management of infection prevention and control practices. This includes ensuring consistent standards of cleanliness in the ambulance stations, vehicles and staff adherence to hand hygiene practices.
- Further improve the provision and monitoring of essential equipment availability for staff at the start of their shift.
- Ensure continued monitoring and improvements are made in medicine management, so that safety procedures are embedded in everyday practice, and are sustained by staff.
- Make sure the skills matrix is more robustly used to ensure ambulance personnel are appropriately allocated, taking into account individual qualifications, experience and capabilities.
- Continue to work with staff to address the issues related to rosters, rest breaks, sickness and absence. Actions taken should demonstrate a fair and consistent approach to managing the demands of the service, along with the health and safety of staff.
- Ensure sufficient time is factored into the shift pattern for ambulance crews to undertake their daily vehicle checks within their allocated shift pattern.
- Ensure there are ongoing robust plans to tackle handover delays at hospitals.
- Identify further opportunities for the executive team to increase their engagement with staff, to ensure the strategy and vision is embedded in their culture, and that the views of staff are heard.
- Review the leadership and management styles of key staff with responsibility for managing emergency and urgent care ambulance crews.
- Continue to build on the programme of work to improve the culture around perceived bullying and harassment. Push forward with the measures it has identified and already established to increase a more diverse and representative workforce with greater numbers of black and minority ethnic staff.

On the basis of the findings of this inspection, it is my recommendation that the trust remain in special measures. I am hopeful that the trust will be able to deliver the necessary improvements and we will return to the trust in the near future to check progress. In particular, the leadership team is very new. As long as this has become properly established I am confident that we will be able to recommend that the trust should exit special measures within a few months.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to London Ambulance Service NHS Trust

London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing services. The trust became an NHS Trust on 1 April 1996. The trust employs around 4,893 staff working across some 70 locations situated across London. This area covers 620 square miles which includes densely populated urban areas and some small rural areas with smaller populations. The trust covers a geography reaching from Heathrow in the west of London to Upminster in the east, and from Enfield in the north of London to Purley in the south. The trust provides services to a population of around 8.9 million people, liaises with five police forces and serves three airports including London Heathrow.

London Ambulance Service provides an emergency and urgent care to respond to 999 calls; an NHS 111 service when medical help is needed but it is not a 999 emergency; a patient transport service (PTS), for non-emergency patients between provided locations or their home address and emergency operation centres (EOC), where 999 and NHS 111 calls were received, clinical advice is provided and emergency vehicles dispatched if needed.

There is also a Resilience and Hazardous Area Response Team (HART).The trust covers the most ethnically diverse population in the country. In the 2011 population census, the three main ethnic groups were: White (59.79%), Asian or Asian British (18.49%) and Black or Black British (13.32%). Life expectancy at birth for both males and females in London is greater (better) than that for England. However, life expectancy at birth for males in London is lower (worse) than that for females. Life expectancy at birth for females in London is the highest in the country.

In the following local authorities, life expectancy at birth for males is lower (worse) than that for England; Barking and Dagenham; Greenwich; Hackney; Islington; Lambeth; Lewisham; Newham; Southwark and Tower and Hamlets. In addition, life expectancy at birth for females is lower(worse) than that for England in the following local authorities; Barking and Dagenham and Newham.

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission

The team included CQC inspectors, inspection managers, assistant inspectors, pharmacist inspector, inspection planners and a variety of specialists. The team of specialists comprised of advanced paramedics, paramedics and an ambulance service manager.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following:

- Emergency Operations Centres
- Emergency and Urgent Care including the Hazardous Area Response Team (HART).

The 111 service was inspected and rated separately in January 2017.

Summary of findings

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about London Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, NHS Improvement; NHS England; Health Education England (HEE); College of Emergency Medicine; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; Parliamentary and Health Service Ombudsman; Public Health England and local Healthwatch groups.

We visited both EOC centres located at Waterloo and Bow where we spoke with over 40 staff. We spoke to call handlers, dispatchers, clinicians, managers, paramedics, trainers, safeguarding leads and professional leads including a Consultant Midwife. We made observations and listened to EOC staff responding to calls during the inspection.

Prior to the inspection we undertook a range of focus group meetings with staff from different roles and grades. We met with LAS staff representative of the black and minority ethnic employees.

We visited 22 ambulance station locations including; Croydon, Twickenham, New Malden, Mill Hill, Steatham, Oval, Greenwich, Kenton, Pinner, New Addington, Ilford, Beckenham, Whipps Cross, Friern Barnet, Waterloo, Mottingham, St Helier, Walthamstow, Bromley, Romford and the two reseliance team stations based in the east of London and Hounslow. We also visited the emergency operation centre.

Our inspection included accompanying ambulance crews on their ride outs to emergency calls, and attendance at emergency departments of a number of hospitals within the capital.

We visited announced on 7, 8 & 9 February and unannounced 17, 24 to 25 February 2017.

We spoke with over 200 ambulance crew, including paramedics, emergency ambulance crew members (EACS), trainee emergency ambulance crew members (TEACS), trainee paramedic students, clinical team leaders, general station managers, and senior managers. We made observations of their activities during the course of their working shifts.

We were shown information and made consideration of this, together with additional documentation provided to us by request.

During our ride outs and arrival at the emergency department, we were able to speak with approximately 50 patients about their experiences.

Facts and data about this trust

Demographics:
The area is made up of:

- approximately 8.9 million people, as well as managing high volumes of tourists and commuters
- covers 620 square miles
- 70 ambulance stations located across London
- two emergency operation centres located at Waterloo and Bow respectively
- works with 18 acute trusts in London
- commissioned to 32 Clinical Commissioning Groups (CCG's)
- involved in five Sustainability and Transformation Plan (STP's) strategies across London

Activity:
Between August 2016 and March 2017 the trust:

- received 787,971 emergency and urgent calls to the switchboard
- Completed 399,250 journeys to a recognised emergency department

Resources and teams include:

- 248 fast response vehicles
- 420 ambulances
- 4 advanced paramedic practitioner vehicles
- 22 motorcyle response units
- 84 vehicles to support the emergency preparedness, resilience and response (EPRR) service
- Two emergency operation centres located at Waterloo and Bow
- 70 ambulance stations and two Hazardous Area Response Teams (HART).

Summary of findings

- The trust has a budgeted establishment of 5,200 whole time equivalent staff. At the time of inspection, there were 4,934.4 wte staff in post (5.1% total vacancy rate)

Frontline staffing

- Paramedics: 2,0885 establishment with 1,896.2 in post (9.2% vacancy rate)
- Apprentice paramedics: 85 establishment with 99.1 in post (-16.6% vacancy rate)
- Emergency ambulance crew (EAC)/trainee EAC (TEAC): 773.2 establishment with 799 in post -3.3% vacancy rate)
- Emergency medical technicians (EMT) and support technicians: 426 establishment with 357.1 in post (16.2% vacancy rate)

Summary of findings

Emergency operations centre staffing

- Emergency operations centre: 378 establishment with 389.1 in post (-2.9% vacancy rate)

Other staff

- 1,449.40 other staff against an establishment of 1,393.9 in post (-2.9% vacancy rate)

Safe

- In accordance with the Serious Incident Framework 2015, the trust reported 65 serious incidents (SIs) which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was Diagnostic incident including delay meeting SI criteria (Including ambulance delay) (53.85%).
- There were 953 incidents reported to NRLS between January 2016 and December 2016. There were four deaths reported by the trust over the period. 719 incidents resulted in no harm; 171 resulted in low harm; 45 resulted in moderate harm and 14 resulted in severe harm.
- Staff survey 2016 - The number of staff who reported that they had witnessed any error, near miss or incident which could have hurt a patient in the last month was higher than the national average for ambulance trusts (33% at trust level versus 26% nationally).
- Staff survey 2016 - The number of staff who reported an incident in which they had witnessed an error, near miss or incident which could have hurt staff or patients was marginally worse than the national average (59% locally vs 61% nationally).
- In the 2016 staff survey, 78% of staff reported that they would know how to raise a concern about unsafe clinical practice. This was worse than the national average for ambulance trusts of 85%.

Effective

- Data from NHS England showed the trust did not meet the national Ambulance Quality Indicators (AQI) A8 target for the percentage of Category A Red 1 (most time critical) calls reached within 8 minutes. Between July 2016 and October 2016, the trust reached 68.3% for July, 68.7% for August, and 70.1% for September 2016 against the national target of 75%. The trust was ranked fourth place out of ten ambulance trusts across England for this quality indicator.

Summary of findings

- The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes was below the national target of 75%. For July 2016 the rate was 63.6%, August 67.4% and September 63.3%.
- The trust performed better for the percentage of category A calls reached within 19 minutes when compared nationally. For July 2016 they reached 93.1%, August 94% and September 92.9% against a national standard target of 95%. The trust was the second highest ranked ambulance service for July and August and third in September for this quality indicator.
- The five second call answering indicator, which measured all 999 calls answered within five seconds for October 2016, was 95.1%, which was in line with the national target of 95%.
- The most recent data for June 2016 indicated there were 97 patients with definite STEMI who received primary angioplasty within 150 minutes of the emergency call being connected to the ambulance service. This gave a proportion of 92.4% of patients, which was higher than the England average of 87.2%.
- The most recent data available for June 2016 (published November 2016) indicated 68.2% of patients received the appropriate care bundle for STEMI, which was worse than the England average of 76.9%.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. The return of spontaneous circulation is calculated for two patient groups, ROSC overall and ROSC Ustein comparator group. The ROSC overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The most recent data for June 2016 indicated there were 342 patients who had resuscitation commenced and continued by ambulance service following a cardiac arrest. Of these 114 had return of spontaneous circulation on arrival at hospital, following resuscitation. This gave a proportion of 33.3% of patients, which was higher than the England average of 29.7%.
- In the Ustein comparator group, 25.5% of patients were discharged from hospital alive, which was the same as the England average.
- The majority of patients (97%) received a complete pre-hospital stroke care bundle consisting of FAST, blood glucose measurement and blood pressure assessment.
- The provision of blood glucose assessment, which had proved to be the most challenging element of the stroke care bundle, had improved from 96.7% (in 2012-13) to 99.5 %.
- The majority of stroke patients (99%) had the onset of symptoms time recorded or it was documented that the onset time could not be determined.
- Almost all stroke patients (99.1 %,) were conveyed to the most appropriate destination for their condition, in compliance with the London stroke pathway.
- The percentage of stroke patients, who received a complete pre-hospital care bundle, was 97%. Initiatives such as staff being provided with personal-issue blood glucose monitoring kits, staff being invited to attend a one- day stroke education event run by the LAS in conjunction with the stroke networks have helped improve care for patients.
- Compliance with the stroke pathway by LAS staff was high, with 99.1% of stroke patients being conveyed to the most appropriate destination for their condition.

Responsive

- Emergency calls from patients for whom a frequent caller procedure was in place. Frequent caller procedures had beenlocally determined; these procedures related to to individual patients and were agreed with the patient and the main care provider, for example, GPs and community mental health teams.
- Between July 2015 and October 2016, the proportion of calls from patients for whom a locally agreed frequent caller procedure was in place was similar to the England average. The trusts frequent caller rate drops below the England average from June 2016 to October 2016.
- We found the percentage of emergency calls resolved by telephone advice at LAS, (10% to 14%) was better than the England average, (9% to 11%), between July 2015 and October 2016.

Summary of findings

Well-led

- Between August 2015 and April 2016, the trust reported a lower sickness rate than the England average. From May through July 2016, the trust's sickness rate was slightly higher than the England average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as requires improvement**	Requires improvement 

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust was aware of its role in relation to the duty of candour regulation which is regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It sets out specific requirements providers must follow which includes an apology to patients. Whilst not all staff were familiar with the term 'duty of candour', they understood the fundamental principles of being open, honest and providing a full explanation and apology to patients when treatment and care had gone wrong. The trust had launched a "Speak Up" campaign which sought to remind staff and managers of their obligations to apply the duty of candour requirements in their roles.
- The Director of Governance/Trust Secretary was the nominated lead director responsible for duty of candour. The trust had a clear and concise duty of candour policy which had been updated in December 2016. Quality governance and assurance managers reviewed incidents and triggered the duty of candour process accordingly. The serious incident group also considered the requirements of the duty of candour regulations when each serious incident case was reviewed.
- The trust took a proactive approach to assigning family liaison officers in cases which met the threshold for duty of candour to be applied. These individuals also acted as duty of candour champions. Additionally, we saw evidence of where the trust had gone to extreme lengths to identify and notify relevant persons in cases where the identity of patients who had died were not known. The trust have reported that over 50 incidents, which had not met the formal threshold for trust to discharge their responsibilities under the duty of candour regulation, had included an apology which had been recorded on Datix.

Safeguarding

- The Chief Quality Officer was the executive lead for safeguarding within the organisation.
- We saw copies of an easy read version of an information document, which helped individuals to understand abuse and how to report it. This was informative and provided clear contact details for additional help.
- The trust received protection plans from local authorities by way of email. On receipt of the protection plan, staff added the plans to the patient care record database, and if in the catchment of the London Ambulance Service, to the Computer Aided Dispatch system; this meant that if a call was received from or about a patient to whom a protection plan was in place, the ambulance crew and dispatcher were automatically alerted to this. The trust acknowledged that the email inbox to which the protection plans were received was not continuously monitored and so there was the possibility that the computer aided dispatch system was not always updated in real time.
- Clinicians at the clinical hub (CHUB) had access to 'The Spine' (NHS National patient database), which contained information relating to child protection concerns. It was noted that at the time of inspection, only eight London local authorities were uploading information to "The Spine" and so the trust was not in receipt of all information relating to child protection. In addition, LAS were signed up to implement the Child Protection Implementation System.This provided access to information about Child Protection Plans (CPP) and children's Looked-After Status (LAC) in all cases where a child accessed emergency or unscheduled care. The process had not yet been fully implemented as it had not received full trust board sign off, but an operational group had been established in anticipation.

Incidents

- The trust had introduced an electronic incident reporting system following our previous comprehensive inspection in 2015. There had been an increase in the total number of incidents being reported by staff following the introduction of Datix. From the launch of the electronic reporting system from May 2016 to November 2016, 3,973 incidents had been reported on the system. This compared to 2,687 incidents reported in the same period in 2015, which showed an increase of 48%.
- There had been significant improvement in the time taken for staff to report patient safety incidents on Datix within four days of the incident occurring when compared to 2015/2016

performance. Performance for 2015/2016 was reported as, on average, 30% of incidents being reported within four days; performance for 2016/2017 had increased to an average 89% of incidents reported within four days.

- Staff were able to report incidents through the 'single point of access team', a team dedicated to inputting incidents reported by front-line staff into the organisations electronic reporting system. Staff were able to call a dedicated line from the ambulance and report an incident, which would be placed into the electronic system by the single point of access team. Staff told us this had made the system of reporting incidents quicker and smoother. From June 2016, the operational hours of this line were extended to 24 hours a day. However, there was a lack of awareness amongst a small number of front-line staff in regards to the existence of the telephone incident reporting team. Staff we spoke with during the inspection reported the dedicated line was sometimes busy and they therefore had forgotten about the incident by the end of their shift. This could mean the trust was losing opportunities to learn from minor but frequently occurring incidents.
- Positively, the organisation was starting to report a sustained increase in the number of patient safety incidents being reported as compared to incidents relating to staff welfare and safety incidents. Whilst it is important to acknowledge the importance of staff reporting incidents relating to their own welfare and safety, it was assuring to see greater awareness across the workforce in regards to incidents relating to patients and the development of a culture orientated towards patient safety.
- We found there was an element of under-reporting of minor incidents across the various operational locations visited. The threshold for reporting varied, and staff told us they were less likely to report any near misses or incidents that did not result in harm. Staff reported that this was because they did not have time to complete the electronic system at the end of the shift.
- During the first three quarters of 2016-2017, 62 serious incidents were raised compared to 43 over the same period in 2015-2016, an increase of 44%. The LAS was now the second highest reporter of serious incidents across England ambulance services for 2015-2016.
- The executive team acknowledged that following the introduction of Datix and an increased awareness of incident reporting among front line staff, there had been an increase in the number of serious incidents being identified and reported. This had led to delays in serious incident investigations being concluded. This could potentially lead to delays in themes and

trends being identified and therefore temporarily increasing the risk of similar incidents occurring in the future. However, the trust had increased human resources within the governance and assurance team to aid in improving the time with which serious incidents were being investigated and concluded; this was however, only a short term measure with no medium or long term strategy in place at the time of inspection to ensure demand did not out-strip capacity.

- Within the 2016 NHS staff survey, 42% of staff witnessed potentially harmful errors, near misses or incidents in the previous one month. This was higher than the national average for all ambulance trusts, reported as 34%. 80% of staff compared to 66% in 2015 had reported a witnessed error, near miss or incident. This was inline with the England average for other Ambulance Trusts.
- In 2016, 43% of staff compared to 31% in 2015, indicated that staff were given feedback about changes made in response to the reporting of errors.
- The 'learning from experience group' provided a coordinated and focused approach to the review of incidents, and monitored how teams implemented improvements for patients, carers and staff. Learning from incidents was captured and disseminated monthly via the trust's governance and action magazine.
- There was recognition within the 2016-2021 clinical strategy that every clinician working for the London Ambulance Service was accountable and responsible for ensuring that all incidents were reported in an open and transparent way.

Staffing

- Between April 2015 and December 2016, the trust had recruited 972 frontline staff. The trust had seen an increased number of patient-facing vehicle hours available to care for patients. When compared with June 2015, the trust had achieved a 175 increase in patient-facing vehicle hours.
- In December 2016, the trust reported a vacancy rate of 16.7 % in Emergency and Urgent Care with a whole number of 567.3 full time equivalent (FTE) vacancies. The overall vacancy rate for frontline staff had increased from 7.1% to 7.2%. The vacancy rate for frontline paramedics had improved from 11.5% to 9.8%.
- Between October 2015 and September 2016, the trust reported a turnover rate of 7.9 % in Emergency and Urgent Care with a whole number of 233.7 FTE staff. Of the 316 staff groups, 197

were reported as having no vacancy. Vacancy rates in the remaining 119 groups ranged from 1.5% (paramedics, Wimbledon ambulance station) to 66.7% (emergency medical technicians at Bounds Green and Feltham ambulance stations).

- From the Integrated Performance report November 2016, we saw the frontline turnover had improved from 8.9% to 8.7%. Frontline paramedic turnover had improved from 8.6% to 8.2%.
- In December 2016, the trust reported a vacancy rate of 3.4% in the Emergency Operations Centre, with a whole time equivalent (WTE) number of 19.3. Administrative and clerical staff in control services management reported a 100% vacancy rate, and nurses in the CHUB reported 61.7%. However, both of these staff groups were very small, with an expected staff of 2.8 and 8 whole WTE respectively.
- Between November 2015 and October 2016, the trust reported a turnover rate of 16.9% in the emergency operations centre with a whole number of 157.5 FTE. The highest turnover rates were reported in the EOC control office and training and development, which both reported rates of 56.6%, or 24.7 FTE. Below these two groups, the next highest turnover rate was 15.2% (12.7 FTE), reported in both the CHUB and A Watch team. Managers and staff we spoke with told us the EOC was reliant on staff being prepared to work overtime to ensure shifts were filled, and staff were very good at offering to work overtime.
- Managers told us the EOC tended to lose staff within 12 months of employment. Managers said work was in progress on a plan to offer enhanced support to staff in the first 12 months. They also told us they were advertising jobs on the NHS jobs website, and had held 'open days. Staff were also being offered 'disruption payments' to encourage them to cover extra shifts.
- Following the last inspection the trust increased its HART staffing establishiment to meet NARU specifications. At the time of this inspection there were 89 whole time equivalent (WTE) paramedics in post and the trust was recruiting additional staff to cover sick and annual leave.
- The trust formally reported HART staffing on a shift by shift basis to NARU. Where staffing fell below required levels mutual aid arrangements with the South East Coast Ambulance Service NHS Trust (SECAMB) HART would be activated, where SECAMB would deploy the HART based at Gatwick Airport to provide a response for London Heathrow Airport. At the time of the inspection this mutual aid plan had not been triggered.
- At the time of the inspection 99% of HART shifts were covered which was a significant improvement since the inspection in 2015 when only 24% were covered.

Summary of findings

Medicines

- Staff told us the biggest improvements they had seen since our last inspection was medicine management.
- The trust had reviewed all their processes and policies relating to medicines management since the last CQC inspection, and recently updated its policy and procedure for the use of medicines by LAS staff including controlled drugs.
- We observed the security of medicines at the logistic department had significantly improved since our last inspection, with coded access to storage areas for medicines including drug packs. The trust had also launched a number of campaigns and staff engagement programmes with the aim to improve drug security and medicines safety. They had also recruited a full time pharmacist.
- An electronic system had been implemented to track the flow of medicines ordered from the logistic department onto distribution to different ambulance stations. This consisted of two digital medicines tracking system apps; Kit Prep, which recorded the signing in and out of general and paramedic drug packs, and Perfect Ward, which was used mainly by the clinical team leaders for auditing on hand held devices. We saw the Kit Prep system in use at some ambulance stations for scanning in and out of drug packs, as well as electronic recording when station based drugs were removed. However, the system had not been fully rolled out to all ambulance stations and significant number of stations did not yet have the system. Paramedics at one of the stations we visited (West Ham Station) had not even heard of the new system.
- Some staff expressed concern that they felt the new Kit Prep system, whilst it was an improvement, did not go far enough to ensure the safe use of drugs. The drugs were still freely available within the cabinets they were stored in. There was no CCTV or ID scanning required, so drugs could still be removed without using the KitPrep tablet and their removal would not have been logged.
- A new electronic drug monitoring portal, 'MedMan' had been designed and implemented to help reconcile drug usage forms from the paramedic drug bags with completed patient report forms (PRF). The trust executives demonstrated to us how this was operated. This new system allowed the management team to search and match medicines taken from the drug packs and tracked their administration to patients. We saw how this was used to track dosage of medicines used by patients, as well as any incomplete fields on the PRF. There were also facilities to investigate and track medicines usage by clinicians; the

Medicines Safety Officer said that this has been very helpful especially when investigating high usage of controlled drugs such as morphine and benzodiazepines, enabling appropriate action including the review of clinical pathways as well as allowing trust staff to identify and act to prevent CD diversion.

- Although the management of medicines had improved, ambulance crews told us they sometimes took their drug packs home at the end of a shift and brought it back in the morning before the checking of medicines had taken place.
- We saw evidence of medicines related incident reporting and how learning from these was used to improve patient care. For example, a number of incidents reported, related to incorrect administration of adrenaline 1:1000 being either via wrong route or wrong dose. Further investigation by the LAS showed a possible confusion in doses outlined in the Joint Royal Colleges of Ambulance Liaison Committee (JRCALC) pocket guide that most likely led to human administration errors. The team had introduced labels to prompt staff on route of administration. New guidance had also been issued to all paramedics and the LAS medicines safety officer (MSO) also contacted the JRCALC to suggest that the "Age per page " pocket book guidelines was altered to make it clearer the different doses for cardiac arrest and anaphylaxis. We saw that learning from incidents was shared widely with staff through publications such as medicine management bulletins and the clinical insight magazine.

Are services at this trust effective?
We rated effective as good.

Good

Evidence based care and treatment

- Care pathways and care bundles were developed in line with NICE. Care bundles were used as a structured way of improving the treatment and management of patients who presented with certain risk factors.
- Staff carried pocket sized assessment tools to help aid them when assessing patients for treatment and these tools provided information on the best clinical pathways of care to follow.
- Care pathways were displayed in stations we inspected. Clear pathway guidance was displayed for Stroke, STEMI, sepsis, asthma, hypoglycaemic, and sickle cell.
- The trust was and is still involved with the new London section 136 pathway launched in December 2016 to devise a better PAN London pathway of care for those patients with mental health issues. The trust is working together with other NHS hospitals, police, mental health and social services to launch a new set of standards to improve the care of vulnerable London patients.

Summary of findings

- The managing of conveyance policy and procedure provided clear protocols for staff on managing section 136 of the Mental Health Act patients with the cooperation of the police.
- The maternity pre-hospital screening and action tool was devised and complimented the Joint Royal Colleges of Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The JRCALC provides ambulance services with a central organisation that supports, co-ordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central resource of information about NHS ambulance services.
- We saw from the monthly-distributed Routine Bulletin Board (RIB) updates of policies and procedures were shared with staff**.** From the 17 January 2017 issue the revised safe haven policy and procedure was explained to staff with information on how staff could gain further information on the policy.
- A quality audit of 1% of all calls was carried out daily for consistency and to ensure staff provided advice in line with agreed clinical protocols used to triage calls. Staff received feedback and were aware of areas where improvements were required.

Patient outcomes

- The trust performed well for patients receiving primary angioplasty within 150 minutes and was better than the England average.
- The proportion of patients discharged from hospital alive following a cardiac arrest was better than the England average. During 2015/16, the trust attended10,116 patients in out-of-hospital cardiac arrest andattempted to resuscitate 4,389 of these. Survival rates remained consistent with the previous year with 9.0% of all patients where resuscitation was attempted surviving to hospital discharge and 31.5% surviving amongst the Utstein comparator group.
- Between October 2016 and and February 2017, the proportion of patients who re-contacted the service within 24 hours following discharge by telephone, was better than the England average,
- Between July 2015 and October 2016, the proportion of calls abandoned before being answered was generally better than the England average. The trusts trend has been similar throughout the period.
- All sectors were failing to meet the trust response times target of 93% of Category C1, serious but not immediately life

threatening, calls reached within 20 minutes, with North Central Sector achieving 51%; in the North East Sector 47%, the North West Sector 53%, the South East Sector 55%, and the South West Sector 58%.

- All sectors were failing to meet the trust response times target of 93% of C2, serious but not immediately life threatening, calls reached within 30 minutes. In the North Central Sector the figure was 51%, in the North East Sector the figure was 53%, in the North West Sector the figure was 59%, in the South East and South West sectors the figure was 62% and 63% respectively.

Are services at this trust caring?

We rated caring as outstanding Outstanding ☆

Compassionate care

- During the inspection, we observed staff consistently treating patients kindly and compassionately. There were many occasions we saw staff deliver care and treatment far above what was expected of them. Patients told us stories of the care and treatment they had received from the ambulance crew. Such comments included “exceptional staff, they have all been so warm and caring”.
- Other comments from patients included ‘they are so professional and I felt reassured.’ ‘I recognise they are so busy, but they are so lovely and kind when they have seen me.’
- We observed ambulance crew caring for patients in public places. They maintained the dignity of patients by covering them with blankets when they were transported in either wheelchairs or stretchers. We heard ambulance crew ask patients if they felt warm and comfortable. We observed staff making sure an elderly patient had socks placed on their feet before they were placed in the ambulance.
- We listened to staff taking telephone calls from the public. Staff spoke to people in a compassionate manner and treated them with dignity and respect. Staff listened to what callers were saying and clarified information when necessary. Staff were sensitive and supportive whilst on the phone. For example, we observed staff speaking with distressed callers on the phone on several occasions.
- We heard staff talking to vulnerable patients with empathy and kindness.

- We listened to 45 calls. Without exception, staff were calm, reassuring, empathetic and kind. Staff were patient with callers when they became anxious. This enabled the caller to relax and answer the questions required to obtain information about the patient.
- Staff induction training included how to be caring and compassionate. The training lead told us there was an emphasis in induction training for EOC staff on customer service and treating callers with dignity and respect.

Understanding and involvement of patients and those close to them

- The Advanced Medical Priority Dispatch System (AMPDS) had standard evidence based advice for callers on what they could do whilst waiting for an ambulance, which ranged from keeping someone warm and comfortable to full cardio pulmonary resuscitation advice. Staff clearly communicated advice to patients when required.
- Relatives and carers told us ambulance crew explained what they were doing and the options available in terms of treatment for the patient. We saw ambulance crew explain to relatives and carers what actions they were taking, such as conveying them to hospital and the reasons why.
- We heard ambulance crew ask relatives and carers if they wanted to accompany the patient if they were conveyed to hospital. During the journey, the crew reassured relatives and carers and we saw good examples of kind and sensitive care.
- During conveying patients to hospital ambulance crew provided reassurance and care for the patient. We saw crew members hold the hand of patients to offer them reassurance and they explained what hospital they would take them to and the care and treatment they would be offered.
- We heard ambulance crew introduce themselves and ask relatives and carers how they would like to be addressed. We observed staff modifying their language, tone, and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.
- We observed staff provide further information of care to relatives and patients. For example, ambulance crew treating an elderly patient were able to arrange with the patients GP a prescription, which was sent straight to the patient's local pharmacist for collection. While the relative went to collect the prescription, the ambulance crew stayed with the patient to observe them and provide reassurance.

Emotional support

Summary of findings

- 108 Friends and Family Test responses were received in February 2017 with 81% of responders stating they are extremely likely to recommend the LAS to friends and family if they needed care or treatment.

Are services at this trust responsive?
We rated responsive as good

Good

Service planning and delivery to meet the needs of local people

- The trust had a control services surge management plan in place to ensure that at times of sustained high pressure the EOC provided a consistent service to those critically ill. The plan allowed for seven colour-coded surge levels to manage fluctuations in demand, as defined by the trust's surge plan. Green was the lowest level and black the most severe level of demand; the levels in order of priority were: green, amber, red, purple and enhanced purple, blue, and black. At the time of our visit the EOC were operating on a surge level red. Surge purple and purple enhanced could be authorised by the on-duty incident and delivery manager. The higher levels could only be authorised by the trust's "gold commander". Surge black, the highest level, had never been used by the EOC.
- The trust had introduced a Non-Emergency Transport service (NETS). This was one of the initiatives supported by commissioners to reduce pressure on the control room and front-line staff. The target was 10 calls per hour to be transferred to NETs with a minimum of one to two hour timeframe. The targeted use of NETs was to enable front-line ambulances to be freed up for the sickest and most seriously injured patients and reduce the delays in responding to the patients whose needs did not specifically require an ambulance and who often waited too long for conveyance to care. The decision to transfer calls to NETS was based on the patients presentation at the time of the assessment and not their past medical history, for example, a patient presenting with a limb injury and a cardiac history did not require a frontline response in order to conduct a routine electrocardiogram (ECG, this is a test of the hearts rhythm and electrical activity).
- The LAS surge management plan ensured that at times of sustained high pressure the EOC provided a consistent service to 999 callers. The purpose of the plan was to ensure that at times of sustained high pressure LAS could take an overview of the whole of London and provide a consistent service to 999 callers. Implementation of the plan release additional vehicles

from normal operational duties and allowed demand to be managed in a manner which continued to enable the patients with the highest level of need to be responded to in the quickest way and provides the safest possible management of all patients.

- The surge management plan allowed for calls related to patients between two and 74 years old to be routinely redirected the 111 service.
- The plan had seven colour-coded surge levels, which with green being the lowest and black the most severe; green, amber, red, purple and enhanced purple, blue, and black. Surge amber and enhanced purple could be only be authorised by the on-duty ambulance operations manager. The higher levels could only be authorised by the trust's "gold commander". The trust had never used a surge black level. The surge level was reviewed four hours post implementation then at eight hourly intervals.
- Dispatch and deployment of HART resources was through the incident management desk (IMD) when it was operational. EOC sector staff liaised with the IMD when they identified a HART suitable call. When the IMD was closed, sector staff liaised directly with the HART team supervisor who advised on the appropriate resource to dispatch.
- As well as the HART dispatch criteria, the team could also be dispatched to Red 1 calls if they were the nearest resource or were required as an additional resource. Where they were the nearest, they would be backed up with sufficient numbers of LAS clinical resources as soon as possible to enable HART to be released for a HART suitable call should one come in.
- We saw from quality reports and minutes of board meetings the operational plans for the service, planning, and delivery were discussed and proved to be challenging.
- A review of activity trends highlighted the following areas that were influencing demand: demand for LAS services was growing faster than population growth; the demand from elderly patients was growing as a proportion of total activity. Demand from patients over the age of 75 was growing at the fastest rate; demand from elderly patients was greater in outer London CCG.
- Demand had exceeded contracted levels by 3.4%. The contract for 2016/17 included growth of 2.2%, overall and 4.0% for Category A calls. Overall, this meant Category A activity had grown by 7.8% on the previous year.

- CCG's in outer London were busier with Category A activity for elderly people. Six CCG's had significant activity and growth in activity for the elderly population. The biggest demand and increase fell within Camden, Bexley, Hounslow Hammersmith and Fulham, Enfield and Bromley.

Meeting people's individual needs

- Between July 2015 and October 2016, the proportion of calls from patients for whom a locally agreed frequent caller procedure was in place was similar to the England average. The trusts frequent caller rate drops below the England average from June 2016 to October 2016.There were registered mental health nurses (RMN) available to provide advice relating to patients with a mental health problem, but this service was not routinely provided 24 hours a day.
- Staff had access to a language support line for 999 calls where the caller did not speak English as a first language. The aim was to achieve language support within 90 seconds from the time a call was received. A senior manager told us this was achieved and callers needing interpreting services needs were met.
- Staff had access to a text service to help people with hearing loss and/or a speech impairment to access the telephone system.
- The call handling system allowed alerts to be recorded for frequent callers, patients with complex needs, learning disabilities as well as for patients from other vulnerable groups. However, in cases where several people lived at the same address, for example, in blocks of flats, staff were unable to establish promptly which flat the alert corresponded to. An area controller told us vehicle crews were required to update the information stored but that sometimes this didn't happen.
- The trust commissioned two vehicles specifically equipped for bariatric patients and these were operated by one of their service providers. However, when speaking to staff, some said there were occasions when they had conveyed bariatric patients to emergency departments and those hospitals did not have the appropriate equipment. They described the process as somewhat undignified for the patient.
- The trust acknowledged they needed to do more for bariatric patients, due to the growing demand for this service. A bariatric working group was set up which included a patient representative who reviewed the bariatric requirements of the service. New bariatric clinical training had been incorporated into the CSR training for 2017/18. This was still a work in progress at the time of our inspection.

Summary of findings

- For patients with learning difficulties, staff carried a communications assistance pocket booklet, which gave guidance on how to communicate and pictorial aids to help patients communicate.
- Mental health nurses based within the emergency operations centre (EOC) were able to offer support to ambulance crew and to patients who made contact through the telephone system.
- The London Ambulance Service was the first ambulance service to "spotlight on maternity" and had taken the following actions. They currently have joint maternity education in progress with midwives across the capital. They have established a maternity risk summit, which meets every six weeks and has a focus on maternity safety, which identified the following themes: recognising deterioration in pregnancy, management of preterm delivery and managing temperature in newborns.
- Following an investigation of a maternal death, all frontline staff were issued with a maternity prehospital screening & action tool along with specific guidance, which detailed the responsibilities of both ambulance services clinicians and midwives within maternity units in London.
- The trust had established the appropriate care pathways group chaired by a consultant paramedic who together with managers and clinicians helped develop pathways in a central forum to share good practice and develop a suite of pathways able to meet the needs of patients. The trust embarked on a pilot scheme, which introduced up to 12 Advanced Paramedic Practitioners (APP) from January 2017. The APP work rotationally in other practice settings to develop an understanding of the wider system as well as clinical competencies, which will enhance their ability to manage patients in the community. These practitioners held an advanced scope of practice in urgent care and were able to provide see and treat services to a wider range of patients, including those with chronic conditions, end of life care needs and minor injuries**.** This system was in the very early stages of being introduced during our inspection.
- The trust had developed a number of pathways with local providers which ambulance clinicians were able to access to provide care for patients with long-term conditions in the community. These included direct access to community wards and admission avoidance teams, specifically for patients with chronic conditions such as diabetes, mental health, and chronic obstructive pulmonary disease (COPD). However, staff informed us the mental health pathways did not work, due to the strains on the mental health service. Therefore, the pathways did not work well for mental health patients.

- The trust worked closely with Co-ordinate My Care (CMC) and was the first UK ambulance trust to begin using this system to identify end of life patients, with care plans in place specifically detailing preferred place of death and ceilings of care. Registered clinicians based within the emergency operations centre had direct access to this system, and were able discuss the case with the attending crew, so all relevant information was available to the crew, so they were able to support the patient to make a decision, or to make a best interests decision if the patient lacked capacity.
- The trust had a system for flagging patient's addresses if they required care outside of normal guidelines. For example, this may be for a patient with a long-term condition, requiring specialist treatment or support. Plans, which did not appear, on CMC were written in conjunction with the patient's lead clinician, and were reviewed yearly.

Access and flow

- We viewed an indicator that reflected how the whole urgent care system was working, rather than simply the ambulance service or hospital accident and emergency departments. It reflected the availability of alternative urgent care destinations, for example, walk-in centres, and providing treatment to patients in their home. We found the percentage of emergency calls resolved by telephone advice at LAS, (10% to 14%) was better than the England average, (9% to 11%), between July 2015 and October 2016. From April to September 2016 the rate of calls being resolved with telephone advice dropped, however this was never lower than the England average.
- When comparing the trust to the average of all ambulance trusts for time to answer calls using the 'Call Connect' 95th and 99th percentiles, the time below which 95% and 99% of calls were answered. The trust were performing in between the England maximum answer time and the England minimum. The trusts figure for this indicator had remained consistent throughout the time period from August 2015 to October 2016 unlike the England maximum and minimum. The trust has reported a consistent median figure of zero from August 2015 to October 2016.
- The total number of abandoned calls for the week commencing 23 January 2017 was 75 abandoned calls, but this in context related to an average of over 32,000 calls per week received in January 2017.

- HART staff and vehicles and mass casualty equipment vehiclces were not used for patient transport, which meant that hospital turnaround times, or issues in the wider healthcare economy did not affect them.
- Records showed that when dispatched to an incident within Home Office Model Response Strategy guidelines, the team had always met the required response times of 15 and 45 minutes.
- The trust had worked in partnership with commissioners to develop urgent and emergency priorities for London STPs, and their operational management structures had been restructured to align to the five STPs so they were locally responsive.
- In addition, the trust had a number mechanisms to manage demand and resources for the most seriously or life threatened patients, including the EOC operating a 'hear and treat' service which resolved around 2,400 calls a week allowing resources to be sent to higher acuity calls. They had a dedicated desk, which reviewed all police calls and provided clinical assessments before an ambulance was dispatched. This provided greater support to the Police and 50% of these calls were now managed on scene. They also utilised the National Resourcing, Escalatory Action Plan (REAP) when demand outstripped capacity on a sustained level. Additionally they used surge management when there were spikes in demand, which were addressed through re-allocation of resources and the ability to refer lower acuity calls through to NHS 111.
- We saw the trusts computer system showed clearly, where there were ambulances stacked at various hospitals. The system let managers know where there were problems and how long each ambulance crew had been waiting in emergency departments.

Learning from complaints and concerns

- Between November 2015 and October 2016 there were 1,024 complaints about all services. 979 (95.6%) of these complaints have been closed. The Trust took an average of 35 days to investigate and close these complaints. At the time of the inspection, there were 45 (4.4%) complaints still open. The Trusts complaints policy states the Trust will aim to provide a substantive response within 25 working days, those cases deemed to be of significant complexity will be afforded a target of 35 working days and the most serious will have a target of 60 working days. The highest reported complaint subject was

Summary of findings

regarding Transport (ambulances and other) 670 complaints. Other high levels of complaints were 156 complaints made regarding attitude of staff and 58 complaints regarding all aspects of clinical treatment.

Are services at this trust well-led?

We rated well-led as requires improvement

Requires improvement

Leadership of the trust

- At the time of the inspection, the Chair, Medical Director, Director of Operations and Chief Quality Officer were all substantive appointments to the Trust Board.
- The Director of Finance was acting as the interim and had been in this role for approximately four weeks prior to the inspection. The trust had launched a recruitment campaign to source a new Chief Executive Officer; at the time of publishing this report, the role of Chief Executive had been successfully recruited to and had started on the 30 May 2017.
- The Chair had undertaken a review of the non-executive appointments and had strengthened the board by appointing specialists in the field of human resources and information technology, and logistics. The Chair was passionate about ensuring the right individuals with the correct skill mix were appointed to the board. The Chair was aligned to ensuring the executive team drove the organisation forwards in terms of delivering high quality, compassionate care and fully embraced the organisations purpose and strategy.
- There was a perception among front-line staff that the executive team were driven by targets and adopted a "Command and Control" style of management. Whilst staff recognised the importance of such an approach, front-line staff reported that this led to a disconnect between the executive and the rest of the workforce.
- The majority of staff felt harassed with the operational targets set, and requirements placed on them, those being the 14-minute turnaround times at emergency departments and the 10-minute pre-checks before the start of shifts. Staff understood the operational demands placed on the service, but were unhappy with the approach from the leadership team. Some staff said they felt pressurised as they were constantly being checked upon and having to justify their actions. It was apparent there was a disconnect between frontline staff and management as to how operational monitoring was managed and communicated.

Summary of findings

- In the 2016 NHS Staff Survey the top five ranking scores for the trust were in good communication between senior managers and staff, opportunities for flexible working, equal opportunities for career progression, and fairness and effectiveness of systems for reporting incidents. The trust scored better than the national 2016 average for ambulance trusts.

Vision and strategy

- In 2014, the trust launched a five year strategy; Caring for the Capital: A strategy for the London Ambulance Service towards 2020. The purpose and vision of the London Ambulance Service was to "Care for people in London: saving lives; providing care; and making sure they get the help they need". (London Ambulance 5 year strategy).
- The trust had set 11 strategic priorities as part of their five year strategy:
  - Make it easy for people in London to get the urgent and emergency care they need quickly
  - Do more for people in London - developing and growing service so that our clinicians can provide more care and treatment for patients at scene or at home.
  - Provide the right response - offer more advice and care via telephone and other technologies; supporting patients to care for themselves.
  - Use technology to improve care so that our clinicians can improve clinical treatment and outcomes; developing telehealth solutions.
  - Develop and invest in our staff so that we have a motivated, stable and engaged workforce.
  - Put clinical standards and education at the heart of what we do.
  - Support the implementation of local priorities and improved urgent and emergency care solutions in partnership with clinical commissioning colleagues.
  - Be a leading health partner - working with partners across health and social care to integrate services so that patients received joined up care and experience better outcomes.
  - Be a leading emergency services provider - collaborate further with other emergency services, whilst remaining at the heart of the NHS, to ensure we are joined up, meeting the needs of, and providing value for people in London.
  - Continue to develop as an organisation with a clear commitment to learning and transformation.
  - Always be there to support London during major events and in times of major incidents.

Summary of findings

- To supplement the five year strategy, the medical director had published a clear clinical strategy which contained clearly defined objectives. The clinical strategy defined how the trust would deliver services in line with the integrated and emergency care plans for each of the five STP footprints pan London. The trust have recognised that there were differences in locally commissioned services and would endeavour to ensure there was an agreed set of minimum standards and appropriate care pathways across London. It was reported the clinical strategy was discussed with 1000 staff who attended the road-shows in October and November 2016.
- There was greater awareness and understanding of the organisations clinical and operational strategy within front-line staff when compared to our findings of the 2015 inspection. There remained small groups of staff who were not able to describe the vision or strategy of the organisation however it was clear that staff were aligned to trusts drive to deliver high quality care.
- In addition to the five year strategy, the executive team were aware of the need for the organisation to align itself with the five key sustainability and transformation plans (STP's) across London. Operational management structures had been restructured in order they aligned with the five STP's so that services were developed to meet the multi-varying needs of the London.
- The trust was working with Commissioners and external health organisations to reduce and manage frequent callers; calls received from care homes; community treatment teams and to address handover delays at hospitals.
- The trust had also developed and utilised an impressive suite of patient specific data to help deliver services tailored to specific areas. For example, the trust was able to use data collected via the emergency operation centre to identify small areas of London where there was an increased frequency of falls being reported. The trust was working with commissioners to deliver services to address this area of concern. The trust acknowledged that further work could be done to address regionally varying conditions and ailments however this required the engagement and input from commissioners and other health providers which was not always forthcoming.
- In June 2016, the trust had also launched a refreshed vision which was labelled "Making the LAS Great". This vision was mapped to the quality improvement plan, which had been introduced following our previous inspection of the trust in 2015.

- All staff received a trust induction which was linked to the LAS values. Staff we spoke with were of the LAS values, as the “3 Cs”, these were care, clinical excellence and commitment. The trust values were also communicated to staff via the trust's intranet 'Pulse'. Whilst almost every staff member we spoke with was passionate about delivering high quality patient care, a number of staff remained cynical about how the organisation brought the values to life. We saw visible signs, posters, and leaflets throughout stations on the trusts vision and purpose. During the inspection, staff fedback they were unhappy with the tall stands, which had been erected at each station we visited. These stands displayed the vision and core values, however staff said they had been purposely made and delivered for our inspection, and some had only been placed at stations the day before our inspection. We observed the stands were too big for some of the stations and had to be placed outside in the enclosed parking areas.

Governance, risk management and quality measurement

- Since our inspection of the trust in 2015, the organisation had migrated it's risk register management to an electronic system within Datix. The trust had undertaken a risk management training programme which had been attended by some 325 managers. A result of the awareness training had led to an increase in the total number of risks being recorded across the organisation. 88% of managers had completed risk management training.
- Whilst there was an increased awareness among managers regarding the identification of risk, there currently did not exist a second tranche of assurance across the operational locations. There was an expectation that local managers identified risks and captured these on their relevant risk register. There was no formal peer review or audit programme available to help identify additional risks within the 70 operational locations spread across the trust; something which the organisation may benefit from to ensure "Fresh eyes" could offer different perspectives in terms of risk management.
- The Risk Compliance and Assurance Group (RCAG) had responsibility for approving the de-escalation of risks currently included on the Board Assurance Framework and trust risk register. Compliance with management of risk at all levels was reviewed by the RCAG, which met monthly.
- Local risks which scored 10 or more were flagged to the trust governance team who would analyse the risk to ensure sufficient and appropriate mitigation's were in place to effectively manage the risk. The governance team were also

responsible for analysing risks across the organisation to aid in identifying commonly reported issues which could be better managed and mitigated organisationally as compared to being locally managed.

- Whilst it is not for the Commission to set policy, as part of the inspection process, we consider compliance against internal policies and identified that, in the instance of risk management within London Ambulance, there existed a disconnect between the organisations risk management policy versus the actual arrangements. We identified examples whereby the corporate risk management policy clearly set out that risks of 14+ would migrate to the trust risk register; we had identified risks of 12 being present on the trust-wide risk register. We had also identified a paper which suggested that risks of 10+ should migrate to the trust risk register. This variation can lead to deviations in policy being applied, as has been the case with the trust.
- Whilst the trust operated a Board Assurance Framework, we concluded that understanding and application of such a framework within the trust was confused. Discussions with both the executive and non-executive team, and a review of the most recent board assurance framework revealed that the BAF was being used as an extension of the trust risk register. The BAF, in it's current guise, included all risks with a net score of 15 or above. Executives described the BAF as being a dynamic assurance framework whereby risks would come and go depending on the net score and agreed mitigation applied to manage risks. There was little correlation between the risks identified on the BAF and the risks likely to impact on the ability of the organisation to deliver their strategic objectives.
- An internal audit on risk management within the organisation was undertaken during July to September 2016. The review included opportunities for improvement, which included changes to the key performance indicator (KPI) for risk management. The new KPI had four measures, which included: having a risk register in place, risk meetings take place on a regular basis, the risk register being complete, and all risks being up to date.
- All risk registers were rated against the four measures and were only rated as green if they were all met. Risk registers were rated as amber if they required minor actions in order to comply with the four elements. Between April to June 2016, 86% of all local risk registers were fully updated. All risks were reviewed monthly and every six months, and rated according to accuracy and frequency of refresh.

- There were a small number of amber rated areas where updates were pending during our inspection. The governance and assurance leads were working with the owners of theses registers to ensure they were regularly updated.
- The Clinical Audit and Research Unit (CARU) provided quarterly update reports to Clinical Audit and Research Steering Group, which included progress against each project and the implementation of actions to improve clinical quality. These reports were also presented to the Clinical Development and Professional Standards Committee who then reported upwards to the Quality Governance Committee and Trust Board.
- The trust produced monthly Clinical Performance Indicators (CPI) and continuous quality monitoring reports that were distributed across services. Key compliance figures were also entered in to the trust's quality dashboard each month, with findings highlighted to the LAS's Executive Leadership Team (ELT) through the monthly Quality Report. In addition, a set of indicators related to Cardiac Arrest, Stroke and St-Elevation Myocardial Infarction were further reported to NHS England through the Ambulance Clinical Quality Indicator dashboard. An Annual Clinical Audit Report, summarising audit findings, achievements and impacts, was also presented directly to the Quality Governance Committee and, through them, to the trust board.
- In order to drive the quality agenda, the trust had appointed a Chief Quality Officer who had taken up post approximately four weeks prior to the inspection. At the time of the inspection, the post holder was undertaking a review of all quality and governance metrics. Further to this, the executive team had identified the need to address the existing executive portfolio arrangements to ensure these were balanced and appropriate. For example, it was identified that currently, not all portfolios leant themselves to ensuring that issues which were likely to impact on quality was held in one place. Whilst matters such as complaints and Coroner rulings fed in to one executive, serious incidents, incident thematics and clinical outcomes fed in to another executive. There therefore lacked a holistic, system wide view of quality. We were however assured that this had been identified and action was being taken to address the matter.

Culture within the trust

- During our inspection of the trust in 2015, it was identified that there existed an underlying culture of bullying within the organisation. The trust had commissioned an independent

external review into bullying and harassment which was undertaken in October and November 2014. As a result of the external review, a range of actions had been instigated to address the concerns and culture within the organisation.

- During this most recent inspection, staff reported that they had seen an improvement in the general culture of the organisation, with a shift towards one of supporting rather than criticising. A small number of staff reported isolated incidents of bullying and harassment continued to exist across the organisation.
- It was noted in minutes from the February 2017 meeting of the Association of Diverse and Minority Ambulance Staff (ADAMAS) forum, which stated that "Any discussions with CQC inspectors should not be minuted/recorded to enable contributors to discuss openly and honestly about their experiences. A lot of attendees (at the ADAMAS forum) raised concerns about being open and honest with CQC inspectors and then being challenged by their managers about their interaction". During this inspection we were advised by staff of such behaviour taking place with anecdotal examples provided whereby people's career progression was dependent on individual interaction with CQC.
- We were given examples of perceived bullying from team leaders and managers to frontline staff. During the inspection, we were shown an example of a message, which had been sent via a local, closed Facebook page. The message was terse and staff at the station told us they were upset at the tone of communication. This then led to the staff feeling dissatisfied and unable to challenge the management for fear of being harassed. For example, they explained their rosters would be altered if they did not agree with the station manager.
- Whilst these examples were extremely isolated, we escalated our concerns to the executive team on conclusion of the inspection and asked for the trust to take the necessary action to ensure the matter was addressed.
- The trust had worked hard to improve the bullying and harassment culture at the service in the past year. The trust recognised they had to do more work to complete in this area. To this end they had recruited a bullying and harassment specialist, who was given the task to deliver a programme to improve culture within the service. So far the service had delivered bullying and awareness training sessions to 716 staff and held 'courageous conversations' workshops attended by 19 staff and mediation workshop attended by 44 staff.
- Bullying and harassment investigation training had been delivered to 69 staff, which had exceeded the QIP target.

Summary of findings

- A new 'Dignity at work' policy had been introduced which placed emphasis on mediation and facilitated conversations to encourage early resolution of concerns. Staff we spoke with were aware of the new policy and of the bullying and harassment contact numbers.
- Both the executive and non-executive members of the trust acknowledged the need for more work to be taken in regards to meeting the requirements of the workforce race equality standards.
- It was widely accepted within the trust, in terms of their workforce, LAS did not represent the local communities within London.
- The trust reported in March 2017 that 84% of the workforce were from a white background, 12.5% from black and minority ethnic (BME) backgrounds and 3% as unknown. This contrasted with the London population of 59% white versus a black and minority ethnic background of 41%.
- We reviewed a proposal document provided by the interim equality and diversity lead, in which it set out its aims to widen the opportunities for black and minority ethnic (BME) people in LAS.
- Current data indicated the LAS employed 5155 staff, of whom only 13% were from BME groups. This was significantly low when the demographics of London were taken into account. BME individuals make up 40% of the London demographics.
- Within the current workforce 101 (11%) BME staff worked in a band 4 role, such as TEACS, EACs and NETs.171 (7.14%) of paramedics and EMTs were BME working at band 5.Non-operational band 5 had 41 (36.6%) BME staff.
- Of the 297 non-operational managers and specialists band 6 & 7, 58 (19.5%) were BME.
- There were 487 Operational teams leaders, senior paramedics and resource staff band 6 & 7, of which 49 (10%) were BME.
- 123 managers band 8a and above, 13 (7.1%) BME. In addition, there were 42 senior managers above band 8c, of whom one (2.3%) were BME.
- No BME staff were employed in the executive team or non-executive director team.
- The majority of BME staff 183 (3%) were employed in operational band 3 roles, followed by 57 (30.5%) in non-operational band 4 roles. Two BME staff (15%) were in operational band 2 roles, and 10 (50%) in non-operational band 2 posts.
- The proposal sets out areas of focus, which include increasing the visibility of leadership, getting ready for future workforce. This would be done by focusing on schools, colleges and

universities, as well as working with voluntary services. Other areas to be addressed include accessibility to recruitment and training opportunities, developing learning opportunities and the re-launch of the leadership programme.

- We reviewed the report presented to the trust board on 4 October 2016, which provided an update on the progress of the workforce race equality scheme, (WRES). This outlined the significant actions taken since the board had signed off the WRES action plan on the 26 July 2016. For example, a board seminar had been held on 8 September for executives and NEDs. This had been led by NHSE joint programme directors. Various meetings had been held with internal and external stakeholders, and external conferences and workshops had been attended. The staff survey undertaken for 2016/17 had also included a number of additional equality and diversity questions.
- The trust had secured £500,000 funding from Health Education England to fund:
  - Outreach into schools to help raise the profile of the London Ambulance Service as an employer and paramedic sciences as a potential career, especially for those from a BME background.
  - Coach and mentor BME staff already within the organisation
  - Support and build the BME staff network to give staff a forum for raising issues and to function as a BME focus group.
- The trust also reported that positive action advertising campaign was underway to encourage BME applicants and applicants from other under-represented communities.
- The relative likelihood of BME staff entering the formal disciplinary process compared to that of white staff entering the same process is a ratio of 0.03 to 0.01 i.e BME staff are three times more likely to enter formal disciplinary processes compared to white staff.
- White staff are 1.6 times more likely to be appointed from shortlisting across all posts within the London Ambulance Service when compared to BME staff; the national average is currently reported as 1.7.
- 74% of white staff believe that the organisation provides equal opportunities for career progression or promotion versus 57% of BME staff. It is of note that the trust has made significant progress in this area when compared to their performance for 2015.
- 18% of BME staff reported that they had personally experienced discrimination at work from a manager or team leader or other

colleagues during the previous 12 months; this compared with 9% of white staff reporting discrimination. Again, the trust has made improvements in this measure when compared to 2015 performance.

- The trust reported that their existing reporting systems did not allow for them to provide specific information to identify how many internal BME staff had applied for and been successfully promoted within the organisation. The trust however reported that of the 41 promotions to have occurred since April 2016, 4 promotions were BME staff. This suggested that approximately 10% of the BME workforce had been promoted in the preceding twelve months.

Fit and Proper Persons

- The trust had a policy and procedure in place for ensuring the trust discharged it's responsibilities as set out in the fit and proper persons regulation. However, whilst the trust had a policy in place, a review of all director and non-executive director personnel files identified missing information. This was contrary to the trust policy, TP107, Fit and Proper Person Policy dated 29 November 2016 and was also contrary to Regulation 5(5)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The trust took immediate action to rectify the shortfalls identified by the inspection team. A follow-up visit to the trust, during which time we reviewed six files belonging to executive and non-executive directors confirmed that all relevant information was contained with the personnel files. The trust had introduced a new system which ensured there was sufficient oversight of director/non-executive records. Each file reviewed contained the relevant information as prescribed by Schedule 3 of the Health and Social Care Act. Gaps in employment history had been explored by the trust prior to any appointment being made; a named executive had been assigned to oversee the ongoing oversight of FPPR requirements. Files were compliant with the trust policy, individuals had signed self declarations as required by trust protocol and insolvency and bankruptcy checks had been carried out. Files contained records of DBS checks, references which reflected the past conduct and performance of directors and proof of identity had also been included.

Public and staff engagement

- The trust had undertaken significant staff engagement activities following the inspection of the trust in 2015.

Summary of findings

- In June 2017, the trust launched "Making the LAS great". This was started to create conversations and engagement locally about personal contributions to the QIP plan. Managers were encouraged to engage with staff on the vision and values of the organisation. 180 conversation packs were issued to all teams, conversation toolkit for managers was provided to support them in engaging with staff, and local videos, social media activity and internal communication channels.
- The corporate communications campaign was a call-to-action for every member of staff around improving the service. The campaign centred on eight must do's, with each having its own communication plan with objectives, deliverables and key messages. Such must-do's included booking an appraisal, medicines management, looking after equipment and keeping information safe.
- We observed posters at stations displayed near medicines with the key message "shut it, local it, prove it, return it". Staff told us medicine management was the biggest improvement they had seen since our last inspection.
- Although the trust had significantly improved their channels, of communication, there was still a sense of disengagement from the staff and this would be an area the trust needs to focus more attention on. For example, although the trust had focused on communicating the vision and core values of the service, staff could not tell us what they were. More focus needed to be spent on why their staff were not fully engaged with the corporate vision and strategy.
- Each week the trust produced a content grid of news stories published across all their internal communications channels on delivery of improvements. This was to ensure received positive stories of the organisation.
- Before our inspection, we held focus groups whereby staff of all levels attended to provide feedback on the service. Staff told us they liked the Facebook closed LAS group. Staff said they were able to ask clinical questions and get answers from senior management. They found it a useful tool for discussing clinical issues. However, local stations had their own closed Facebook and WhatsApp groups and we were not assured of how senior management monitored these.
- In April 2016, the executive leadership team approved the LAS using the University of Warwick's healthcare engagement scale (HES) to measure the engagement of patient facing staff in the different areas of the service. The aim in using HES was to, measure the engagement levels of patient facing staff in

specific areas so they could identify different gaps in each area, and then support local managers to take the right local action. This also gave managers the intelligence to engage with their workforce to improve delivery of the QIP programme.

- 653 members of staff completed the HES survey. The results of the correct survey indicated staff engagement was generally low and the report provided details of staff groups, which were more engaged than others were.
- The results showed staff engagement was more dependent on staff role than staff location. The trust recognised there were current shortfalls in staff engagement, partly due to operational manager's ability to have protected time to have conversations with their staff and the skills and training to enable them to be effective. The director of communications was working with the operations directorate to produce an action plan, which would become part of the director of operations review of the management structure.
- Road shows attended by the chief executive, medical director, and senior leaders in operations were attended by 1000 staff. Some staff told us they had attended the roadshows and found them useful; others said they had not attended due to time constraints.
- The trust undertook a staff friends and family test (FFT) which gave staff the opportunity to feedback on the services provided and whether they would recommend the service to friends and family who may require similar care. There was an increase from 15% in 2015 to 23% in 2016 for the question, "enough staff at my organisation to do my job properly". For recommending the organisation as a place to work, 42% of staff agreed compared to 29% in 2015. For the question "if a friend/relative needed treatment, would you be happy with the standard of care provided" 70% of staff said yes compared to 56% in 2015. This showed the trust was improving in certain areas; however, it was recognised there was still some way to go in increasing staff morale and engagement. The trust will be measured again when the service takes part in the HES survey for 2017.
- Staff were able to nominate staff regardless of role for the services VIP awards, which recognised staff's contribution across the organisation. For 2015/16, 329 nominations were received for staff and 13 finalists were put forward for the award. Over 300 staff attended the event for employee of the year.
- The embargoed staff survey results for 2016 showed out of a total of 88 questions asked the trust were significantly better on 67 of the questions and significantly worse for 0 questions.

Summary of findings

- 42% of staff recommended the organiation as a place to work compared to 29% in 2015. 61% of staff said their immedicate manager valued their work, compared to 47% in 2015. 95% of staff said they had not experienced discrimination from a manager or team leader compared to 85% in 2015.63% of staff often/always felt enthusiastic about their job compared to 55% in 2015. However for the question "not put myself under pressure to come to work when not feeling well enough" had risen from 9% in 2015 to 11%.
- Staff engagement also took the form of newsletters and magazine, for example "Routine Information Bulletin" and, "Insight", a new magazine aimed at providing patient real case scenarios and the sharing of clinical advice and information. Staff were able to get company e-mails through their mobile phones. However, staff still felt disengaged from the management of the service.
- The trusts website provided information on the service and how the public could get in touch and become involved. The website provided information on how they were able to arrange visits for schools, local community events, and colleges. Staff at Isleworth and Croydon station told us of how they attended schools to promote the "Safe drive, stay alive" campaign to promote safe driving for young people. The community involvement officer at Croydon had actively liaised with local CCG's and community services to create local pathways of care and help prevent unnecessary ambulance callouts through training. A few station managers who did not have community officers commented how they would benefit if they did.
- There was an independent Patient's Forum, which met with the trust on a monthly basis. The forum was made up of members of the public. The monitoring of their information was made public on their website and we were told there had been increased engagement with the trust since our last inspection. The Patient's Forum was a diligent well-managed forum that served to improve the patient experience within LAS and provided the voice for the public on services provided by the trust. We would recommend continued strong engagement with the Patient Forum, to enable quality patient insight and empower patients' opinions to be heard within the trust.Some members of the public provided a voluntary service and operated as community first responders. They were given the training to provide care and treatment to patients.
- In 2016, London Ambulance Service opened its doors to the BBC, for a new prime time television series. As a result: over 88% of staff felt proud to work for the service following the documentary, up from 54%. Job applications for control room

and paramedic vacancies more than doubled during the broadcast period. YouGov research found that the programme had changed public perception and two fifths would think twice about calling for an ambulance if the situation was not an emergency. A third of people said will now use other healthcare options, rather than using London Ambulance Service in a non-emergency.

- After the 'What Tops' alcohol awareness campaign, from 1-31 December 2016, LAS attended 5% (307) less alcohol related incidents than 2015, despite a 7% rise in the overall demand. The campaign received 1.9 million impressions across social media channels and the communications team ran two live social media events, which profiled the work of control room and front line staff during a particular busy period.

Innovation, improvement and sustainability

- Several quality improvement projects were underway to ensure cost effective systems were in place. The new vehicle Make Ready hubs had been trialled and were in the process of being implemented across London. Since the introduction of the Make Ready hubs, the trust had seen a reduction in out of service related issues to vehicles and equipment.
- The clinical strategy set out an overarching clinical leadership, responsibilities, and behaviours needed with clear emphasis on assessment and treatment at the scene and in community settings, with transportation to hospital no longer the default option. The strategy included developments and progression focused around the need for strong clinical audits, education, and development requirements and enhanced care provision to specific patient groups.
- The LAS worked together with NHS England to produce the emergency department capacity management, redirect, and closure protocol. These are a set of procedures and protocols emergency department must follow to ease handover delays for LAS staff. This was currently being implemented.
- There was provision of a maternity Pre-Hospital Screening and Action Tool, had helped to give clinician's additional support when attending obstetric related calls.
- The new electronic portal 'MedMan' had enabled the trust to reconcile drug usage forms with completed patient report forms. This also had helped the trust to search and match drugs taken from drug bags and track their administration to patients
- The trust had won "Best social media account of the year" in December 2016 for the most engaging organisation online.
- The trust won a Stonewall award for being one of the top five health and social care organisations. 2016.

Summary of findings

- At the 2016 Pride of Britain Awards, the trust were winners in the emergency services category for a pioneering balloon procedure, which prevented a cyclist from bleeding to death at the roadside.
- The trust was part of the new model of care vanguard scheme, which aimed to provide care in the community setting and reduce the number of patients going to hospital.

Overview of ratings

Our ratings for London Ambulance Service

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Outstanding	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre (EOC)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience	Good	Good	Not rated	Good	Good	Good
NHS 111 service	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Good	Requires improvement	Requires improvement

Our ratings for London Ambulance Service NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Outstanding	Good	Requires improvement	Requires improvement

Notes

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- We observed staff behaviours and heard staff interactions, which demonstrated outstanding care and treatment to patients, and their relatives. Staff were committed to the provision of a compassionate and caring service towards patients, and treated patients and callers on line and at the scene with dignity and respect.
- The trust had employed mental health nurses at their clinical hub to provide expert opinion and assistance to frontline staff when they treated patients with mental health concerns.
- A maternity education programme and maternity pre-screening tools and action plans had ensured staff were able to respond to and support maternity patients.

Areas for improvement

Action the trust MUST take to improve

- Take action to improve staff uptake of mandatory training subjects, including safeguarding vulnerable people and infection prevention and control. The recording of such training must be more efficient and subject to scrutiny.