CareQuality Commission

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust

Quality Report

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Unannounced visits on 12, 17, 19 June 2015.
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information know to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Inadequate	🔴
Emergency and urgent care services	**Inadequate**	🔴
Patient transport services (PTS)	**Requires improvement**	🟠
Emergency operations centre	**Requires improvement**	🟠
Resilience planning	**Inadequate**	🔴
Are acute services at this trust safe?	**Inadequate**	🔴
Are acute services at this trust effective?	**Requires improvement**	🟠
Are acute services at this trust caring?	**Good**	🟢
Are acute services at this trust responsive?	**Requires improvement**	🟠

Summary of findings

Are acute services at this trust well-led?	Inadequate ●

Letter from the Chief Inspector of Hospitals

The London Ambulance Service NHS Trust (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London, which has a population of around 8.6 million people. The trust employs around 4,251 whole time equivalent (WTE) staff who are based at ambulance stations and support offices across London.

The main role of LAS is to respond to emergency 999 calls, 24 hours a day, 365 days a year. 999 calls are received by the emergency operation centres (EOC), where clinical advice is provided and emergency vehicles are dispatched if required. Other services provided by LAS include patient transport services (PTS) for non-emergency patients between community provider locations or their home address; NHS 111 non-emergency number for urgent medical help and/or advice which is not life-threatening; and resilience services which includes the Hazardous Area Response Team (HART).

Our announced inspection of LAS took place between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12, 17 and 19 June 2015. We carried out this inspection as part of the CQC's comprehensive inspection programme.

We inspected four core services:

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

We did not inspect the NHS 111 service provision during this inspection.

Overall, the trust was rated as Inadequate. Caring was rated as Good. Effective and Responsive were rated as Requires Improvement. Safe and Well-led were rated as Inadequate.

Our key findings were as follows:

- The trust was making efforts to recover from a decline in performance which had worsened in late 2014. At

the time of our inspection the interim chief executive was appointed substantively to the post. This was seen as a positive move by many front line staff to assist stability. There had been two previous chief executives in post or appointed since 2012.

- The trust was operating with a shortage of trained paramedics in the light of a national shortage and due to paramedics leaving its service for a number of reasons including better pay elsewhere. It had conducted recruitment of paramedics from as far afield as Australia and New Zealand to combat this.
- We had significant concerns about a reported culture of bullying and harassment in parts of the trust. The trust had commissioned an independent report into this which it had received in November 2014. However this was only presented to the trust board in June 2015.
- We had similar concerns about the trust's provision and use of HART paramedics and the trust's ability to meet the requirements of the National Ambulance Resilience Unit (NARU).
- The trust had been facing increased contractual competition for its patient transport services (PTS) leading to a diminishing workload. It was trialling a new non-emergency transport service (NET) which had begun in September 2014.
- During our inspection we found staff to be highly dedicated to and proud of the important work they were undertaking. At the same time they were open and honest about the challenges they were facing daily. They were largely supportive of their immediate managers but found some senior managers and executives and board members to be remote and lacking an understanding of the issues they were experiencing.

We saw several areas of good practice including:

- The trust's intelligence conveyancing system to help prevent overload of ambulances at any particular hospital emergency department.
- Good levels of clinical advice provided to frontline staff from the trust's clinical hub.

Summary of findings

- We observed staff to be caring and compassionate often in very difficult and distressing circumstances.
- The percentage of cardiac patients receiving primary angioplasty was 95.8% against an England average of 80.7%
- Good multi-disciplinary working with other providers at trust and frontline staff levels.

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

Importantly, the trust must:

- Develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- Recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- Improve its medicines management including:
- Formally appoint and name a board director responsible for overseeing medication errors.
- Review the system of code access arrangements for medicine packs to improve security.
- Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- Set up control systems for the issue and safekeeping of medical gas cylinders.
- Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- Ensure staff report all appropriate incidents and are always encouraged to do so.

In addition the trust should:

- Review and improve trust incident reporting data.
- Ensure all staff understand and can explain what situations need to be reported as safeguarding.
- Review the use of PGDs to support safe and consistent medicines use.
- Improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- Ensure sufficient time for vehicle crews to undertake their daily vehicle checks.

- Ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- Set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- Ensure adequate and ready provision of protective clothing for all ambulance crews.
- Ensure equal provision of ambulance equipment across shifts.
- Improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- Ensure full compliance with bare below the elbow requirements.
- Review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- Set up a system of regular clinical supervision for paramedic and other clinical staff.
- Ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- Increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- Review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- Review patient handover recording systems to be more time efficient.
- Provide NICE cognitive assessment training for frontline ambulance staff.
- Improve training for staff on Mental Capacity Act assessment.
- Ensure all staff receive annual appraisals.
- Review development opportunities for staff.
- Improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- Review maintenance of ambulances to ensure all are fully operational including heating etc.
- Review arrangements in the event of ambulances becoming faulty at weekends.
- Review and improve patient waiting times for PTS patients.
- Ensure PTS booking procedures account for the needs of palliative care patients.
- Develop operational plans to respond to the growing bariatric population in London.

Summary of findings

- Review operational guidelines for managing patients with mental health issues and communicate these to staff.
- Ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- Communicate clearly to all staff the trust's vision and strategy.
- Develop a long term strategy for the Emergency Operations Centres (EOCs).
- Increase the visibility and day to day involvement of the trust executive team and board across all departments.
- Review trust equality and diversity and equality of opportunity policies and practice to address the perception by ethnic minority staff of discrimination and lack of career advancement and by frontline staff that rotas are not family-friendly .
- Review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

On the basis of this inspection I have recommended that the trust be placed in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Inadequate 🔴	The emergency and urgent care service needed to improve several aspects of their services including incident reporting, frontline staffing, medicines management, response times and governance arrangements. Incident reporting was particularly challenging for ambulance crews due to staff shortages and lack of allocated time to complete the forms. As a result, incidents were not consistently reported by staff. The service was affected by a national shortage of paramedics within the NHS and there were a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months. Current staffing numbers and skill mix were monitored to ensure the quality of the service provided and to minimise risk to patients. However, staff worked long hours and many reported feeling high levels of stress and fatigue. Until March 2014 the service was consistently the best performing service in the country to category A calls. Since then there had been a substantial decline in performance, and the target time of 75% of calls being responded to within eight minutes had not been met. Although every ambulance service in England had missed this response target since May 2014, LAS response time for Red 1 and Red 2 category A calls was the worst in the country. We found a large number of frontline staff to be demoralised. Most ambulance crews told us the organisation was a good place to work in the past, but now they felt unsupported by the service and were forced to work with a new rota system which was very demanding with little or no rest between shifts. This had also increased the number of days they were working overall. Bullying and harassment

was a major concern for the organisation. Several frontline ambulance staff perceived that they were bullied by managers; and an independent, external review into bullying and harassment in the organisation found that the problem was widespread.

Staff had access to clinical advice by telephone or over the radio from the clinical hub based at the emergency operation centre (EOC) at any time they required it. However some staff complained of a lack of sufficient direct clinical supervision and observation by senior staff on the road to support them when they were on duty and especially during the winter months. Some newly qualified paramedics told us they had very little support when they first started and were expected to work on the frontline without the guidance of an experienced or senior paramedic while they settled into the role.

Staff were caring and compassionate to patients and people important to them. They explained treatment options in a way that they could understand. Patients and relatives or carers received good emotional support. There was support for vulnerable patients (such as those with a learning disability), bariatric patients and for people whose first language was not English.

Patient records were hand written to a high standard and in accordance with clinical practice guidelines 2013 and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Timely patient assessments were carried out and included a thorough examination prior to taking a course of action, such as providing advice, treating and discharging or conveying to a hospital.

Most frontline staff told us local leadership at their station or substation was reasonably good. However they felt the senior leaders of the organisation were not visible and appeared disconnected from frontline staff and how operational changes affect the day-to-day workload at ground level.

Summary of findings

Patient transport services (PTS)

Requires improvement ●

Some staff were unclear which type of situations needed to be reported as incidents and a culture of under-reporting was evident; however actions were taken to make changes in practice when incidents had been reported. Awareness of safeguarding principles and processes was variable among PTS staff.

Several oxygen cylinders were found to be significantly out of date, and daily vehicle checks were not being completed when required.

Cleanliness of vehicles and equipment used for PTS were not consistently at the expected standard.Some personal protective equipment (PPE), such as gloves, were available on PTS and NET vehicles, however none of the vehicles we inspected contained the full complement of PPE as LAS guidance required.

Clear patient eligibility criteria were in place and key performance indictors (KPI) were identified for each contract. PTS achieved slightly below the KPI target of 95% throughout 2014/15. Service level agreements formed part of the provider contracts and updates were sent through to the service which had commissioned PTS at regular intervals.

PTS crews received regular teaching sessions delivered by work based trainers, either in groups or on a one to one basis if needed. NET crew and control room staff received additional training to complement their new roles.

During our inspection, all observations of care provided by PTS showed patient dignity being maintained and patients treated kindly. PTS crews were respectful to patients and treated them with compassion. Patients and their relatives were complimentary about their interactions with PTS crews and gave examples where crews had tried to create a positive transport experience.

The booking process did not account for the needs of palliative care patients, which meant these vulnerable patients often had

Summary of findings

long waits for transport. Other care providers also described patients having long waits for transport home. PTS did not proactively inform patients or care providers of delays to their transport.

There was demonstrable inconsistency of service oversight within PTS management, such as overseeing day to day tasks, like the accurate completion of daily vehicle checks. Incident reporting and response was also variable depending upon the overseeing manager.

The PTS management team had a thorough understanding of the diminishing workload PTS was facing and had presented a structured exit plan in early 2015, which had been presented to the finance and investment committee, but had yet to receive board approval. There were clear aims for the NET service and plans for its expansion. Staff were positive about the PTS managerial team and their interactions with them.

Emergency operations centre	Requires improvement 🟠	We found that the emergency operations centre was poorly led and it required improvement across the safe and responsive domains. We also found that staff were caring and the emergency operations centre was effective. Staff were not provided with feedback in response to incidents reported by them and did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety. There were also limited opportunities for learning from complaints. Patients' complaints were not routinely discussed to prevent future occurrences or improve the quality of service in response. The surge management plan was not implemented effectively and its incorrect use allowed for routine delays in ambulance dispatch and for prolonged response times. There were delays in call backs made to re-assess risk and provide patients and their relatives with an update. There was no long term strategy for the EOC. There was insufficient operational overview

Summary of findings

and management of staff training development and appraisals. Staff reported a bullying culture and told us that the trust did not proactively act to address it. The restructure of the EOC had not been managed well. Staff reported that there had been no perceived staff involvement and that the restructure had been imposed from the top down. There was no effective flagging system for frequent callers, patients with complex needs, learning disabilities as well as for patients from other vulnerable groups.

We found that calls were monitored for consistency and to ensure advice in line with correct clinical protocols was provided by EOC staff. LAS performed much better for call abandonment than the England average and was best amongst ambulance trusts in England. LAS performed better than all ambulance trusts in the time taken to answer calls. The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust in England. Emergency operations centre services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect.

Resilience planning

Inadequate 🔴

Serious concerns were identified about how the trust had been fulfilling their responsibilities to deliver a Hazardous Area Response Team (HART) capable service to the National Ambulance Resilience Unit (NARU) specification, because of insufficient paramedics. As a result there was not a safe system of working where an effective HART response could be utilised. Incidents were recorded in a log book and staff debriefing took place following major incidents. However, some staff did not routinely receive feedback about the incidents they reported.

Several gaps were identified in the overall skill, training and competence of HART paramedics. For example, low numbers of

Summary of findings

staff had undertaken training in 'confined space' and initial operational response (IOR); and there had been no physical competency assessment of staff in the past two years. There were appropriate special contingencies for dealing with acts of aggression such as improvised explosive devices (IEDs), aircraft incidents and public disorder. The trust worked with national groups to develop policies and support staff around operational HART guidelines.

When the emergency operations centre (EOC) received a 999 call for an incident that would be suitable for a HART response, the call handler sent the nearest HART resource to the incident. However, there was a sense from staff that the HART service was being under-utilised.

The trust's overall emergency preparedness resilience and response (EPRR) assurance compliance levels, showed that plans and work programmes did not appropriately address one or more of the core standards that the organisation was expected to achieve. The risk register did not list insufficient HART paramedics, when we would have expected it to. The NARU NHS Service Specification 2015/16 for HART teams had not been fully implemented.

Some staff felt supported by colleagues and senior management within HART but others felt undervalued by managers outside of the team.

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Overall rating:

Inadequate ●

London Ambulance Service NHS Trust

Detailed findings

Services we looked at

Emergency and urgent care; Patient transport services (PTS); Emergency operations centre (EOC); Resilience planning.

Detailed findings

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Background to London Ambulance Service NHS Trust

London Ambulance Service NHS Trust (LAS), was established in 1965 from nine previously existing services. It became an NHS Trust on 1 April 1996 and covers the capital city of the United Kingdom, which has a population of around 8.6 million people. The trust employs around 4,251 WTE staff.

London Ambulance Service provides an emergency department service to respond to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency; a patient transport service (PTS), for non-emergency patients between community provider locations or their home address and emergency operation centres (EOC), where 999 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: Dr Andrew Welch

Head of Hospital Inspections (Interim): Robert Throw, Care Quality Commission

London Ambulance Service was visited by a team of 54 people including CQC inspectors, inspection managers, national professional advisor, pharmacist inspector, inspection planners and a variety of specialists. The team of specialists comprised of paramedics, urgent care practitioners, operational managers and call handlers.

Detailed findings

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

• Urgent and Emergency Care

• Patient Transport Services

• Resilience Team including the Hazardous Area Response Team

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCGs), the Trust Development Authority, NHS England, and local Healthwatch organisations.

We held interviews, focus groups and drop-in sessions with a range of staff in the service and spoke with staff individually as requested. We talked with staff from acute hospitals who used the service provided by the trust. We spoke with patients and observed how they were being cared for. We also talked with carers and/or family members and reviewed patients' treatment records.

We carried out the announced inspection visit between 1 to 5 and 17 and 18 June 2015 with unannounced inspections on 12 and 19 June 2015.

Facts and data about London Ambulance Service NHS Trust

The London Ambulance Service (LAS) is one of 10 ambulance trusts in England providing emergency medical services to the whole of Greater London. It employs up to 4251 WTE staff who are based at ambulance stations and support offices across London.

Their main role is to respond to emergency 999 calls, 24 hours a day, 365 days a year. Other services they offer include providing pre-arranged patient transport and finding hospital beds.

LAS works closely with other emergency services including the police and the fire services to provide emergency services during major events and in response of any major incidents.

The trust serves entire population Greater London.

Activity:

• The emergency and urgent care service made over 1.4 million vehicle responses to incidents in 2014-15
• The EOC received around 1.9 million 999 calls which averages 5,193 calls per day, in 2014-15

• The PTS made around 115,468 journeys transporting patients across London, in 2014-15

Staff (WTE December 2014): 4251

– 2864 Qualified ambulance service staff

– 1287 Support to clinical staff

– 86 NHS infrastructure support

– 14 Qualified nursing, midwifery & health visiting staff

• **Locations:** 86

• **Financial Performance**

• Fiscal Year 2014/2015

• Income **£301,874,000**

• Full Costs **£300,874,000**

• Surplus **£1,000,000**

Currently the LAS Operations Directorate is being transformed in a formal reorganisation.

Detailed findings

Three geographical areas and the other elements in Operations have been made into four Operational Divisions, each managed by a Deputy Director of Operations.

North and South Divisions deliver the operational core response across the LAS operational area.

Central Operations is a pan London division responsible for Emergency Planning Resilience and Response Department, Cycle and Motor Cycle response units as well as operationally responding managers. Control Services Division also provides the Emergency Operations Centre across London and 111 Call Centre function at Beckenham.

The trust has a total of 70 ambulance stations across London which, for management purposes, currently sits within 26 local operational areas, known as complexes.

Overall performance indicators:

Safe:

95% of 557 incidents reported to NRLS between Jan 2013 and Feb 2015 are reported as 'Low' or 'No' harm.

• There were 26 incidents reported as 'Moderate' harm.

Effective:

LAS performed better than the England average with ROSC overall and Utstein Comparator Group although this has recently dropped below the England average.

• LAS performed best amongst Ambulance Trusts in England for the provision of Primary Angioplasty within 150 minutes.

• LAS performed similar to other Ambulance trusts in all other Clinical Indicators.

Caring:

LAS performed similar to other Ambulance trusts in all questions in the ambulance 'Hear and Treat' survey.

• The number of written complaints received by LAS has increased every year and has doubled over the last five years.

Responsive:

LAS performed much better than the England average and best amongst ambulance trusts in England for call abandonment.

• LAS had the best (lowest) re-contact rate with 24 hours for patients discharged from care by phone.

• LAS performed much better than the England average and best amongst ambulance trusts in England for emergency calls resolved by telephone advice

• LAS performed better than most trusts in the time taken to answer calls.

• LAS has a slightly higher frequent caller rate than the England average.

• LAS performed slightly worse than the England average for incidents managed without the need to transport to an A&E Dept.

• LAS performed similar or slightly worse than other trusts in time to treatment of Category A calls.

• LAS is the worst performing ambulance trust for getting to Category A calls within eight minutes and has failed to reach the 75% target since May 2014.

• LAS has also failed to reach the 95% target for Category A calls reached within 19 minutes since May 2014 and is worse than the England average.

• LAS had the worst (highest) re-contact rate with 24 hours for patients following treatment and discharge at the scene.

Well led:

• LAS staff sickness rate has risen above the England average since May 2014 and has continued to rise.

• The 2014 staff survey results show 29 negative findings with only one positive and one neutral.

• The trust has had more than two changes in chief executive in recent years. At the time of our inspection its interim chief executive was appointed to the post substantively.

Our ratings for this location

Our ratings for this location are:

Emergency and urgent care services

Safe	Inadequate ●
Effective	Inadequate ●
Caring	Good ●
Responsive	Requires improvement ●
Well-led	Inadequate ●
Overall	Inadequate ●

Information about the service

The main role of emergency and urgent care service is to respond to emergency 999 calls, 24 hours a day, 365 days a year. LAS works closely with other emergency services including the police and the fire services to provide emergency services during major events and in response to major incidents. The LAS emergency and urgent care service has nearly 2,864 qualified ambulance staff including paramedics and emergency medical technicians (EMTs) working on the front line services. The trust also has Advanced Paramedic Practitioners (APP), who had extended training to treat and discharge patients.

The APPs received additional training and responded to the most serious one to two per cent of life-threatening incidents. These include patients in cardiac arrest and those who were continually fitting and were difficult to be conveyed to hospital. They were trained to administer more powerful drugs currently only given by a doctor. Their training included a four day trauma course with doctors from the Service and London's Air Ambulance and an advanced paramedic science course at Hertfordshire University. At the time of the inspection there were only 12 APPs in post with a further 12 to be recruited.

Medical staff were employed to provide support to ambulance crews at serious road accidents and other major trauma incidents.

The LAS supported the work of volunteer lifesavers in the capital through a registered charity 'London Ambulance Voluntary Responder Group'. These volunteers provide basic levels of clinical intervention to patients prior to or during the arrival of an ambulance crew. It is made up of : Emergency responders who are clinically-trained volunteers responding on blue lights alongside ambulances to 999 calls; Community first responders who were defibrillator-trained St John Ambulance volunteers. They attend to calls from their homes and respond to 999 calls in their own car without blue lights alongside ambulances; and public-access defibrillator sites where people who work at these locations are trained to use a defibrillator and respond to emergencies while an ambulance is on the way.

The trust has 70 ambulance stations across London. The stations sit within 26 local operational areas known as complexes. The service has a fleet of around 680 emergency vehicles, which include emergency ambulances, fast/rapid response cars, motorcycles and bicycles.

During the inspection we visited 16 ambulance stations across London, and spoke with approximately 110 staff in various roles including paramedics, emergency medical technicians, paramedic students, team leaders, duty station officers, senior managers and the voluntary responder group (VRG). We also conducted focus group discussions with frontline ambulance staff, support staff and community volunteers, to hear their views about the service. We spoke with 45 patients and relatives who had used the service in their own homes or in emergency departments. We also observed patient handovers at emergency departments.

We inspected 36 ambulances and reviewed patient records. We visited 15 hospitals, where we observed the interaction between the ambulance and emergency department staff.

Emergency and urgent care services

We spoke with staff in the emergency departments and other areas of the hospital including maternity, critical care units, stroke units and catheter laboratories about their experience of using the LAS.

Summary of findings

The emergency and urgent care service needed to improve several aspects of their services including incident reporting, frontline staffing, medicines management, response times and governance arrangements. Incident reporting was particularly challenging for ambulance crews due to staff shortages and lack of allocated time to complete the forms. As a result, incidents were not been consistently reported by staff.

The service was affected by a national shortage of paramedics within the NHS and there was a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months. Current staffing numbers and skill mix were monitored to ensure the quality of the service provided and to minimise risk to patients. However, staff worked long hours and many reported experiencing high levels of stress and fatigue.

Until March 2014 the service was consistently the best performing service in the country to category A calls. Since then there had been a substantial decline in performance, and the target time of 75% of calls being responded to within eight minutes had not been met. It was acknowledged that every ambulance service in England had missed this response target since May 2014. However, LAS response time for Red 1 and Red 2 category A calls was the worst in the country.

We found a large number of frontline staff to be demoralised. Most ambulance crews told us the organisation was a good place to work in the past, but now they felt unsupported by the service and were forced to work with a new rota system which was very demanding with little or no rest between shifts. This had also increased the number of days they were working overall. Bullying and harassment was a major concern for the organisation. Several frontline ambulance staff perceived that they were bullied by managers; and an independent, external review into bullying and harassment in the organisation found that the problem was widespread.

Staff had access to clinical advice by telephone or over the radio from the clinical hub based at the emergency

Emergency and urgent care services

operations centre (EOC) at any time they required it. However some staff complained of a lack of sufficient direct clinical supervision and observation by senior staff on the road to support them when they were on duty and especially during the winter months. Some newly qualified paramedics told us they had very little support when they first started and were expected to work on the frontline without the guidance of an experienced or senior paramedic while they settled into the role.

Staff were caring and compassionate to patients and people important to them. They explained treatment options in a way that they could understand. Patients and relatives or carers received good emotional support. There was support for vulnerable patients (such as those with a learning disability), bariatric patients and for people whose first language was not English.

Patient records were hand written to a high standard and in accordance with clinical practice guidelines 2013 and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance. Timely patient assessments were carried out and included a thorough examination prior to taking a course of action, such as providing advice, treating and discharging or conveying to a hospital.

Most frontline staff told us local leadership at their station or substation was reasonably good. However they felt the senior leaders of the organisation were not visible and appeared disconnected from frontline staff and how operational changes affect the day-to-day workload at ground level.

Are emergency and urgent care services safe?

Inadequate 🔴

Figures showed a decline in incident reporting from 5,025 in 2013/14 to 4,175 in 2014/15. There were limited measures and monitoring of safety performance. Staff did not always recognise concerns, incidents or near misses and were afraid of or discouraged from raising concerns and there was a culture of blame. When concerns were raised or things went wrong the approach to reviewing and investigating causes was insufficient and slow. There was little evidence of learning from events or actions taken to improve safety.

There was little systematic and robust incident reporting and management systems in place in terms of comprehensive incident recognition, incident reporting, documentation and closure of reported incidents. Many frontline staff told us they under reported incidents due to the lack of time to complete the paper forms during their shifts and forms not being readily available on vehicles. We also found there was some apathy to reporting incidents due to the lack of feedback.

The safety and risk management team of the LAS could not be assured that there was consistent and accurate reporting of incidents by all members of staff. However, there were some staff making time to report incidents even though they found it very challenging. The LAS used various communication methods to feedback learning from incidents such as the monthly clinical update. However, not all staff accessed these due to lack of time and access to computers on the job. There were no systems and processes in place for LAS to assure itself that all staff had received and read clinical updates. There could really be an important change which all staff need to adhere to. However, if staff were not able to access it on the job, managers would not be able to know whether staff had read the updates.

The LAS had no systems, checks or regular audits in place to ensure medicines removed from paramedic or general drug packs had been administered to patients. This included oral morphine solution and diazepam injections.

Emergency and urgent care services

We found substantial or frequent staff shortages increased risks to people using the service. LAS was affected by a national shortage of paramedics which resulted in a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months. However, there were still insufficient numbers of appropriately trained staff with the necessary skill-mix. Staff reported that working more hours was increasing their fatigue and stress and reduced their recovery time between shifts.

There appeared to be inconsistency in how staff completed their mandatory training. Staff were paid for three days or 24 hours of training per year and were responsible for their own training portfolio. However, staff training was affected by operational pressures and scheduled training was at times cancelled to a due low number of attendees. Clinical advice and support was available to ambulance crews through the central hub at the headquarters at Waterloo, which they could access when on the scene or in transit.

Incidents

- Incidents involving patients or staff were reported on a carbon copy paper form (LA52) by staff. Staff were meant to fill this form in during or at the end of their shift and take it to their home station. A manager based at the station investigated the incident and risk rated it using the trust's risk matrix to establish an appropriate response and level of investigation required. They were expected to write a report on their findings and the outcome and solution if it was addressed locally. However, we saw this was inconsistently adhered to. For example the information provided by the manager in forms we saw was often a repeat of the how the incident occurred and did not identify any lessons learnt.

- The carbon copy of the incident form was filed in the staff member's personnel file; we were told that this allowed managers to identify whether a member of staff was having a recurrent issue with aspects of their work. The top copy of the LA52 was forwarded to the safety and risk team, who input the data onto the electronic incident reporting database called Datix®. After inputting the data, the incident form was sent to the most relevant department for further investigation where appropriate or for their information only. For example, incidents relating to vehicles were forwarded to the fleet department and serious incidents (SIs) to the serious incident department.

- Significant clinical incidents, such as a patient's adverse reaction to a drug, were reported immediately to a manager and control room and/or the safety and risk management team.

- Figures showed a decline in incident reporting between 2013/14 and 2014/15. During the period April 2013 to March 2014, the trust records showed a total of 5,025 incidents; 1,661 incidents related to patient harm and 3,361 related to other issues such as staff accidents, abuse towards staff and equipment issues. However, during the period April 2014 to March 2015, the trust had recorded a total of 4,175 incidents; 1,374 were concerned with patient harm and 2,801 related to other incidents.

- We found the trust did not have good quality, real-time data. The trust's policy was that LA52 forms should reach the safety and risk management team within seven days. However, the average time for forms to reach the team was 12-15 days. We noted the first incident form we tracked indicated the incident took place in August 2014 and although it been investigated at the station within a week the form had not arrived with the safety and risk team until the end of April 2015.

- The safety and risk management team of the trust had a backlog of incidents to input into Datix®. Staff estimated there were around 30 incidents per day across approximately 70 stations. The substantive safety and risk management team was small and understaffed. They relied on a clinical member of staff seconded to the team to input the information. To ensure any serious incidents were not missed, all forms were date stamped and read on the day they received them. Any serious incidents or incidents of concern were identified and forwarded to the relevant department immediately.

- We found that there was an under reporting of incidents across the trust. The safety and risk management team could not be assured that there was consistent and accurate reporting by all members of staff. Several frontline staff told us they under reported incidents due to the lack of time to complete the forms during their shifts and the forms were often not on the vehicles. They told us that when they got back to the station at the end of their shifts, all they wanted to do was 'go home'. Several frontline staff also told us they received limited feedback about the incidents they reported, which resulted in a disincentive to complete the forms in the first place.

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- However, other staff reported completing incident report forms at the end of their shifts in their own time. Nevertheless, many also felt incident reporting was not seen in a positive light by the senior management team and was used as a way to hold them individually to account. We noted that some staff tended to use the LA52 as an accident form, as opposed to an incident form, by which even near misses should be reported.

- Datix® electronic incident reporting was due to be rolled out across the trust from July 2015. This was the third attempt since 2012. It was seen as a positive move as reporting of incidents locally would give the trust and each complex the ability to see concerns in 'real-time', as opposed to months later. As a result, the trust would be able to react in a timely manner rather than miss opportunities to improve. The system would allowed for the feedback from incidents that staff wanted to receive and, with time, themes could be identified. Some staff did express concerns that the roll-out could fail without addressing the current reporting culture or by not rolling it out effectively with the right training.

- Serious incidents (SIs) were investigated in a timely manner and any learning or outcomes were identified by the governance department. However this department was not always completing the evidence of the investigation and outcome on Datix®. Therefore the safety and risk management team were not able to compile any meaningful data and the 'loop' was not being closed.

- All SIs were reviewed by the medical directorate, six months after the incident to ensure learning and changes in practice were appropriate and embedded. However, we found some staff were not aware of the learning from incidents, such as changes to practice, equipment or policy, because they were not presented as being as a direct result of an incident. Despite staff telling us that there was little learning from incidents, we found several examples of such learning. For example, the introduction of paediatric advanced life support bags, team leaders being trained in supraglottic airway management in children and the issuing of personal issue kits that included tympanic thermometers and blood glucose monitoring (BM) kits, were all as a result of learning from incidents.

- Private ambulance providers, who were subcontracted by the LAS to fill gaps in the service, completed the trust's incident report forms and followed the same process as internal crews. There was an LAS responsible officer who coordinated private and voluntary groups and it was their responsibility to investigate any incidents raised by these teams. However, the mechanisms to be assured that these temporary staff members reported all incidents were not robust.

- Some staff reported receiving feedback on reported clinical incidents at a local level whilst others did not.

- At a local level, managers had various ways of sharing important changes in policy or procedure with frontline staff, such as leaving briefing notes in the vehicles. Changes were also communicated through the trust's intranet and on noticeboards. We noted that all notice boards were up to date or held current information. We were also told that changes to practice following incidents were also discussed in training sessions when held.

- We found that the when we questioned frontline staff about the principles of the 'Duty of Candour', this was not well understood by them.

- Serious incidents relating to mental health went to the mental health lead to review. The last major one was in 2012 when the emergency and urgent care teams were called out several days in a row to the same patient who then went on to commit a homicide. The lessons learnt were to do with the importance of LAS contacting mental health services in similar circumstances, because the emergency operations centre (EOC) does not automatically flag people who had called repeatedly; this currently relied on local knowledge.

Mandatory training

- Many staff reported not having received mandatory training for a number of years. Some ambulance crews told us they had not completed any practical manual handling training for five years and other staff who had completed the training did so in their own time as there was no protected time offered to them to undertake training other than the three days allocated to staff at the beginning of the year. Mandatory training figures provided by the trust confirmed that between April 2014 and March 2015, only 52% of front line emergency and urgent care staff attended manual handling, safeguarding level 2 and mental health/dementia awareness training. This was against a trust target of 60%. The figure was lower for bank staff at 29%, for the same training during the corresponding period and with the same target.

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- Frontline staff told us that the training required for them to carry out their jobs was provided and available. We found there to be inconsistency across the service in how staff completed their mandatory training. In some ambulance stations staff were responsible for their own training portfolio and could arrange their training at a time that was suitable to them. They would be rostered as being on a training day accordingly. Other teams were allocated a 'team day' for training and development. This was not consistent across all ambulance stations.

- Staff were paid for 24 hours (three days) per year to undertake mandatory training.This was paid at the beginning of the financial year. If staff did not complete the training, they were 'challenged' by their managers and either had the days deducted from their pay or worked extra days to cover the payment. In these circumstances the mandatory training was not completed.

- Some staff we spoke with perceived they were required to complete mandatory training on their rest day, as opposed to a shift day. There appeared to be some resentment from staff in regard to this as they clearly did not understand that they had been paid for these training days as part of their annual salary.

- There was a mixed opinion as to how often face-to-face training courses were cancelled. Some ambulance crews told us it was rare and only due to operational needs, while others told us it happened regularly, especially if there were not enough people attending. However we found that cancelling courses and not re-instating them left staff unhappy as it meant, due to no fault of their own, their pay was deducted or they had to work an extra day to cover the annual pre-paid training days.

- Most training was via e-learning modules, but the staff found it difficult to access computers during work time, which resulted in low completion rates.

- We found that not all paramedic emergency service staff had completed their mandatory training. Trainers told us that staff training was affected by operational pressures. Some told us that mandatory training was not managed well over the year, resulting in a lot of training to be completed towards the end of the year. Some trainers themselves felt there was not enough subject matter to be cascaded to staff as mandatory training.

- Support staff told us they had access to and completed the required mandatory training; most of which was done through e-learning.

- We were told all ambulance crews were meant to attend conflict resolution training. However, some staff told us they had not received a refresher course on this training for over ten years. However, the safety and risk management team was currently running refresher courses and every member of the ambulance crew was due to have completed their refresher by the end of April 2016. This was repeated on a three yearly basis.

- A member of staff who was an emergency medical technician (EMT), told us they had been working in the service for over six months in a new job role without being formally trained for the job. However, they indicated that the training had been scheduled for the end of August 2015.

- Some of the long serving ambulance crews reported that due to the number of new recruits, training was more focused on new paramedics than existing staff and this was causing some resentment as long-term staff felt devalued.

- Driving training was provided to the Institute of Healthcare Development (IHCD) Ambulance driving standard (the industry standard qualification for ambulance services both in the public and independent sector). A driving licence was required plus C1 category licence. Staff received three days training on ambulance emergency response driving (blue light driving). Staff driving a rapid response vehicle (RRV) were assessed by an LAS driving instructor. However we found some staff who had been in the service for a number of years and drove an ambulance or RRV had not received a driving course or assessment. Although this was not a legal requirement long term operational staff had been told that all drivers would be assessed by an LAS instructor.

Safeguarding

- Staff had a good understanding of what safeguarding concerns might be and all were clear about the process for reporting concerns. However, most of the staff we spoke with had not undertaken any form of safeguarding training but felt they could benefit from undertaking such training[SA1]. Figures provided by the trust confirmed that between April 2014 and March 2015, only 52% of front line emergency and urgent care staff attended safeguarding level 2 training, which was

combined with other training as quoted above. This was against a trust target of 60%. The figure was even lower for bank staff at 29%, for the same training during the corresponding period and with the same target.

- All staff understood what was meant by safeguarding children and vulnerable adults. They could describe the process and the forms used to report concerns. Staff said that they prioritised safeguarding concerns and would report it as soon as possible; however they were not always given the time to complete safeguarding reports. Staff told us they did not get feedback from concerns reported, but as their contact with families or individuals was very brief, they did not see this as a problem.

- Updates to the safeguarding policy and procedures were communicated through the trust's intranet and leaflets. We saw a leaflet updating staff on the key changes on adult and children safeguarding which came into effect in April 2015. Staff we spoke with were aware of the changes and understood the implications for their work.

- Where crews suspected child abuse, a safeguarding referral had to be made for any children in the household to children's services using an LA279 form. Consent was not necessary in this situation.

- Emergency department staff at hospitals told us the ambulance crews were proactive in reporting safeguarding concerns and always identified issues during handovers or privately if more appropriate.

Cleanliness, infection control and hygiene

- We found variable standards of cleanliness, infection control and hygiene across the ambulance stations we visited. Some frontline staff confirmed they had not been trained on infection control. In addition, LAS stipulated that staff should receive annual refresher training on infection control. However some staff had not attended this training for over four years. There was information about infection control available to staff via the trust's intranet 'The Pulse'. There was also an infection control handbook given to each member of staff, which gave guidance to them. However, despite asking the trust for their infection control policy, this was not provided.

- The service had a 'make ready' cleaning team provided by a private contractor. They were the responsible for cleaning and stocking non-24 hour vehicles at night as

well as deep cleaning the vehicles. This work included swabbing for micro-organisms such as methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (C Diff).

- Ambulance crews reported that the performance of the cleaning contractors was variable but were unsure who monitored their work as it took place at night.

- There was inconsistency in the cleanliness of the ambulances we viewed. We found some were visibly clean, whilst others were not. We were shown an ambulance at a station which was identified as having been cleaned 10 days prior to our unannounced inspection and ready to be used. However on physical inspection we noted it had a thick layer of dust on the back of seats, grime in the stretcher tracks and empty wrappers on the floor. Deep cleaning of vehicles happened at different intervals. At some stations it was reported to be every six weeks and others every two months. There was no consistent program of deep cleaning of ambulance vehicles across the service.

- Some ambulances had a deep cleaning identification disk clearly visible in the windscreen. However in many cases, we found these were out of date. We were unable to ascertain whether this was an oversight or whether ambulances were not being deep cleaned as scheduled. It was the ambulance staff's responsibility to clean the ambulance after each patient and we observed staff doing this. If the ambulance was contaminated with bodily fluids after a patient had been conveyed, it was taken out of service until the crew had cleaned it appropriately. Heavily contaminated vehicles were taken out of service for an 'out of schedule' deep clean if this was considered necessary.

- We observed some non-compliance with trust policies such as carrying out a glucose test without wearing gloves. Compliance on using PPE and hand sanitising gel was seen to be high. The trust met with 95% of its 100% target. In North West London hand hygiene audits were done by Duty Station Officers (DSO) going to hospitals and observing staff. The last one that was done was on 9 May 2015. Seventeen crew members were observed and the results were reported to be all very good. At Silvertown ambulance station hand hygiene audits were performed by the team leader.

- All ambulances we viewed had hand-sanitising gel available. Staff had access to hand wash sinks at hospitals' emergency and other departments. We

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observed most ambulance staff washing their hands after caring for a patient.However this was not consistent, as we also saw that some staff did not wash or use hand-sanitising gel prior to leaving the hospital.

- Personal protective equipment (PPE) such as gloves was available for staff to use. We saw most staff wearing gloves during patient contact. However the service had an infection control workbook which stated that aprons do not have to be worn unless appropriate for the situation.

- We observed several ambulance staff were not adhering to the principles of 'bare below the elbow' as a way of minimising the spread of hospital-acquired infection. For example, several kept their wrist watches on, wore rings with stones in and had nail varnish on.

- Cleaning of ambulance stations was contracted out to an independent contractor. We found some ambulance stations we visited not to be clean and some were contaminated with black dust. This dust covered boxes which contained medical supplies. And in some stations the cupboard where sterile supplies were kept were not closed nor locked. Staff told us there was a lack of clarity about what was expected of cleaners and to whom they were accountable.

- We noted colour coded mops and buckets for cleaning were used in line with good practice. However in many places we noticed the buckets were covered with dirty water marks which indicated they had not been washed out adequately and could spread dirt and infections between vehicles. We saw the cleaning schedules for ambulance stations and vehicles, which was done out of normal working hours.

- Sterile consumables were stored correctly on ambulances and soiled equipment such as blankets were generally left at hospitals for cleaning. Where possible ambulance crews obtained replacement blankets from hospitals, but sometimes had to reuse blankets when no spares were available. Crews were aware this was an infection risk and contrary to policy and told us they only reused blankets if they had no bodily fluids or spillages on them. We were told that the reuse of blankets had been a long-standing problem in LAS and there were plans in place to address it.

- We found clinical waste bins overflowing at one ambulance station. We also found clinical waste bins

were not individually locked at many of the stations we visited. However they were locked within the ambulance stations and therefore not accessible to unauthorised persons.

Environment and equipment

- Each ambulance was set out in the same way in respect to the position of the stretcher, chair, and Lifepack machine (which takes blood pressure, does ECGs and blood gas saturation) and internal cupboards and fixings. One make and model of defibrillator was used. However, we found each ambulance crew stored the consumables slightly differently. This meant that should a crew use a different ambulance there may be delays in accessing equipment and consumables in an emergency and vital time could be wasted trying to locate the items.

- Staff on the early shifts tended to take out the newer vehicles and ample supplies of equipment which sometimes left other vehicles for late start short of equipment. Staff reported always having to go round looking for equipment for their vehicles. Some vehicles were not always ready for use. We observed one crew arrive for an 11am shift start; the vehicle had not been left on charge and therefore the electronic equipment on it was not able to be used. At one garage, we observed that none of the waiting ambulances had been plugged in to an electrical supply, therefore the electrical equipment on board might not be charged.

- Some staff told us they would go out on the road as long as they had the two essential items, a defibrillator and bag/valve mask (to force oxygen into the lungs of someone who had stopped breathing). However, LAS had a policy that a paediatric advanced life support (PALS) pack should be carried on all response vehicles. We found some ambulances did not have these in place and were therefore on the road without the required equipment used for children.

- We found that an intraosseous vascular access system was not on all vehicles. This is used in critical situations and life-threatening emergencies, such as cardiac arrest and where there is difficulty in obtaining vascular access.

- Some staff reported a lack of blankets, pillows, finger probes for pulse oximeters (to measure oxygen in blood) and ECG leads (to measure heart rhythm). However,

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others told that there were enough supplies at the central store of each station and that the supply of consumables was said to have improved in recent months.

- Each vehicle was equipped with a mobile data terminal (MDT). This provided staff with all the information they required when attending to calls and details pertaining to the patient, situation, maps and routes. However, there was no backup system such as paper maps, pen and paper, should the MDT fail.

- Not all hand-held airwave radios were working and therefore not all staff carried one each which could place them and a patient at risk if they were unable to contact their colleague or control. We observed on one occasion, a handheld airwave radio was left between the passenger and driver's seat in an unsecured ambulance outside a hospital.

- We were told the service used a flexi-fleet system, where vehicles were used service wide, and no individual station had control of any vehicle. Most of the staff we spoke with said the flexi-fleet system of using vehicles had not worked well. Most staff would have preferred vehicles belonging to an ambulance station for ease of use and proper maintenance and tracking of the vehicle. With flexi-fleet, there was no personal accountability for vehicles. Therefore it was difficult to ascertain how and when damage to a vehicle or equipment may have occurred.

- We were told that the St Helier Ambulance Station had appropriate procedures to ensure that ambulance vehicles were serviced and had valid Ministry of Transport (MOT) test certificates. Records of these tests were kept electronically at the head office. The service had an electronic recall system for calling in vehicles due for service and MOTs. There were staff whose main role was to pick up and drop vehicles to various stations and workshops when they were due for servicing and or MOT.

- Ambulance staff told us there was an effective and efficient system for reporting repairs and breakdowns of equipment. In most ambulance stations, there was spare equipment and a box for keeping faulty equipment for repairs. Some spare equipment was held at the ambulance stations and staff were able to swap faulty equipment where possible. Faulty equipment was labelled and tagged before it was placed in the box for

collection by the logistics team for repairs. We were told that requests for the replacement of faulty equipment were quickly actioned and dispatched to the required ambulance station.

- Ambulance crews reported sharing equipment amongst themselves if something was found to be missing or faulty in their ambulances. A trial of using station-based ambulances to rectify equipment problems was thought by staff to be promising.

- The equipment we inspected was serviced and labelled to show the last service date and when the next service was due.

- Restocking of ambulances, other than the 24 hour ambulances, was carried out by an external contractor. However staff told us the thoroughness of this was variable. For example the "make ready team" sometimes added leads that were not compatible with monitors, so paramedics had to check this daily, and in some cases there was not enough time at the start of the shift to check the vehicle properly. The 'make ready' team were responsible for stock rotation and stocking ambulances to a standard specification.

- In-between calls, ambulance staff could ask for further stock from a hospital, if they were unable to return to an ambulance station. We observed hospital staff offering blankets and oxygen to departing ambulance staff.

- Newer ambulances had scoop stretchers for potential spinal injury, but not all ambulances had this equipment on board.

- The LAS had clearly defined processes in place for reporting vehicle faults through the Vehicle Resource Centre (VRC) 24 hours a day, and staff were made aware of these processes through out of service guidance. In respect of fixing faults, the trust's workshops are in operation seven days a week, with 10 open at weekends during the day. For out of hours the trust has 24 hour cover in place from commercial breakdown services to resolve problems by the roadside or to recover the vehicle to a workshop. These contracts cover general repairs, tyre replacement and vehicle recovery. These services are contacted through the VRC and would be mobilised as and when staff reported a problem. Where vehicles cannot be repaired out of hours the VRC will work to find a replacement vehicle for the crew.

- However we were told by some staff that if there was a problem with an ambulance at weekends, there was no one to report it to or to fix the vehicle. One staff member

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said "some of the vehicles were held together with tape" and showed us where an ambulance had tape to hold the rubber seal to the lift. Also, the light sensor on this vehicle had been taped into position.

- We found ambulance stations were secure. External gates, buildings and garages were locked at all times.

Medicines

- The trust followed the NHS Protect guidance; security standards and guidance for the management and control of controlled drugs in the ambulance sector. There was a controlled drugs accountable officer who submitted quarterly reports to the controlled drugs local intelligence network. We saw controlled drugs were stored securely and managed appropriately. Stock levels were checked daily by senior ambulance station staff and there were clear records when controlled drugs were administered to patients.

- The trust had a list of medicines that could be administered by ambulance staff; this detailed which grades of staff were trained to use each of them. This list was reviewed by the medicines management group. We saw each member of clinical staff were issued with a pocket book 'The UK Ambulance Service Clinical Practice Guidelines 2013' which gave information on the correct dose and type of medicine to be used. Any updates to staff were circulated to staff via the weekly newsletter or the monthly clinical update.

- The trust had a medicines management group which met quarterly. Reports from these meetings showed controlled drugs, Medicines and Healthcare products Regulatory Agency (MHRA) alerts and drug errors were standing items on the agenda. There had been 36 drug errors recorded in the trust between April 2014 and May 2015, and it was the role of the medicines management group to review these.

- The patient report form (PRF) was used to record the administration of medicines. Details of any medicines administered were also verbally given to the emergency department staff during the handover of a patient.

- Paramedic staff were administering medicines under the legal group authority that entitles paramedics to administer some prescription only medicines without a prescription. However the authority to administer some medicines that were used was less clear. Subsequent to our inspection the trust undertook to review these arrangements and ascertain if a PGD (a written

instruction for the administration of medicines to a group of patients who may not be individually identified before presentation for treatment) may be needed for some of these circumstances.

- We were told by the chairman of the medicines management committee, that there was one PGD in place for medicines in the paramedic shift based drug pack, this was for tranexamic acid. This was confirmed by paramedic staff we spoke with.

- The LAS had no effective systems, checks or regular audits in place to check that medicines removed from paramedic or general drugs packs had been given to patients, this included oral morphine solution and diazepam injection.

- However, following a request for further information to the trust after the inspection, they stated that they had reviewed the operational policy and procedure governing the stock control for morphine sulphate for injection and were confident they were robust and fit for purpose. Since our inspection, we were told that the trust had finalised the implementation of a new operational management structure. The trust also submitted their procedures governing the control and distribution of diazepam and were satisfied that their current procedures were robust.

- Medicines were stored in both paramedic shift-based, drug packs and general shift-based drug kits. At the start of each shift, paramedics and technicians collected the appropriate packs from a central store at their base ambulance station and the pack number recorded on a daily check sheet. Any medicines which were administered to patients were recorded on a patient record form (PRF). The packs were then returned to the store at their base ambulance station after the end of each shift. If the pack had been used, staff were supposed to complete a drug usage form which was then returned to the logistics support unit with the used pack for repackaging. However we saw staff were not routinely completing this form and there were a lot of uncompleted opened medicines packs of the same medicines in the medicine cupboard that had not been reused nor returned to the logistics department for re-packing.

- We noted during the inspection that the trust had not responded to the NHS England and MHRA patient safety alert: Improving medication error incident reporting and learning (March 2014) which was a stage 3 directive. The aim of the alert was to increase reporting, improve data

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quality and maximise learning and guide practice to minimise harm from medication errors. The directive stated that by 19 September 2014, each NHS trust should have identified a board level director to have responsibility to oversee medication error incident reporting and learning and identify a Medication Safety Officer (MSO) who would be a member of a new medication safety network. We were told the MSO role had been informally delegated to the chair of the medicines management committee, until a permanent arrangement was in place. However, following a request to the trust for further information after the inspection, senior managers confirmed that they had since appointed an interim MSO who took up the role on 5 August 2015.

- We found the code number for the store cupboards for new medicine packs, the used medicine packs, oxygen and entonox supplies, was the same at each station across London. We were told this was because the logistic support unit collected the packs and it was easier to have the same code number across the entire trust. No one could remember when this code had last been changed. Many of the locks were left on the code number for ease of access.
- The paramedics would not sedate a mental health patient; but if another healthcare professional had administered sedative medication, they would be expected to travel in the ambulance with the patient.
- We observed staff carrying and using the JRCALC Guidelines, which detailed the presentation, indications, contra-indications, actions, cautions, side effects, dosage and route of administration for each drug. Expiry dates of drugs were checked before they were administered.
- Drugs such as hypostop, aspirin, salbutamol, ipratropium bromide and GTN spray, were kept at ambulance stations and ambulance black bags were stocked from this as required. We found quantities of paracetamol and ibuprofen in storage cupboards on racking and work surfaces. There appeared to be no audit trails for prescription only medicines.
- Medical gases were stored safely in locked cages however there was no system in place to identify if gas cylinders were lost or stolen. The trust was not following the NHS protect guidance on the security and storage of medical gas cylinders. It did not have a policy in place for the management and security of medical gas stock and there were no standard operating procedures in

place for escalating concerns around the loss or theft of medical gas cylinders. The trust was not following the NHS protect guidance on the ordering, requisition, receipt and internal distribution of medical gases.

Records

- We reviewed sample of records and found the majority were clear and legible. The format of the patient clinical record form was clearly laid out and followed JRCALC guidance and medical model of patients' record. Patient assessments were carried out by paramedics and included a thorough examination of any life threatening conditions.
- Completed PRF records were kept in the ambulances before being transferred for storage at ambulance stations. We found some of them tucked in the sun visor and left on seats in ambulances. However, this was not always safe as these ambulances were regularly left open and unlocked outside hospitals and sometimes people's homes.
- The Clinical Audit and Research Unit (CARU) undertake specific clinical audit projects. These audits cover a spectrum of patient groups and are usually based on audits of patient records. However most of the staff we spoke with were not aware of any patient records audit being undertaken by the service.
- An automated system audits the delivery of patient records to Management Information (MI) who were responsible for scanning the documents into the portal system. The IT system predicts the number of records that should be generated by counting the number of occasions a responding vehicle is booked at scene via the Mobile Data Terminal. The number of records received by MI is then compared with this figure to identify if any records are missing.
- Hospital staff at receiving hospitals said the level of information from paramedics when handing over patients was appropriate. A copy of the PRF was provided to the receiving hospital and a carbon copy retained by the ambulance crew. If a patient was treated and discharged at the scene, a copy of the PRF was left with the patient.
- Patient record forms required crew members to transcribe information already on work computers such as time call picked up and time of arrival. The carbon copy of the PRF was given to hospital staff and some of them complained that this could be hard to read, especially staff names. This caused problems when

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these forms were scanned into electronic patient records. LAS retained the top copy of the PRF, which was posted in a black box at the ambulance station at end of shifts, to be collated and sent to the headquarters for scanning. The third white carbon copy of the PRF was discarded at the ambulance station, but it was not clear why.

- The system used by the end of life care networks to register advanced care planning (ACP) in London is called Coordinate My Care (CmC). When a new patient was entered on the system, CmC sent an automatic e-mail and the LAS flagged the address.
- The LAS operated a 'location alerts register' to warn frontline staff of possible risks of violence or abuse on entering certain premises. This was based on previous instances involving LAS staff and/or the police attendance at that address. Because the register was address and not person-specific, there did not appear to be a process for multi-occupancy addresses to determine whether the person(s) involved in the original incident still actually lived at the address.
- Staff initially made notes on scrap paper or the back of their gloves when they used a number of treatment interventions quickly. These notes were transferred onto the patient record form on arrival at hospital or at the scene if the patient was not transferred.
- Most staff (apart from two) did not recognise that when a patient had been detained under the Mental Health Act1983 (as amended) (MHA) that the completed forms needed to be brought in the vehicle with the patient. (MHA Code of Practice 17.21)

Assessing and responding to patient risk

- We observed handover of patients to the care of the emergency department healthcare practitioners. Handovers included brief details of the patient's medical history, medication regime, allergies, present condition and details of pre-hospital treatments and observations. Vital signs such as respiration, pulse rate, blood pressure, heart rate monitoring and the patient's condition were recorded on the PRF. Any changes or deterioration in a patient's vital signs or condition was used to inform the clinical decision making process and urgency of the situation.
- In the event of a patient's condition changing or deteriorating, systems and processes were in place for

staff to seek specialist clinical support and advice from the clinical hub based at the EOC whilst at the scene or in transit. Ambulance crews had access to clinical advice 24 hours a day.

- Staff told us if there were concerns over their own or other people's safety they would escalate the matter to the EOC and seek support. They would also contact their team leader or DSO for support where appropriate. There were processes in place for ambulance crews to request back-up from other ambulance crews if the situation required it.
- The service had a clear pathway for ambulance crews to follow when responding to life threatening conditions, emergency or responding to non-life threatening conditions.
- Paramedics monitored patients' condition and had a range of drugs they could use with deteriorating or seriously ill patients. If additional staff were needed, requests could be made to the EOC and support would be dispatched. We were told that on one occasion additional resource requests had not been met by the service.
- Some paramedics expressed frustration about the volume of inappropriate calls that they felt did not require their attendance. They claimed that the Advanced Medical Priority Dispatch System (AMPDS) which triaged calls was ineffective. For example if a patient indicated they were having problems breathing an ambulance would be dispatched immediately. However if the patient was talking coherently with the call handler it was unlikely they were having problems so severe that it required an immediate blue-light response.
- Community first responders and co-responders operated within defined parameters and within a specific locality. They had a cohort of team members who they worked with to cover a specific geographical area.

Staffing

- London Ambulance Service was affected by a national shortage of paramedics which resulted in a high number of vacancies. This led to the recruitment of paramedics from Australia and New Zealand over the past six months.
- Current staffing numbers and skill mix were monitored to ensure the quality of the service provided and to minimise risk to patients. However, we were told by all

Emergency and urgent care services

the ambulance crew members we spoke with that there were insufficient numbers of appropriately trained staff with the necessary skills mix to ensure that patients were safe and received the right level of care. We were told that it was not uncommon for an average of five vehicles not to be staffed for operational use in any given day in some ambulance stations across London.

- Staff shortages meant that fewer ambulances were put on the road than there should be. For example, in North West London, one senior manager told us "on average there should be 280 ambulances, but due to staff shortages we put out 234."

- Following an information request to the trust after the inspection visit, they told us that the establishment for frontline paramedics, emergency medical technicians (EMT) and emergency ambulance crew (EAC) in the emergency and urgent care service was 3162 whole time equivalent (WTE). There was a 5% vacancy rate which was used to allow for overtime incentives, leaving a recruitment target of 3004 WTE posts. This figure was broken down into 1713 paramedic WTE and 1291 non-registered frontline staff (e.g. Emergency Ambulance Crew) WTE.

- However, staffing figures submitted for July 2015, showed shortfalls of between 16 and 26 per cent each day for the number of frontline staff rostered versus the actual number on each shift.

- About a quarter of paramedics were solo responders on fast response units, whilst the vast majority (about 95%) of non-paramedics were crewed with another person in an ambulance.

- Following an information request to the trust, they told us of initiatives they had taken since our visit in June to increase the number of operational frontline staff. These included continuing the recruitment campaign locally as well as from Australia and decreasing the amount of time it takes for new staff to become fully operational. Senior management of the trust expressed a high level of confidence that they would fill their target of 3004 WTE frontline staff in post by the end of November 2015. However, the trust acknowledged all newly recruited staff will not be fully operational until the first quarter of 2016/17, so the staffing pressures will persist until then.

- Staff told us that staff sickness levels and recruiting difficulties posed particular challenges and pressures to those managing and delivering the services at the local level.

- Some staff told us they often worked overtime because the volume of calls had increased and their shifts ran over their finishing time. This has had a negative impact on their work/life balance. Staff told us they were sometimes working beyond the end of their shift to complete their work with a specific patient. Most of the staff we spoke with said they were not able to take their assigned meal breaks. They reported that even when they were allocated a meal break it was sometimes cancelled or they got called back on duty before scheduled.

- We observed staff having drinks and snacks during their shifts, so they were not working for 12 hours without refreshments. Ambulance crews generally alternate driving between themselves to reduce driving pressure.

- Most of the staff we spoke with said they were still being paid on a band five pay scale (5), whereas some of their counterparts elsewhere in the country were being paid at band six (6).

- We were told that the introduction of a staff bank was having a positive impact on staffing levels. Bank staff were satisfied with the pay and conditions of their contracts and comprised of qualified staff wanting flexibility, as well as permanent staff looking for overtime hours. We were told that the Global Resource System (GRS) had 418 active members on the Bank Register.

- The LAS had around 2,000 trained community first responders (CFR). These were volunteers who were trained to attend emergency calls and provided care until the ambulance arrived. There were community defibrillators available to be used by these volunteers. The LAS did not monitor the CFRs directly, as they were line managed by St Johns Ambulance.

- We were told that it was normal for one paramedic in a rapid response vehicle (RRV) to respond to Red 1 and Red 2 calls. These vehicles might on occasions have an additional member of staff, such as a trainee. The role of the paramedic in the RRV is to provide care until supported by the ambulance crew.

- Ambulance crews consisted of one paramedic and one technician/trainee emergency ambulance crew (TEAC), or occasionally have two paramedics working together. If additional paramedics were needed e.g. to help with treatment of patient while travelling, an RRV paramedic might also travel in the ambulance to the hospital.

- There were approximately 120 volunteers in the voluntary responders group (VRG) were not readily

recognised by the regular ambulance staff. It was reported that many DSOs did not know about the VRG as they were not assigned to a particular duty and volunteered for shifts through a diary system.

Anticipated resource and capacity risks

- The service had undertaken rota reviews as part of a service improvement programme to ensure that staffing levels and risks were being managed. Frontline staff were largely unhappy about changes to the existing rotas.

- Some staff we spoke with were aware of the LAS major incident procedures and how such incidents were escalated to the incident command centre. However, other staff we spoke with were unaware of the major incident procedures and most ambulance crews had not been trained in major incident procedures.

- If hospitals were temporarily unable to receive ambulances, they were sometimes diverted to other hospitals. This information was sent to the ambulance crews by the EOC.

- Ambulance crews were aware that they might be called upon if there was a major incident in their own or a neighbouring area. Ambulance crews we spoke with were not involved in planning for major incidents, but had been involved in rehearsals, such as for the Olympics in 2012.

- The EOC monitored the resourcing escalator action plan (REAP) level and staff were asked to be available for overtime, in case additional staff were needed because demands were unexpectedly high.

Professionally requested inter hospital transport

- We spoke with hospital staff at a number of critical care units, maternity and labour wards and cardiac departments in hospitals across the London area about their working relations with the LAS. All of them reported positive working experiences with the LAS.

- Hospital staff were positive about the response from LAS for urgent inter-hospital transfers. Medical professionals from the transferring hospital accompanied patient to the receiving hospital. LAS was not commissioned to undertake non-urgent inter-hospital transfers. These are provided by the hospital patient transport service (PTS).

- Hospital staff told us they had confidence in the LAS staff transporting the patients. They valued the paramedic support particularly when transferring critical patients.

- Most of the hospitals we visited told us they rarely used LAS for 'hospital to home' transfers as most had their own contracted transport services.

Are emergency and urgent care services effective?
(for example, treatment is effective)

Inadequate ●

We found some outcomes for people using the service were below expectations compared with other similar services. The service was not meeting the target response times for category A calls and was the worst performing ambulance trust on this measure. Not all staff were supported to participate in training and development opportunities and there were gaps in management and support arrangements for staff, such as appraisals, supervision and professional development.

The LAS followed both National Institute for Health and Care Excellence (NICE) and Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines. The service had effective relationships with the emergency department and other wards at acute hospitals where they conveyed patients to and from those facilities. There were multidisciplinary working arrangements with acute hospitals, clinical commissioning groups (CCG), community organisations and other emergency ambulance providers.

London Ambulance response times for Red 1 and Red 2 category A calls was one of the worst in the country. Since May 2014 there had been a significant decline in the number of Category A calls attended within the target time of eight minutes. LAS was the worst performing ambulance trust for getting to Category A calls within eight minutes and has failed to reach the 75% target since May 2014. The service had also failed to reach the 95% target for Category A calls reached within 19 minutes since May 2014 and it is worse than the England average. LAS had the worst (highest) re-contact rate within 24 hours for patients following treatment and discharge at the scene.

Most newly recruited ambulance staff had induction programmes, mandatory training, supervision and appraisal, however this varied between each station. Most ambulance staff had training opportunities, but this was inhibited by lack of time to undertake the training as there

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was no in-built training session during a shift. There was also an issue of a limited number of computers for staff to use. Some staff expressed a concern about a lack of career development opportunities.

Staff who drove a vehicle had only attended driver training once since joining the service. Some staff reported that they had not been required to undertake refresher training.

Team leaders had a clinical responsibility for a team of frontline staff and there was a plan for team leaders to supervise frontline staff on their shifts. However, this had not been happening.

There were training and e-learning facilities at designated ambulance stations, where training aids were available and ready for use across the patch and to support the development of JRCALC and NICE guidance. NICE guidelines were circulated to staff through the clinical bulletin updates and service directives. We observed up to date clinical directives on display noticeboards in most stations.

Evidence-based care and treatment

- We observed all staff carrying a copy of the JRCALC guidance and referred to it in their assessment and documentation of patient care.
- We were told by a DSO and other frontline staff that NICE guidelines were circulated to staff through electronic bulletins, clinical updates and directives and staff bulletins. We saw up to date clinical directives and updates on display noticeboards in resource centres or kept in resource files at the ambulance stations we visited.
- Some ambulance staff confirmed they had not been provided with NICE cognitive assessment training that enabled them to identify patients who may have dementia and help with issues such as pain control.
- Training rooms and e-learning facilities were available at some stations, where training aids were available and ready for use across the patch and to support the development of JRCALC and NICE guidance.

Assessment and planning of care

- Ambulance crews followed medical protocols in assessing patients and planning their care. They made effective use of other available protocols, supporting guidance and pathways in their assessment of patients. For example, we saw pathways for congestive

obstructive pulmonary disease (COPD) being used on a patient with exacerbation of their COPD. These protocols and care pathways included children of all ages and other patient groups such as COPD, stroke etc.

- Guidelines in the assessment documentation, prompted ambulance staff to follow a set process when attending to patients. We observed ambulance staff following the assessment process and documentation being completed appropriately. For example, the staff we spoke with demonstrated a clear understanding of the use of alternative care pathways. This pathway was used to assess patients and made an appropriate decision of either conveying the patient to the emergency department or referring them to other more appropriate services. Ambulance crews explained that an increasing number of patients were treated at the scene by ambulance crews ('see and treat') without needing conveyance to hospital.
- Community first responders (CFRs) had been trained to be the first person on scene at an incident. CFRs were deployed effectively to support emergency response and were being integrated into frontline teams. We were told by some of the CFRs that they were not adequately equipped or supported by the LAS to undertake their role. For example in a cohort of 10 CFRs, in a given geographical area, only had one defibrillator available for their use.
- Ambulance crews were required to take patients to the nearest appropriate hospital for treatment. For example, trauma patients would go to a hospital that took trauma patients. A pregnant women were also conveyed to the nearest maternity unit if they were unwell or there was a risk to the unborn infant. However if there is no medical emergency they will, where practicable, be conveyed to their booked unit.
- LAS used a variety of care pathways, in line with what was agreed with their local clinical commissioning group (CCG). For example in Croydon, we saw an alternative care pathway for dealing with falls, cardiac arrest and respiratory failures. Staff had folders with all the reference materials needed to make decision whilst on the scene. LAS referred patients to other services when needed. We saw an example, where the paramedic went on a call, assessed the situation and as a social care were identified, made an appropriate referral to the social services.

Emergency and urgent care services

- "See and treat" was used for about 30% of cases. We did not see many examples of 'see and treat' during our time with crews. Most of our observations involved 'see and convey', as all the calls we attended resulted in taking patients to hospital.
- At hospitals, ambulance crews discharged patients to clinically qualified hospital staff and record the destination code on the PRF.
- We were told that many calls were not appropriate for an ambulance response and the LAS often had to transport people that other agencies should be dealing with.
- The LAS had a special triage worker to screen police requests for ambulances as some were inappropriate for LAS to attend.

Response times

- LAS was consistently the best performing region in the country to category A calls until March 2014. However since then there has been a substantial decline in performance and the target time have not been met in the required percentage of calls.

- The Department of Health requires that 75% of category A (life-threatening) calls should be responded to within eight minutes by a rapid response vehicle (RRV) or ambulance. It was acknowledged that every ambulance service in England had missed this target since May 2014. The England average was 72% of calls responded to within in eight minutes and LAS met this in 67.6% of responses to Red 1 and 59.7% of Red 2 calls between April 2014 to Feb 2015.

- If Red 1 or Red 2 calls were initially attended by an RRV and onward transport was required, the national target stipulates that an ambulance should arrive on the scene within 19 minutes in 95% of cases (A19). LAS achieved 92% of A19 calls responded to within the target time. This was marginally worse than the England average of 93.9%.

- The number of calls nationally has risen by 5% over the last three years and there has been almost a 14% increase in the total number of calls for life-threatening emergencies. The failure to increase the number of ambulance staff at the same pace as demand have contributed to the reduction in performance.

- We were provided with information from the patients' forum that stated 65% of ambulances failed to arrive within the target time of 19 minutes for non-emergency calls. This statistic included patients who had had falls and people suffering from dementia.
- We were told that patients who fell at home experienced long waits for care as a result of a shortage of manned vehicles that could respond in a timely manner.
- Ambulances transporting patients to hospital on Red 1 and Red 2 calls had a 30 minutes turnaround time, from arrival to departure. This included the time to handover to patient and 'down-time'. Crews had 30 minutes from the time they arrived at hospital to the time they left. This comprised of 15 minutes from arrival to handover and then 15 minutes from handover to 'green time' for another call. Staff told us they were often 'pressured' by managers not to maintain the 15 minute down-time. They said they were often made to turnaround without having their 'down-time' between calls.
- There were problems with the service provision in the winter months, when emergency departments were at their busiest. This resulted in ambulance crews being stacked outside emergency departments waiting to handover the patients. Ambulance crews were not allowed to handover patients to emergency departments when the hospital was full. Hence, we heard that in winter, ambulance crews were sometimes queuing to handover patients to emergency departments and therefore unable to answer further calls.
- In March 2015, 2,661 patients across London waited more than 30 minutes in an ambulance outside emergency departments for emergency care and 221 patients waited for 60 minutes.

Pain relief

- Patients were assessed for pain and relief was provided in accordance with the NICE guidance. Staff gave examples of when they had contacted the clinical hub for clinical advice on how to relieve patient's pain. Good pain relief was reported by patients and their relatives. We saw the effective use of entonox being used for pain relief.

Emergency and urgent care services

Patient outcomes

- The proportion of incidents attended and managed without the need to convey the patient to the emergency department was 34%, - the England average was 37%.
- 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.
- LAS achieved 31.6% for ROSC at the time of arrival at hospital following cardiac arrest (April 2013 to November 2014), which was better than the England average of 27.5%.
- The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure.
- LAS achieved 56.5% for the 'Utstein comparator group' at the time of arrival at hospital following cardiac arrest (April 2013 to November 2014), which was better than the England average of 49.9%.
- Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply. Reductions in STEMI mortality and morbidity is influenced by those patients who received the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis.
- LAS had the highest proportion of cardiac patients receiving primary angioplasty within 150 minutes (April 2013 to November 2014). They achieved 95.8%, which was better than the England average of 80.7% and was the best performing ambulance trust. However, in relation to the number of patients who achieved an appropriate care bundle for angioplasty, LAS achieved 72.6%, which was worse than the England average of 80.7%.
- As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.
- The proportion of stroke patients receiving thrombolysis within 60 minutes by LAS (April 2013 to November 2014) was 60.1%. This was just below the England average of 60.6%. In relation to the proportion of suspected stroke patients assessed face to face who received an appropriate care bundle (April 2013 to November 2014), LAS achieved 96.7%, which was just below the England average of 97.1%.
- Coronary heart disease (CHD) is the single most common cause of death in the UK today, and the most common underlying condition to cause patients to die as a result of CHD is cardiac arrest. The presence of a paramedic (or doctor) significantly improves response to and outcome from a cardiac arrest as the paramedic or doctor on scene can begin Advanced Life Support (ALS). Survival to discharge is calculated for two patient groups, the overall group and the same Utstein comparator group.
- LAS achieved 8.3% for the proportion of patients with CHD, discharged from hospital alive (All patients) following cardiac arrest (April 2013 to November 2014), which was just below the England average of 8.7%.
- LAS achieved 28.9% for the proportion of patients discharged from hospital alive (Utstein comparator group) following cardiac arrest (April 2013 to November 2014), which was better than the England average of 26.3%. However it was hard to separate out the role of LAS from the treating hospital. This data has shown a dip in the number of patients discharged alive since September 2014.

Competent staff

- Most frontline staff we spoke with had not received an appraisal in the last three years. This was due to operational pressures and staff shortages which did not allow for staff to be taken off the road for their appraisals. There was a mixed view from staff on the effectiveness of appraisals.
- Paramedics were required to revalidate their registration every two years. As part of the revalidation, they were required to receive clinical supervision. All the ambulance crews we spoke with were registered with the Health Professional Council and therefore had received appropriate clinical supervision for their

Emergency and urgent care services

revalidation requirement. However, we found there were a varied number of opportunities for further clinical supervision as supervisors in some ambulance stations were too busy to attend to facilitate these due to operational pressures.

- Some staff reported that developmental opportunities were limited due to time constraints and lack of appraisals and personal development plans to identify further learning needs. However, this varied across ambulance stations, as some staff spoke positively about access to training in advanced paramedic skills.

- Staff training was via e-learning on computers and face to face modules classroom, but operational staff found it difficult to access computers during work time. Staff did not have dedicated time for non-mandatory training and as such the completion rate for this was low.

- The LAS had preceptorship and clinical supervision sessions for their staff and some staff we spoke with confirmed this. However, some technicians informed us they did not have any form of supervision or preceptorship for over three years.

- Staff who drove a vehicle had only attended driver training once since joining the service. Some reported that they had not been required to undertake refresher training. Staff who had been in the service for many years had never had a driving course.

- There were training facilities at some of the larger ambulance stations such as Brent, Fulham, New Malden and Bromley. Training for new staff such as trainee emergency ambulance technicians and student paramedics combined lessons with practical placements with a mentor and workshops, so knowledge gained in the classroom could be put into practice on the road. There was also training for overseas trained paramedics to work in the UK and for returners from, for example, maternity leave. Staff told us there were more training opportunities for paramedics than for other staff such as Emergency Medical Technicians.

- International recruits had a three week induction period. The corporate induction for British recruits undertaking clinical duties was half a day and for office and support staff, it was one day. Newly recruited paramedics were supported when coming into the service.

- We were told that staff were appropriately trained to provide a safe service to children of all ages. We observed service training for LAS paramedics facilitated by consultant midwives and specialist midwifery advisers from acute hospitals in London.

- Some of the support staff told us they had regular one to one meetings with their line managers and most had an annual appraisal on their performance as required.

- Frontline staff told us they had 'individual learning accounts' (24 hours study days), which were built into their annual duty rota. However, we were told that these days were often cancelled, due to operational needs.

- Paramedics had access to e-learning and annual core skills refresher training, which included one day of mental health training. There are 12 advanced paramedic practitioners, who all had an extra days training on mental health.

- A charity in Croydon sent people who use services to speak to the EOC staff to give them advice and guidance on interacting with people with mental health needs.

- Conflict resolution is a mandatory component of Core Skills Refresher (mandatory) training. 84% of frontline staff attended this training between April and July 2015.This training covered de-escalation, when to call for back up, and the use of reasonable force, but not all frontline staff had had this training.

Coordination with other providers

- From observations we noted staff worked effectively with external organisations, such as the emergency departments in the hospitals. We saw several handovers where information relevant to the patient, including any special notes, was explained in detail to the receiving emergency department staff and a copy of the PRF was left with the staff for their records.

- We spoke with emergency department staff who confirmed that they had a close working relation with the ambulance staff and had never witnessed any poor or concerning practice by ambulance staff. Nursing staff commented that LAS frontline staff were "marvelous". They told us they had a "very good" relationship with them.

- We observed effective joint working and clearly defined roles when we attended a scene of an accident with the police and fire brigade in attendance.

Emergency and urgent care services

- We saw an agreed pathway for patients in mental health crises with a local mental health trust. Patients had to be medically stable and be able to be left alone or with a carer after LAS had attended.
- Patients were transported to the appropriate service based on their needs. For example, renal patients with hospital passports were taken directly to hospital wards.
- We were told that there were mechanisms in place to monitor the effectiveness of the contract with independent emergency ambulance service providers and the 'make ready' team.
- Frontline ambulance staff could access all the contact details for local mental health services so that they knew who to contact when needed. However, when we spoke with paramedics there was limited knowledge of these pathways.
- There were appropriate care pathways agreed with each of the mental health trusts these varied within working hours and out-of-hours. Outside of working hours the patient was more likely to be taken to the emergency department as other appropriate services were closed. Professionals, such as the local crisis team, were then contacted to put in place an appropriate care pathway. This was thought to work well during office hours but there was consistent concern about the support that was provided out-of-hours.
- Local teams had community involvement officers who led on local communication with different agencies.
- Ambulance operations managers tried to attend local meetings with other NHS trusts and healthcare bodies. However operational pressures did not always allow for regular attendance.
- LAS participated in the mental health partnership board with the police and NHS trusts. One of the current issues was about the police just conveying the patient straight to the 'place of safety' and not involving the LAS.
- The trust participated in the National Ambulance Mental Health Group, which facilitated the sharing of best practice across NHS ambulance services; and had worked with two mental health NHS trusts to produce training DVDs on Section 136 of the Mental Health Act 1983 (as amended) and restraint.
- The police made calls to the LAS for an ambulance when people exhibiting agitated mental health behaviour required transporting from one place to another. However, staff told us that it was not uncommon to be 'stepped down' en route, as the situation was often resolved before the ambulance got to the location.

Multidisciplinary working

- The emergency departments, urgent care unit, maternity units, critical care unit and other departments within the acute hospitals were positive about the coordination of care with the LAS staff. The emergency department consultants and other staff we spoke with were all positive about the service provided by the LAS and reported that the co-operation between frontline staff and emergency department staff was very cordial and professional.
- Staff told us about ongoing work with external stakeholders to improve the quality of the services they provided. One example was working with the residents of the Addington Village Estate in the Borough of Croydon to design care pathways, signage and directions for essential services within the estate.
- We observed ambulance staff referred patients to social services for assistance following "see and treat" episodes of care.
- The MDT alerted crews to patients that might present a risk of violence as part of alerting them to jobs.
- They were building up a team of mental health nurses, located in the control room in the "clinical hub". Four were in post at the time of our inspection with a view to recruit a further two. They assessed patients over the phone, help decide if the patient needed to be "conveyed" and if needed have "clinician to clinician" conversations with the trust and arrange for the patient to see a member of staff from the trust. When we spoke with staff working in the ambulances, there was varied knowledge of this resource. Some staff told us they had sought advice and found it helpful, while others were unaware of its existence.
- We witnessed good inter-agency working relationships between the London Ambulance Service and the London Fire Brigade. The London Fire Brigade were contacted to assist with moving a patient from a building site and into the ambulance. They arrived on the scene in rapid time and immediately took control of the situation. The London Fire Brigade used their

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equipment and crew and successfully lifted the patient out of the building and onto a trolley so that the patient could be taken to the hospital for further care and treatment.

Access to information

- General information for staff was through The Pulse intranet and was accessible through the computers in ambulance stations. This contained updates to medical information. Some services on The Pulse could be accessed by staff from their home computers. Information could also be accessed through a monthly Routine Information Bulletin (RIB) which signposted other updates. There was also a "Team Talk" newsletter for less formal staff communication, which was also available in an audio version.
- Ambulance crews had access to special notes including advanced care plans/ directives and 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders through the EOC and were always informed of this before they arrived on the scene.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they involved family and carers if they had not been able to obtain the consent of the patient.
- Paramedics received training in the Mental Capacity Act (MCA) 2005 as part of their induction and mandatory training. LAS provided e-learning on the MCA. There was annual core service refresher training that included the MCA. The mental health leads perception was that staff were more confident in using the MCA and completing MCA assessments (use a standard form called LA5). When we spoke with staff we found variations, with some staff being more confident than others.
- Many staff expressed a lack of confidence working within the Mental Capacity Act 2005 (MCA) and working with mental health patients. Staff were varied in their views on whether they felt they had received sufficient training in this subject, and described it as "very limited". Some training was given during their initial induction and six-monthly core skills refresher training (up to 2 hours).
- Some of the staff we spoke with lacked understanding in relation to 'reasonable restraint' permitted by the MCA generally and Mental Health Act (MHA) during the

conveyance of patients liable under the MHA. Ambulance staff were skilled in de-escalation and the use of equipment, straps and gentle holds to prevent patients from harm.

- The LA5 form was used for formal capacity assessments. This required assessment in accordance with the requirements of the MCA 2005 and the Mental Health Act (MHA) Code of Practice 13.20.
- All ambulances carried a simple decision tool on capacity and consent. Ambulance crews understood that they could intervene with a person with mental health issues in order to provide 'a life-sustaining intervention' or to do a 'vital act to prevent a serious deterioration in their condition'. There was access to mental health support through mental health nurses in the clinical hub.
- There was an algorithm for dealing with mental health patients by ambulance crews. However, most of the ambulance staff we spoke with said they were not confident in dealing with patients with mental health issues. There was guidance on conveying mental health patients, which all staff had to adhere to for their safety and security.
- The EOC notified ambulance crews if a patient had a known mental health problem, but this was not always clear when calls were assigned to the ambulance crews.
- Staff experience of delivering care and treatment to people with mental health needs was varied, with few regularly supporting people with mental health needs, and others having limited experience.
- The paramedics will always risk assess the situation and ask for police assistance if a patient is or may be aggressive. The LAS had introduced a risk assessment tool – to assist paramedics to assess patients and record decisions. There was varied knowledge of this. Not all staff made reference to it, although others noted that they found it helpful.

Are emergency and urgent care services caring?

Good ●

Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treat people.

Emergency and urgent care services

Frontline staff treated patients with respect. Ambulance crews explained treatment and care options in a way that patients understood. We saw staff respected patient choices and preferences and were supportive of their cultures, faith and background.

Patients and their relatives and carers felt well-informed and involved in the decisions and plans of care. Ambulance staff explained and involved patients and their relatives in decisions about whether to it was appropriate to take them to hospital or not.

Patients were supported to manage their own health by using non-emergency services such as their GP or local urgent care centre when it was appropriate to do so. Patients, their relatives and other people important to them received emotional and practical support.

Compassionate care

- Patients and relatives told us they were 'satisfied' with the treatment and care they received from ambulance crews. A patient and their relative told us they were treated with "respect", whilst being conveyed to hospital. They described how the ambulance crew, carefully and compassionately escorted the patient from the house to the ambulance.
- We observed patients being treated with respect by ambulance staff throughout our inspection. Ambulance crews consistently showed patience and sensitivity to the needs of patients. Ambulance crews asked how patients wanted to be addressed and introduced themselves
- We observed ambulance crews caring for patients in public places. They maintained their dignity through the use of blankets and by asking bystanders to move away. Once the patient was stabilised, they were moved to the ambulance for further tests and/or treatment. Ambulance doors were closed to ensure patient privacy.
- Patients conveyed to hospital were covered in a blanket to maintain their modesty and keep them warm while on a stretcher or in a wheelchair. Ambulance crews maintained the dignity of patients when transferring them from stretcher to a cubicle bed.
- We heard ambulance crews speaking to patients in a kind and supportive manner while treating them. We also heard ambulance crews interacting with patients on a personal level and speaking to them in a reassuring way.

- Patients told us ambulance crews were professional and had a warm and understanding manner which reassured them. One person said "they were the epitome of kindness".
- Ambulance crews were able to describe how they would support a person with mental health concerns through reassurance and calm interactions.
- All the interactions we observed were non-judgmental and treated each patient as an individual whatever their circumstances were.

Understanding and involvement of patients and those close to them

- Patients and those close to them reported being involved in their care and treatment. They told us ambulance crews explained what they were doing and the care and treatment options available, such as being treated at the scene followed by discharge or being conveyed to a hospital if that was the assessed as the most appropriate option.
- One patient told us the ambulance crew had spoken to their relative in India over Skype (an internet communication) in order to reassure the family and to explain the situation and the next steps.
- We observed during handovers from ambulance to emergency department staff that patients were engaged in the conversation and were encouraged to ask questions and raise any concerns they had as part of the handover process.
- Carers were asked to help with assessments and were also allowed to accompany the patient if they were taken to hospital.

Emotional support

- All the patients we spoke with said ambulance crews consistently reassured them. One patient said, "they asked me about my life and talked about general things, it really cheered me up and distracted me while I was in pain."
- We observed ambulance crews being very calm and supportive to distressed patients and their relatives. We saw a member of an ambulance crew give an emotional relative a reassuring hug.
- Ambulance crews told us how they supported families and people close to patients who died in their care. They were aware that at this time, the most important people were the bereaved. They explained they would stay with the family until such time it was appropriate to leave. They were also able to explain how they would

Emergency and urgent care services

support the family in understanding the next steps. We saw a bereavement booklet the ambulance staff, gave to relatives if they attended a call to someone who had died.

Supporting people to manage their own health

- We heard an ambulance crew member telephone a relative about their family member who was treated and discharged at home for whom it was decided would be more suitably referred to the community nursing team.
- We observed an ambulance crew give health advice to patients on how to treat their symptoms of chronic illness at home. For example, one patient's relative was reminded to give paracetamol at the first sign of a high temperature and consult their care plan for corrective action to be taken. Another patient who had chronic obstructive pulmonary disease (COPD), was advised to use their oxygen and nebuliser and contact their GP if the situation got worse.

> **Are emergency and urgent care services responsive to people's needs?**
> (for example, to feedback?)
>
> **Requires improvement** 🟠

The emergency and urgent care service was being planned around the needs of the population of the greater London area. The service was dealing with an increasing number of emergency calls and action was being taken on long waiting times for ambulances. LAS had also introduced measures to ensure that people were monitored while waiting and high-priority calls took precedence over non-urgent calls.

The service had limited specialist vehicles for obese or bariatric patients. However, we were told that newest range of LAS ambulances being introduced had a trolley bed capable of carrying patients weighing up to 50 stone.

A telephone translation service was available. Staff said they used this when necessary and they were sometimes assisted by family members when in a person's home.

LAS had a low rate of abandoned calls, so most callers were able to make contact with the ambulance service. However, London also had a higher than average number of frequent callers.

Service planning and delivery to meet the needs of local people

- LAS tracked the locations of its ambulances and RRVs (which were all geotagged) to identify the nearest vehicle to respond to a call. Arrival of ambulances at emergency departments and their departure was also monitored. This enabled the service to centrally manage the response times to calls and to identify pressure points in the area.
- The service had introduced a more advanced triage system resulting in an increased use of the 'hear and treat' system. This improved responsiveness as patients were able to receive faster care and treatment through more appropriate pathways.

Meeting people's individual needs

- A telephone translation service was available. Staff said they used this when necessary and they were sometimes assisted by family members when in a patient's home. We spoke with one translator and a patient they were supporting. They had been called to the patient's home and stayed with the patient at the hospital. They told us the ambulance staff had been very patient and explained everything very clearly in order for them to translate to the patient.
- Staff carried a booklet with clear pictorial aids that could be used for people with learning difficulties. There was also a multi-lingual pocket phrase book to help staff communicate with patients who spoke little English. In addition, the back of the PRF showed pictorially different levels of pain and this could be shown to a patient to assess their pain score. This part of the PRF also contained an assessment guide for helping ambulance staff identify people with mental health needs, including assessing their mental capacity and obtaining consent.
- Some staff had training in caring for patients living with dementia and we saw some positive interactions with these patients. LAS community involvement officers, in areas where they were available, worked with care homes to minimise inappropriate ambulance calls for older people who could often be cared for more appropriately in a familiar place.
- A family member told us the ambulance crew waited for them to get into their car so they could follow the ambulance to the hospital as they were unsure of the way.

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- Ambulance staff were aware of the patient passport system, which some patients with specific conditions used, for example renal conditions and cancer. This passport indicated the specific hospital and ward to attend if presenting with certain symptoms. This meant patients received care in the most appropriate place for their needs in a timely manner
- LAS commissioned focus groups with the Alzheimer's Society and Age Concern to hear about how the services could improve.
- The service had limited specialist vehicles for obese or bariatric patients. For most people in this group, the first response crew would provide immediate support. If specialist transport was required the DSO attended the scene to assess the needs of the patient and approve the use of a bariatric vehicle or of the Hazardous Area Response Team (HART) which is a team comprised of specially trained personnel. Staff admitted that this potentially delayed the patient's admission to hospital. We were told that the newest range of LAS ambulances had a trolley bed capable of carrying patients weighing up to 50 stone which would decrease any potential delays for this patient group in future.
- There were no operational plans to respond appropriately to the growing bariatric population in London or to train staff in the assessment of patients and the use of specialist manual handling and clinical equipment during their care and treatment of this group of patients.
- The Mental Health Act (MHA) Code of Practice (Parts 17.3 to 17.6) states that consideration should be given to the most appropriate method of transport for mental health patients. We found that mental health calls were triaged and if a person was at immediate risk, a Red call was put out. Patients under Section 136 of the MHA were conveyed in general ambulances and not in cars or police vehicles.
- There was some inconsistency across London in managing patients with mental health issues. This was in part because of the capacity of emergency departments, and ambulance crews reported that some hospitals offered better support than others. There were stronger relations between the service and mental health services in some areas than in others. Patients in emergency departments needing to be transferred to a more appropriate facility or place of safety could often wait for more than 60 minutes as they were considered a lower risk than a patient at home.

- There was a flagging system for addresses for a number of issues: where there were risks of violence to ambulance staff, where drugs were misused, or where specialist equipment had been used in the past.
- We saw a number of care pathways used to redirect appropriate patients with minor ailments and minor injuries to health centres.
- LAS had contracts with private ambulances (to meet shortfalls in the service provision), and where clinically appropriate used taxis to convey patients to hospitals. Using these services meant there was no advanced notification given to the hospital as these vehicles and calls could not be tracked through the central monitoring system which was displayed in the emergency department. Hospital staff we spoke with told us that they had not come across any instances where a patient was inappropriately transported this way and not knowing about their intended arrival had not caused any issues to the service.
- Volunteer community first responders were used (including people from the armed forces and off duty police). They had a five day training course organised in conjunction with the St Johns Ambulance; and monthly updates as necessary. They used an online diary to book in and staff that were aware of their existence said they provided a valuable supplementary support service to the LAS.
- We saw a number of care pathways used to redirect appropriate patients with minor ailments and minor injuries to health centres or GP services.

Access and flow
- LAS had a low rate of abandoned calls, so most callers were able to make contact with the ambulance service. However, London also had a higher than average number of frequent callers.
- The presenting symptoms described in the call determined how quickly an ambulance was dispatched. Nationally, the total number of ambulance calls had risen by 5% over three years and there had been a 14% increase in the number of calls classified as urgent.
- Response times of emergency vehicles were monitored centrally. Ambulance staff said that sometimes no vehicles were available to attend a red call in a specific area. In such circumstances, a call would go out on the open channel asking for teams from other areas to assist.

Emergency and urgent care services

- LAS resolved more calls by telephone (13.3%) against an average of 8% nationally, but was below average for managing incidents without taking patients to emergency departments.
- In some areas, there was an agreement with the acute trust (Agreement Flow) on the number of ambulances that could arrive within an hour (e.g. Croydon hospital's agreement for seven ambulances an hour). This helped ensure the hospitals could receive and treat patients efficiently without ambulances queuing outside emergency departments which both delayed patient treatment and prevented ambulances from responding to new calls. Where these agreements were in place, they were subject to regular review.
- There was a high proportion (nearly 8%) of re-contact of people treated and discharged at the scene, but a very low re-contact rate of others who were conveyed (2%).
- We were told that the LAS had a focus on not taking patients with mental health problems to hospital unnecessarily. They may choose to contact the local mental health services instead. This sometimes meant ambulance staff had to stay with the patient for their own safety until other appropriate care professionals arrived.

Learning from complaints and concerns

- Some patients and relatives gave positive feedback to ambulance staff at the time, and others wrote to the headquarters. We were told that compliments received centrally were disseminated to relevant staff and sometimes used as a staff magazine feature.
- LAS had a central patient experience team to manage feedback and complaints. This team instructed the DSO or team leader of the relevant local ambulance station to investigate a complaint and respond to them with their findings. Following the investigation and findings a formal letter outlining the investigation and outcome was sent to the complainant. Complaints were logged by ambulance station and categorised by main themes and sub themes.
- There was no information on how to make a complaint in ambulances. Frontline staff did not have any information to give to patients or relatives about how to make complaints, but said that if asked, they would advise people to contact the headquarters or look at the

LAS website. Ambulance crews said where possible, they would try to allay the concerns of patients or relatives at the time, so their concern did not lead to a formal complaint.
- The LAS website had a section for enquiries, feedback and complaints. This explained the LAS agreed standard of responding to enquiries within 25 working days where possible. It also highlighted the possibility of reporting an incident such as ambulance delay, communication issues or clinical care provided by ambulance staff. The vast majority of complaints were about response times. However, most people we spoke with were pleased with the service and did not wish to complain.
- Although the LAS vision included using staff and patient feedback and experience to improve care, ambulance crews were not able to give us clear examples of change resulting from complaints. However, some staff told us that investigation of specific complaints had led to them being asked to reflect on their practice.
- Some frontline staff reported that some learning took place following complaints, but staff were not always aware of these. Learning was disseminated during the core service refreshers training and the monthly clinical update. Staff could give us examples of learning through complaints, such as the current ectopic pregnancy procedure which was developed as a result of a complaint.

Are emergency and urgent care services well-led?

Inadequate 🔴

Staff perceived there to be a bullying, harassing and discriminatory culture in the organisation. Staff were not engaged with the vision and values of the organisation, although they displayed them through their own attributes. There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. The lack of openness and transparency resulted in the identification of risk, issues and concerns being discouraged or repressed. We found that there was minimal evidence of learning and reflective practice and the impact of service changes on the quality of care provided at ground level was not understood.

Emergency and urgent care services

The LAS had a vision and strategy for the way in which they wanted to provide the service. However, most ambulance staff were not clear about what this was and were not engaged with the development of the service's vision and strategy. Some staff were positive about the direct local leadership, but felt that there was a lack of consultation and consideration by senior management about how things worked on the frontline. There were significant concerns raised by many staff about their perceived bullying and harassment culture within the organisation and they did not feel valued or listened to. Governance arrangements were inconsistent and many frontline staff had no named line manager.

Public engagement activity took place in many forms including community liaison, school and town fayres and presentation to other stakeholders. Regular communication with remote and lone workers took place through the weekly 'Routine Information Bulletin' (RIB). Some staff had identified the need for more engagement about shifts and flexible working. The impact of changes to the management structures was also raised as a concern. Recent starters confirmed they had had preceptorship in which they were supported by a mentor to gain confidence in the role and learn necessary skills for their new profession. Some frontline staff felt the organisation was good to work for and they felt supported by the service. However, many thought and we witnessed that the morale of frontline staff was very low.

Individual stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/satellite stations. This meant the DSOs and other staff had no way of monitoring their risks.

Vision and strategy for this service

- Duty Station Officers (DSO) and team leaders were aware of the purpose and values of the service. However, most of the ambulance staff were not able to articulate this in the words used by the trust. However we could see through discussions, observations and their commitment to emergency care and saving lives that their individual values and behaviour aligned with the trust's objectives. Most frontline staff told us they did not feel that they had been involved in developing the service's values and strategy.
- Information about the service vision and strategy were not displayed anywhere within the stations we visited, although the LAS's presentation to the CQC during the

inspection was on the noticeboards in some of the larger ambulance stations. Most of the ambulance crews we spoke with could not name the three values of 'Care, Clinical Excellence and Commitment', although we saw staff displaying these patient-focused values in practice.

- Most of the ambulance crews we spoke with demonstrated their passion and drive to provide a high quality and safe service; however they were not aware that the LAS's values included supporting and developing staff.
- Most communication with staff was in writing via noticeboards, emails or recorded messages. The different shift patterns and limited time spent at base stations, inherent in operational roles, limited the opportunities for face to face meetings.

Governance, risk management and quality measurement

- Performance was monitored and reported at ambulance station level. The Resourcing Escalator Action Plan (REAP) level was displayed in stations and managers received comparative performance data on stations.
- Individual stations did not hold local risk registers to identify issues or concerns relating to the station and its sub/satellite stations. This meant the DSO and staff had no way of monitoring their risks. Ambulance crews and other office-based administrative staff we spoke with had no knowledge of what their risks were. However, we were told that operational managers monitored their risks through incident reporting and real-time data about demands on the service, but this information was not shared with the staff at local level.
- Although incident reporting was centralised, DSOs were responsible for grading incidents and investigations, which gave them some overview of incident trends locally and were in a position to discuss issues as necessary with individual staff.
- Ambulances on the scene were sometimes left unattended, but locked while staff treated patients. We found examples of ambulances at emergency departments left unlocked and unattended. However, cupboards in the ambulances were locked; doors were shut and no medicines were in view. The mental health lead monitored the numbers of incidents and complaints, and went out to meet and discuss mental health patient care with ambulance crews.

Emergency and urgent care services

- An internal mental health committee meeting occurred every two months and monitored the progress with meeting the actions agreed for mental health services.
- The work of Voluntary Responder Group (VRG) is monitored. Regular monitoring is undertaken through Core Performance Indicators (CPIs) for all VRGs, reviewing their PRFs and selected PRFs are reviewed by Team Leaders (TLs) and individual feedback given. All VRG members are required to attend Continuous Professional Development (CPD) evenings and central records are maintained.
- All CFRs and ER teams have a coordinator and there are quarterly co-ordinator meetings that they attend to share best practice, receive updates and consult on service developments. They are then required to share this information with their teams. The CFRs as individuals have a bi-monthly team meeting and they are required to attend at least one per month which is used for the same purpose.
- However, some of the VRG's we spoke with during the inspection, told us their work was not monitored by the service and they received no feedback on how their support contributed to the LAS performance.
- People using the service had basic information collected about them and this was audited using a clinical practice indicator to ensure information was collected appropriately.

Leadership of service
- Staff told us local leadership at ambulance stations was reasonably good but the senior leadership of the organisation was not visible and disconnected from frontline staff.
- Several members of staff told us the management style of the chief executive was received favourably by the staff. Many staff thought having a chief executive with a clinical focus would improve the service and staff retention and provide a balance to the operational need to achieve their target.
- However some technicians told us they had never seen their team leader and had found contacting them 'difficult'. They stated that they were unable to contact anyone by phone and the more senior the person was, the harder it was to contact them. They commented on the lack of team meetings and found it difficult to access training, which was often cancelled.
- Team leaders did not manage a dedicated team, but were available to support any member of the frontline

team who required support. However, they were generally known to ambulance staff because they were based at ambulance stations, although face to face contact was limited because of different shift patterns and because managers also had an operational role so were often attending incidents as well. Not all team leader posts had been filled under the new structure, which further exacerbated this problem. Most of the communication with crew members was in writing.
- Some of the staff we spoke with thought local leadership from DSOs, team leaders and clinical supervisors at their station or substation was good. They felt, there was a good camaraderie among frontline staff that enabled effective mutual support, encouragement and advice to each other. We saw evidence of this in the way staff interacted both in attending incidents and at shift changeover in the ambulance station.
- Operational staff said they rarely saw senior managers based at the headquarters. Some frontline staff believed very senior managers lacked understanding of the day to day reality of their working lives. Staff said there had been a lack of consultation about the restructuring and the changes to rotas and shift patterns introduced in September 2014.
- Sickness amongst ambulance staff in London had traditionally been higher than the England average and had risen over the previous year to 7% compared to England average of 6.4%.
- Staff were aware of national targets. They recognised that ongoing problems of staff shortages and staff turnover in the service, meant that time targets were often not achievable. Staff felt senior managers had little recognition of the pressure that unachievable targets imposed on staff. Some staff said they prioritised patient safety over meeting time targets. Some staff were concerned that working long hours without rest breaks or working shifts of six days in a row was a risk to their own health and safety, as well as potentially to patient safety.
- There was a policy for lone workers to follow to promote their safety. This included flowcharts of when to wait for back-up before attending an incident, when a call had been deemed high risk. Staff we spoke with who worked alone on rapid response vehicles (RRVs) and motorbikes did not express any concerns about their personal safety. They all told us they would request assistance from an ambulance crew or the police if needed.

Emergency and urgent care services

- The director of nursing and quality was the lead director for mental health. There was also a clinical lead for mental health to provide leadership, who worked to the director of nursing.
- Administration staff were accountable to the managers at the station they worked from. Each administration team had developed their role at a local level. We were told that it would be difficult for them to work across stations in order to provide support for absences'; this was because no two stations had the same responsibilities. The administration staff told us they would like to have the opportunity to meet with other ambulance station administrative teams in order to discuss issues and concerns and new ways of doing things. They told us they would value an administration manager who had oversight across the organisation.

Culture within the service

- Some staff reported a culture of fear amongst frontline staff. Some told us they were unwilling to use their initiative when appropriate or raise concerns with their managers out of fear of repercussions. One paramedic told us "If I saw something really bad I might report it, but the organisation doesn't support whistleblowing." Several others told us that they would not 'whistleblow' for fear of reprisals. Several frontline crew members reported that they would still convey a patient to hospital, even though they did not require it, due to fear of being disciplined or dismissed. However, support staff told us that felt able to raise their concerns with their line managers.
- Bullying and harassment was reported to us by several frontline staff, and a few black and minority ethnic staff stated that at times they felt 'humiliated' and 'ignored' by managers. Some claimed that they were overlooked for promotion.
- We were given many examples of perceived bullying and harassment experienced by frontline emergency and urgent care staff. For example, a few staff perceived that they were bullied into complying with the 14 minute turnaround time at emergency departments.
- During the inspection, we were made aware of the findings of an independent external review into bullying and harassment in LAS, which was undertaken in October and November 2014. The reason for the review was the rise in reported incidents of bullying and harassment in the 2014 LAS results from the NHS Staff Survey. The executive team having sight of this report in

November 2014, but only presented to the board in June 2015. Both the report and the delay in presenting it to the board was concern for us. The report found that there was bullying and harassment in LAS with 68% of the 327 staff surveyed stating that they had been bullied and harassed in the workplace. The report made 11 recommendations, none of which had been actioned by the time of our inspection. There was no written action plan to address report findings and recommendations.

- Frontline staff reported that there was a 'heavy' use of disciplinary action by management and black and minority staff were said to be over-represented.
- One staff member stated the London Ambulance Service "has been a difficult place to work in the past year". They told us that the organisation has been under "a lot of pressure, but there have been improvements in the past few months". They claimed that the focus on performance had been the main driver of the pressure.
- One team leader told us "our utilisation rate was ridiculous; staff cannot keep going to call after call". Another said that "although frontline staff utilisation rate was at 85%, they were challenged by commissioners to be more efficient".
- Several frontline staff reported morale to be low due to 'workload pressures'. These included a high number of resignations, mental exhaustion, lack of career progression, lack of feedback from managers, long working hours, pay scale in comparison to other services and lack of recognition for hard work. Morale also tended to be lower amongst the staff in central London due to higher call out rates. However, despite low morale, most frontline staff told us that they enjoyed their job and were committed to their work. One told us "it is a brilliant job, I like looking after patients."
- Some ambulance staff told us there was an open and friendly culture at station level. They felt confident to raise concerns with their team leaders and DSOs and many stated they loved their jobs. However, they were frustrated with changes imposed by the top level management and did not feel valued by the organisation. Some staff who had been employed by the service for many years said they were counting the days to retirement. A number of staff perceived that a particular member of the senior management team was dismissive of their concerns and grievances and how operational changes affected the staff on the ground in their work.

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- Staff spoke positively about the high-quality care and services they provided for patients and relatives and said they were proud to be part of the emergency services. We observed that staff appeared dedicated and committed to their job, although a number said they would value a better work/life balance.
- Administrative staff worked alone in ambulance stations and this was often part time. They felt support was insufficient, although some liked the working style. For example, one person preferred the independent working style instead of a standard office job.
- We were told managers were rarely seen and tended only to contact crew for negative things such as missing the 14 minute turn around.
- Welfare checks on staff undertaken by DSOs during or following a crew dealing with significant or traumatic events was inconsistent. We found examples of when they were carried out when necessary and others when they were not.
- We heard mixed views form LAS staff on how supportive the service was to them and their needs. There were positive stories about staff being supported through difficult situations and returning to work after periods of absences. For example, a member of staff was given a flexible working pattern, so that they could support their spouse's medical needs. However, there were also a number of staff who felt unsupported or pressured, for example being unable to take compassionate leave twice in the same year, even though the trust had a clear policy for special leave with includes compassionate leave and does not limit the number of times it can be accessed in a year.
- LAS had part-time paramedics, but they can only work as relief paramedics, meaning they could work at different stations every day. We were told that part-time staff do not get promotions. One part-time paramedic told us, "I went for a promotion and it was declined because to get a promotion you have to be a mentor; but you can't be a mentor if you work part time."
- If staff needed counselling, they could self-refer to the Link service. This service was supported by members of ambulance staff who were trained in supporting colleagues with emotional issues. Staff who had used this service reported positively about it saying that it was easier to talk to a peer as they understood what they were going through. Each member of staff had the contact details for Link and they could also visit the occupational health department.

- Most of the staff reported changes in the rota system had made it very difficult for them to undertake their duties and this has led to some staff resigning from their post. Most of the staff we spoke with were unhappy about the introduction of new rotas. The new rotas, introduced September 2014, were in theory aligned to demand and did not allow flexibility and family friendly working. There were 15 different shifts a day over 24 hours. Ambulance crews informed us that the rotas did not allow for adequate rest between night duty and moving back to day shift.
- Following a rota change, staff now had a fixed rota for a year. The trust gave us documentary evidence of consultation, listening events and final rosters at some individual locations. However, some staff told us the rota change was imposed with no consultation and had led to staff tiredness. We were told that in at least one ambulance station, all staff left after the rota change. One manager told us that whilst they were aware that staff were not happy with the change in the rota, it was done to align the service to meet people's needs.

Public and staff engagement

- Outreach work by the LAS across London was proactive and extensive. For example, the ambulance service had recently taken part in fayres organised by local councils. LAS staff took part as volunteers (though paid overtime or time in lieu) and met diverse groups and communities in this way. Children and young people learnt when and how to call an ambulance and we saw a good range of age appropriate material. However, we did not see evidence that the impact of this programme overall had been evaluated or of service-wide improvements as a result.
- South Croydon station had a community involvement officer who liaised with CCGs and other stakeholders such as care homes and nursing homes. This person had been able to help prevent unnecessary ambulance call outs through training.
- Staff engagement took place through the 'Routine Information Bulletin' (RIB) and monthly 'Team Talk' newsletter. Management communicated with staff via emails and mobile phones in addition to the RIB and Team Talk newsletters. Despite this, many of the staff said they felt disengaged from the management of the service.

Emergency and urgent care services

- We were told by ambulance crews that patients were supported to use alternative services, by sign posting them to various community-based services.

- There is an independent Patients' Forum that monitored services provided by the LAS and which met monthly. It is made up of members of the public. The Patients' Forum held their meetings on the premises of LAS and was supported the organisation's leadership. Their monitoring information was made public on their website. Where they identified concerns about the care of the elderly and other vulnerable patients, they presented these to the LAS management team.

- Feedback from members of the forum included that the general public appreciated and respected the LAS. They felt that paramedics generally demonstrated good interpersonal skills when dealing with the public. Concerns by the members of the forum included delays in ambulance handover to emergency department staff and inappropriate equipment for bariatric patients.

Innovation, improvement and sustainability

- The service was involved in research projects led by St Georges University of London (SGUL). One such research trial was called Aneurysm FILTR. The research was investigating whether a smartphone application can identify Ruptured Abdominal Aortic Aneurysms (rAAA), which are notoriously difficult to diagnose and can often be fatal. Training sessions had been provided to staff who were interested in the trial. The leads reported that involvement in these projects had enhanced the awareness and understanding of frontline staff of the importance of evidence-based practice.

- The mobile phone app showing care pathways was a useful innovation enabling staff to have ready access to information.

- The communications book for people with learning disabilities or speaking other languages was regularly used and a helpful aid to clarifying patients' needs.

- Advanced practitioner paramedic roles were considered to be doing things 'fantastically well' by those working in those roles. For instance, caring for the victims of heart attack, stroke and major trauma. They claimed that the work being done with major trauma and cardiac arrests was 'world leading'.

Patient transport services (PTS)

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

Information about the service

The patient transport service (PTS) offered transportation for non-emergency patients between community provider locations or their home address, according to eligibility criteria determined by the commissioning care provider. In 2014/15 a total of 115,468 journeys were supported by PTS, ensuring crucial access to healthcare services for potentially vulnerable patients. Journeys were made to contracted locations within London, although longer journeys were also supported by the service if required. All referrals and bookings were made by staff at community provider location (none were made directly by patients), and managed within the PTS control centres.

PTS had lost several contracts over previous years and, as a result, activity within the service had decreased, putting the future sustainability of the service in doubt. There were 68,624 fewer journeys completed in 2014/15, in comparison with the previous year. Due to the logistical difficulties associated with the diminishing workload, it was necessary for PTS to use private subcontractors for some calls. PTS also used private sub-contractors for conveying specific patients groups.

A trial of a new non-emergency transport (NET) service began in September 2014 and was intended to support the work of emergency ambulance crews, by conveying category three and four (non-emergency) patients to healthcare facilities. The NET service was managed within the PTS directorate and used PTS vehicles, along with PTS ambulance persons. The NET service transported 35-45 patients within London each day.

We visited both PTS control centres (Becontree and Bermondsey), the NET control centre (Waterloo), four ambulance stations and several care providing locations over the course of four announced inspection days and one unannounced inspection day. We also inspected seven PTS vehicles and observed PTS staff transporting patients. We gathered further information from data provided by the trust.

During our inspections, we spoke with 37 members of PTS staff including ambulance persons, drivers, control room staff and PTS managers. We also spoke with 16 patients and relatives, as well as 11 healthcare staff whose patients used PTS.

Patient transport services (PTS)

Summary of findings

Some staff were unclear which type of situations needed to be reported as incidents and a culture of under-reporting was evident. However, actions were taken to enable changes in practice when incidents had been reported. Awareness of safeguarding principles and processes was variable among PTS staff.

Several oxygen cylinders were found to be significantly out of date, and daily vehicle checks were not being completed when required.

Cleanliness of vehicles and equipment used for PTS were not consistently at the expected standard. Some personal protective equipment (PPE), such as gloves, were available on PTS and NET vehicles. However, none of the vehicles we inspected contained the full complement of PPE as LAS guidance describes.

Clear patient eligibility criteria were in place and key performance indictors (KPI) were identified for each contract. PTS achieved slightly below the KPI target of 95% throughout 2014/15. Service level agreements formed part of the provider contracts and updates were sent through to the service which had commissioned PTS at regular intervals.

PTS crews received regular teaching sessions delivered by work based trainers, either in groups or on a one to one basis if needed. NET crew and control room staff received additional training to complement their new roles.

During our inspection, all observations of care provided by PTS showed patient dignity being maintained and patients treated kindly. PTS crews were respectful to patients and treated them with compassion. Patients and their relatives were complimentary about their interactions with PTS crews and gave examples where crews had tried to create a positive transport experience.

The booking process did not account for the needs of palliative care patients, which meant these vulnerable patients often had long waits for transport. Other care providers also described patients having long waits for transport home. PTS did not proactively inform patients or care providers of delays to their transport.

There was demonstrable inconsistency of service oversight within PTS management, such as overseeing day to day tasks, for example, the accurate completion of daily vehicle checks. Incident reporting and response was also variable depending upon the overseeing manager.

The PTS management team had a thorough understanding of the diminishing workload PTS was facing and had presented a structured exit plan in early 2015, which had been presented to the finance and investment committee. This had yet to receive board approval. There were clear aims for the NET service and plans for it's expansion. Staff were positive about the PTS managerial team and their interactions with them.

Patient transport services (PTS)

Are patient transport services safe?

Requires improvement ●

Some staff were unclear which type of situations needed to be reported as incidents and a culture of under-reporting was evident. However, actions were taken to enforce changes in practice when incidents had been reported. Awareness of safeguarding principles and processes was variable among PTS staff.

Several oxygen cylinders were found to be significantly out of date, suggesting the daily vehicle checks were not being completed accurately. Additionally, some staff described situations where they had administered oxygen to patients without adhering to PTS protocols.

Cleanliness of vehicles and equipment used for PTS were not consistently at the expected standard. Most staff followed infection prevention and control procedures. However, the full complement of personal protective equipment was not available on any of the PTS vehicles we inspected. We observed some staff returning equipment to the vehicles after patient use without cleaning it.

Staff used several assessment methods to monitor patient risk and we observed these methods in action. The process for assisting paramedic colleagues with patient transfers was unclear and staff did not know who would be responsible for patient care when a shared transfer was planned.

Incidents

- Incidents were initially reported via telephone to the PTS control centre who would then pass information onto the relevant PTS operational manager (POM). The POMs were responsible for completing the incident forms, investigating the incidents and suggesting actions based upon their findings.
- Part of the POM's role when reviewing incidents was also to assess any injury and the well-being of all involved, including staff. Support options available for staff included a counselling service, occupational health check and physiotherapy.
- Incidents were reported on a paper based form called an LA52. Vehicle damage was recorded on a separate form, called an LA420.

- Forms were completed whilst on the PTS vehicles. Once completed, POMs verified the details with the completer and risk rated the incident as minor, moderate or major. Incidents were also reviewed by the senior team who identified any themes or trends.
- Data provided by the trust showed there were six LA52 forms completed in 2014/15.
- Staff provided some examples of reporting incidents which caused actual harm. Some staff were clear that incident reporting should also include near misses and non-harm related incidents; but this was not consistent. For example, one person told us about an issue they had raised involving patient confidentiality, but they had no awareness of the incident reporting system.
- We were told about one on-going incident investigation involving a subcontractor. This came to light as part of a complaint from a patient's relative, rather than from the subcontractor directly or via an incident report. We were not able to identify the presence of a system for ensuring that PTS subcontractors were aware of the need for, or the process to follow around incident or near miss reporting.
- We were given recent examples of learning from incidents; the life pack box held on board vehicles was changed due to a significant number of instances of staff injuring their hands when removing it from its storage.
- Some PTS staff could also describe learning from an incident which occurred in the previous year where a vehicle rolled backwards down a hill whilst parked, causing minor injury to a member of staff and a patient. We observed staff adhering to the newly introduced procedure during patient collections, in order to prevent a recurrence of this type of incident.
- To ensure information was received by all staff, bulletins or instructional notes were sometimes attached to staff pay slips or individually handed to staff by the PTS work-based trainers (WBT) who required a signature confirming receipt.
- Staff told us the learning from incidents and near misses was also communicated during monthly "Team talk" meetings and via the "PTS directorate bulletin" which was circulated on an ad hoc basis. We saw an example of the PTS directorate bulletin on display in one station, dated May 2015, which reminded crews to complete LA52 forms for accidents, incidents and near misses.

Patient transport services (PTS)

Mandatory training

- Staff received mandatory training upon commencing employment with LAS as part of their induction process.
- Staff told us basic training for a PTS driver would include basic life support and defibrillator training. For an ambulance person, there would be additional training in moving and handling as well as the use of oxygen. Non-emergency transport (NET) crews received further first aid training.
- Core Skills Refresher (CSR) days were held for PTS and NET staff at each main ambulance station on an annual basis, to update their mandatory training. These training days were led by the PLM. Staff could attend sessions at other stations if they missed their local training.
- Data showed 76% of PTS staff attended a CSR training day in 2014/15.
- We saw an internal PTS computerised spreadsheet which showed a wide range of training was provided. The recorded dates of staff training were largely within the past year.
- Some training was also delivered via online learning.

Safeguarding

- Annual safeguarding training refreshers were included on the mandatory training study days held for PTS staff, including NET crews. We were told by a local manager that safeguarding training was completed at levels 1 and 2.
- Awareness of safeguarding processes and procedures was variable among PTS staff; some were able to describe what would constitute a safeguarding concern and provide examples, whereas other staff were unfamiliar with the term and what they would do if they were worried about a patient they were transporting. One staff member gave an example of collecting an elderly patient from a care home and noting bruising on her arm. The staff member told us he would keep an eye on the lady next time he picked her up and would raise concerns if bruises were spotted an additional "three or four times" which meant there was a risk that staff were not aware of their responsibility to report any concerns.
- NET staff could describe what safeguarding meant in practice, how they would raise concerns and provided a recent example of an appropriate safeguarding concern which had been raised the previous week.

- Some staff that worked for a community provider, who had worked with PTS crews, gave examples where safeguarding concerns were reported back to them by the crews after they had taken people home.

Cleanliness, infection control and hygiene

- Day to day cleaning of PTS and NET vehicles was completed by the crew assigned to the vehicle each day. Additional internal deep cleaning was completed by a subcontractor on a quarterly basis.
- The 'LAS daily vehicle audit' form itemised a number of checks including patient areas needing to be dust free, all seating clean and intact, consumable packs available and the cabin clean and dust free. These were rated as good, average or poor with room for comments. We were shown examples of completed forms and actions taken following spot checks. One example was a spot check following the private contractors deep clean which found poor quality of cleaning and hygiene, resulting in the contractor repeating the deep clean.
- In one service delivery area we reviewed the daily vehicle audit forms for a full week. All were comprehensively completed and the process for raising matters of concern was explained to us and accurate. In other service areas though, practice was not as consistent.
- It was the responsibility of the POMs to spot-check whether vehicles had been sufficiently cleaned, both after deep cleans and crew-led daily cleaning.
- The internal cleanliness of vehicles we inspected was variable; some had dust on equipment and rubbish, such as used tissues, on the floor whereas others were noted to be clean and tidy.

- We observed PTS and NET staff followed infection control procedures, including washing their hands or using alcohol gel after patient contact. Staff were observed to be bare below the elbow.

- Some personal protective equipment (PPE), such as gloves, were available on PTS and NET vehicles however none of the vehicles inspected contained the full complement of PPE as LAS guidance recommended.
- We were shown an instructional note from March 2015 outlining which cleaning items should be on all PTS vehicles and staff responsibilities for cleaning and maintaining vehicles. This included universal, sporicidal and spill wipes, hand rubs, floor cleaner and disinfectants.

Patient transport services (PTS)

- Cleaning of vehicle equipment after use was variable; we observed some staff cleaning equipment thoroughly, whereas others returned equipment to the vehicle after using it with a patient without cleaning it.

Environment and equipment

- There were two different makes of vehicle used for PTS and NET services. We were told vehicles are normally replaced once they start to require a lot of upkeep and become expensive to maintain. This was usually when a vehicle reached six or seven years of usage. When visiting one main workshop, we found the oldest vehicles in use were no more than eight years old in 2015.
- PTS vehicles were on a planned six monthly maintenance schedule. A maintenance checklist for each different model of vehicle was in use and offered a thorough assessment of the condition of the vehicle.
- A computer system was in place intended to indicate each vehicle's previous history, work that needed to be completed and other vehicle details. At a workshop we visited, the database where this information was meant to be recorded had all the relevant information for emergency vehicles recorded but there was no information recorded for PTS vehicles other than the make and model of the vehicle.
- A paper based spread sheet indicated when PTS vehicle MOTs were due for renewal and the workshop managers worked alongside the POMs to ensure vehicles were assessed before the required date. We were told vehicles rarely missed their MOT due date, unless they were having bodywork repairs by an external company, which could take a long time to complete.
- Daily inspections of vehicles took place and were recorded on a check sheet. This ensured itemised routine checks took place of all parts of the inner and outer vehicle and also checked condition such as fuel levels, oil leaks and dash warning lights.
- A POM told us crews were responsible for checking equipment on their own vehicles on a daily basis. Daily checks were monitored by POMs who carried out random spot checking.
- The vehicle audit form itemised a number of checks including equipment fitted as per instruction, availability of consumables and vehicle mechanical items function. These were rated as good, average or poor and there was space on the form for comments. In one service area we were shown examples of completed forms and, usually, actions that had been taken following daily checks.

- These checks did not happen routinely in all service areas and there was inconsistent practice depending on which local manager had oversight, rather than an identifiable programme of local audit.
- Defibrillators were available on all PTS vehicles. They were in an accessible location on each vehicle and had been recently safety tested.
- PTS vehicles had on-board wheelchairs available for patient use, which were secured at the rear of the vehicle. All vehicles could accommodate patients in their own wheelchair, which would be suitably secured against a back rest in the vehicle.
- Most PTS and all NET vehicles could transport patients requiring transfer on a stretcher bed.
- All NET vehicles were equipped with a patient manual handling kit, containing equipment such as slide sheets, manual handling belts and a swivel board. Staff told us they would use this equipment if someone had mobility difficulties and required a high level of support to move around.

Medicines

- PTS and NET vehicles did not carry any medicines for emergency purposes with the exception of oxygen.
- PTS and NET staff told us they would assist patients travelling with their own medications by helping them transport the medicines onto the vehicle, along with the patient's other belongings. The medicines would be stored with the patient's other belongings in the back of the ambulance.
- During one NET patient pick up, we observed the crew place the patient's medications in the ambulance then return into the patient's house, leaving the doors to the ambulance open.
- Oxygen was available on board all PTS and NET vehicles and should have been checked on a daily basis. During our inspection, we noted several oxygen cylinders on PTS vehicles which were significantly out of date (such as one which expired in December 2012), indicating the daily checks weren't occurring. Oxygen on NET vehicles was seen to be in date. All oxygen across PTS and NET vehicles was stored appropriately.
- PTS staff told us they were supposed to exchange used, or out of date, oxygen cylinders at ambulance stations.

Patient transport services (PTS)

- Patients requiring oxygen were identified in advance and would always be transported by a two person crew. If there was no friend or relative to accompany the patient, the second crew member would sit in the back of the vehicle with the patient.
- Patients not normally receiving oxygen therapy but found to be suffering from injury or illness could be given oxygen by PTS or NET staff as part of the primary or secondary survey assessments, in line with guidance charts provided by the ambulance service. NET staff provided an example where they had to unexpectedly give oxygen to a patient who appeared short of breath. When asked to describe the process behind deciding to give the patient oxygen, staff told us they had not measured the patient's oxygen levels, which was not in-line with guidance provided by the trust.

Records

- Booking forms contained confidential patient information. This was a standardised form containing patient details such as mobility needs, mental health, appointment details and any special notes or instructions. Information was also placed on to the 3TC system for an electronic record which drivers could access on board vehicles.
- On PTS vehicles, no paper patient records were held. All patient related information was passed onto the driver on a hand held computer link called the PDA (Personal Data Assistant).
- NET control room staff told us their workload management computer system was not compatible with the PDAs and required information to be manually uploaded onto the Meridian system before it could be handed over to the NET crew.
- NET crews completed an LA04 form for each patient referred to the crew. The form required sensitive information such as patient name, address, date of birth and presenting complaint. These forms were held unsecured in a cardboard folder in the NET vehicle for the remainder of the day, until the crew returned to their base. As the vehicle was not always supervised, this could potentially have led a confidentiality breach if the forms were misplaced or stolen.
- At one NET base, the LA04 forms were kept in a locked container overnight until the following morning when the crew would have to take the previous day's forms to a nearby ambulance headquarters. The information from the forms would then be inputted onto a computer

database. NET staff told us it was not always convenient to travel to the other headquarters as their first patient collection may be in the opposite direction and having to transport the paperwork wasted valuable time.
- PTS and NET crews told us they would assist in transporting any medical records the patient might be carrying alongside any other personal items as standard practice.
- Members of PTS crew told us they often share information with the receiving clinic or provider and felt this worked particularly well when they, the staff and the patients knew one another.

Assessing and responding to patient risk

- Patients' needs were assessed by PTS control room staff as part of the booking process. This allowed them to allocate the most suitable resources according to each individual patient's needs. For example, a patient requiring oxygen needed supervision throughout the journey required a two person crew to be deployed.
- The dynamic risk assessment framework (DRAM), required all PTS and NET staff to complete a visual assessment of mobility and frailty as well as other patient risks when arriving to collect a patient. This was a situational assessment prior to moving the patient which involved assessing the surroundings, such as property access difficulties, like the presence of clutter or the size of doorways.
- Support from emergency crews could be obtained via the control centre if PTS or NET staff observed a patient's health had deteriorated upon their arrival or during the journey. At the time of our inspection, there had been no patients that had been incorrectly triaged or had deteriorated sufficiently to be inappropriately allocated to a NET crew.
- NET crews described using the Glasgow Coma Scale to assess patient's consciousness levels if they were concerned someone was becoming more unwell. If they noted a low or falling score, they would contact the control centre and request support from emergency service colleagues.
- PTS and NET crews were alerted by the control centre if a patient they were transporting had a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order in place. NET crews told us they would also confirm upon arrival to collect a patient whether or not the patient was for resuscitation.

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- A POM told us that if a patient did not appear to be at home to be collected there was a risk based process to follow. This included looking through a letter box or window if possible to ascertain whether there were any signs of the patient being at risk. The driver would then leave a contact card and contact the control centre who liaised with the receiving care provider and other contacts such as relatives and key workers. The controller would then contact the driver again before the job was aborted.

- PTS staff were able to describe this process and we observed a PTS crew following procedure, including calling the control centre before leaving a calling card to say they had visited. We were also told the control centre would contact the relevant outpatient clinic to inform them the patient was not home to be picked up.

- Patients transported by PTS were considered to be 'heavy patients' if their weight was over 127 kilos. If these patients needed transporting in a wheelchair or on a stretcher bed, a crew with specialist training and a bariatric vehicle would be used. Only some crews were able to transport bariatric patients, partly due to vehicle capabilities, but also because not all staff had training in this area. Senior staff told us they were conscious of the need to maintain staff competence once they had received this training, so limited this work to a small group of staff.

- Due to their ability to transport bariatric patients and patients in motorised wheelchairs, NET crews were sometimes used to transport patients who had been triaged to receive care from an emergency crew. A referral for this type of patient occurred during our inspection and the NET crew were unclear of the support they would receive from their paramedic colleagues during the transportation of this patient. They spoke to NET control who were unclear whether the paramedics would ride on-board with this patient or leave the patient in the care of the NET crew. There were no criteria or guidance for NET crews or NET control. Each decision was dependent on the paramedic's clinical assessment.

- All vehicles were fitted with a panic button which contacted the control room, enabling them to hear what was happening in the vehicle. The control room staff would then generate an appropriate response such as sending an emergency ambulance or contacting the police. Drivers told us they had never needed to use the panic button.

Staffing

- The PTS staff comprised of band three ambulance persons and band two PTS drivers. There was one volunteer PTS driver at the time of our inspection. Staff told us there were no crew vacancies at the time of our inspection, although in the management team, there was one POM vacancy and one WBT vacancy.

- PTS staff worked either alone or in a two person crew (usually one ambulance person and one PTS driver), according to patient need.

- During our inspection we noted the use of sub-contracted two person crews and were told this was in order to meet the service demands for two person crews. We were given an example where, in Haringey, they had drivers but not enough ambulance persons and so private providers were brought in.

- A lone working policy was in place to support those working alone and vehicle locations were tracked, providing additional security. PTS crews could contact the control centre via the vehicle radio system or call on mobile phones to obtain support.

- NET staff always worked in two person crews, made up of two ambulance persons. Staff told us they always worked with the same person and cover would be sought if their colleague was on leave or off sick. If cover could not be arranged, the remaining staff member would revert back to regular PTS duties rather than completing NET journeys.

Major incident awareness and training

- In the event of a major incident, use of PTS vehicles may be required. POMs would be instructed to pull back vehicles from routine duty based upon the grading of emergency which had occurred. For instance, essential journeys would still take place for those attending appointments such as for chemotherapy, dialysis and other complex care. If there was an extreme weather event, the same process would also be followed.

- PTS and NET staff were aware of the role of LAS in the event of a major incident. They were able to describe the gold, silver or bronze rating system relating to the level of emergency which had occurred. They described that their role would be to support the transport of the 'walking wounded' to hospitals or other centres that might be set up to care for people.

- No staff we spoke with had been involved in major incident simulation training whilst working for the service.

Patient transport services (PTS)

Are patient transport services effective?

Good ●

Clear patient eligibility criteria were in place and key performance indictors (KPI) were identified for each contract. PTS achieved slightly below the KPI target of 95% throughout 2014/15. Service level agreements formed part of the provider contracts and updates were sent through to the service which had commissioned PTS at regular intervals.

PTS crews received regular teaching sessions delivered by work based trainers, either in groups or on a one to one basis if needed. NET crew and control room staff received additional training to complement their new roles.

Staff had access to information via the personal digital assistant on each vehicle and could access trust policies and procedures via the trust internet.

Evidence-based care and treatment

- The trust had specific contracts in place with various organisations within London. Each agreement outlined certain eligibility criteria for using PTS, based on national guidelines for the non-emergency transportation of patients.
- PTS guidelines for the administration of oxygen followed national ambulance pre-hospital and British Thoracic Society recommendations.
- We were told one comprehensive vehicle audit happened annually, which included all aspects of vehicle and equipment quality. The most recent comprehensive audit occurred in January 2015 and found various items of equipment, such as defibrillators, missing from some vehicles. Tasks correcting the issues found were allocated, as a matter of urgency, to relevant individuals such as the PLM who were held accountable for ensuring completion.

Patient outcomes

- Key performance indicators (KPIs) for PTS included dropping patients off no more than 30 minutes ahead of their appointment time, collecting patients within an hour of them being ready to leave and successfully completing their journey.
- A target of 95% was set for each of these KPIs and we saw data demonstrating arrival and departure times

were slightly below their target throughout 2014/15. Senior staff told us patients more frequently were dropped off too early rather than arrived late, which meant they did not miss their allocated appointment time at the care provider.

- Standards and expectations of the service were stipulated in service level agreements. Examples we viewed included details such as service operating hours, specific methods of control centre operations, pick-up locations included in the contract and the principle contacts of both organisations. They also stipulated what was included or excluded as part of the agreement; for instance, outpatients, discharges, day patients would be included but not patients requiring a secure vehicle, those within specific mobility categories or patients requiring support above the skill level of PTS crews.
- With most contracts, the community care providers themselves determined patient eligibility through their own transport coordinators. Locations that used PTS completed an internal form assessing questions such as can the patient walk, could they use public transport, is there accessible public transport, does the patient require oxygen and what is the patient's specific health condition. This enabled the community provider to determine patient eligibility for patient transport services.
- When PTS had a busier workload, there were two evaluating coordinators who would mark patient eligibility against specific contractual criteria. This is not now required due to a reduction in PTS contracts provided by the ambulance service.
- The SLAs included expected levels of activity based on mileage bands of distance travelled and any variation to the expected range of this. This was measured as part of performance data and cost analysis. If a patient needed to travel beyond determined mileage bandings, it was classed as an extra contractual journey (ECJ), which incurred extra cost to the community provider and had to be signed off prior to the journey. Journey types such as complex stretcher patients and bariatric patients were also considered to be an ECJ. If the service could not support these journeys, the journey would be completed by a subcontractor.

Patient transport services (PTS)

- Data regarding aborted journeys was collated in KPI information sent to commissioning trusts. Data on each individual journey was attached as an appendix to the KPI information and included reasons for aborted journeys.
- NET staff were provided with one, two or four hour targets by which to collect the patient allocated to the crew. Staff told us these targets were usually achievable and it was obvious to them whether they were achieved or not because their PDA stated the expected pick-up time.

Competent staff

- All new PTS staff were inducted upon commencement of employment with the trust.
- The PLM and the WBT were responsible for assessing what training needed refreshing and when new training sessions were needed.
- Additional training was provided by PTS WBT (1 full time equivalent position currently vacant), who delivered one-to-one or group training on specific subjects. Over 100 work based training sessions were delivered between January and March 2015, covering topics such as using the new defibrillator machines and wheelchair harnessing and securing.
- Staff received training on oxygen delivery in line with national ambulance pre-hospital clinical guidelines as part of the work based training programme. They also received teaching regarding pulse oximetry to guide their administration of oxygen.
- Staff spoke positively about the training they had received and were able to describe examples where they had requested training in certain topics and this had been provided quickly and effectively. They also described how training sessions used expertise from across the team.
- NET staff were recruited from the current network of PTS staff and provided with further training for their new role. For example, first aid training was provided to NET staff (in addition to the basic life support training received by all PTS crews), who would be required to administer first aid if first at the scene of an incident.
- New NET staff were allocated a mentor who was a current member of the NET team to guide them through their first few months and provide support.
- Control centre staff responsible for the NET service received additional training including the deployment computer system and workload prioritisation. At the

time of our inspection there were five members of staff able to work on the NET control centre desk; an additional eight members of staff were due to commence training in the coming weeks.
- Professional development reviews (PDR) were meant to be completed annually with all staff. So far in 2014/15 approximately 35% of staff had completed their PDR. The leadership team said they were placing more emphasis on getting PDRs completed and POMs were responsible for this task. The organisational target was for 100% staff to have completed PDRs by 31 July 2015.
- POMs told us if there were competency issues with PTS staff they would be addressed with the member of staff, which could lead to additional refreshing training or closer supervision. We were given an example where there had recently been an issue around the use of defibrillators picked up in monthly team talks. This led to the PLM and WBTs working together to address this competency for all staff.

Working with other providers

- PTS staff liaised closely with staff at various centres that provide care, such as clinics and hospices.
- Staff at these centres described the PTS crews as being patient focused and friendly. They told us PTS crews create a good rapport with their patients and are always pleasant to staff working on the wards or various departments within the care centres. One member of community provider staff told us she was very impressed at how the PTS crews never leave a patient at the provider location until they are sure the patient is comfortable and has everything necessary to hand.
- Community staff responsible for booking PTS told us the control centre staff were easy to get hold of and friendly to speak to, although they told us that they are not pro-active in informing them when delays occur.
- An increasing proportion of PTS work was carried out by private subcontractors; 15.5% in January 2015, 24% in February 2015 and 26.3% in March 2015.

Seven-day services

- NET services were available Monday to Friday between 9am and 11pm. Staff told us they were under consultation in regard to modifying the NET contracts so that weekends were included.

Access to information

- Staff were provided with patient information on their PDAs, some of which was abbreviated to codes

Patient transport services (PTS)

indicating specific patient requirements. If further information was required, they could access more information by calling the control centre who had access to the original patient transport referral.

- Staff could access relevant policies and procedures online via Pulse on the trust intranet. Staff told us this system was easy to use and they could easily find the information they were looking for.

Are patient transport services caring?

Good ●

During our inspection, all observations of care provided by PTS showed patient dignity being maintained and patients treated kindly. PTS crews were respectful to patients and treated them with compassion.

Patients and their relatives were complimentary about their interactions with PTS crews and gave examples where crews had tried to create a positive transport experience.

Formal feedback was obtained from service users in the form of quick question cards.

Compassionate care

- Throughout our inspection, we observed patients were treated with compassion and kindness by PTS and NET staff. We observed staff addressing patients politely and in a respectful manner.
- PTS and NET staff maintained patient dignity at all times, ensuring patients were suitably dressed or covered during their journey. One PTS crew described how they had used a blanket over a patient's knees when they were transferred in their pyjamas.
- In outpatient departments and clinics where PTS staff drop-off and collect patients, we were told crews were always friendly and cheerful with patients, even when they were in a rush or running late.
- PTS staff told us they enjoyed having continuity with patients so they could build a relationship and make the journey more enjoyable for their patients.
- Patients spoke highly of the PTS crews and described how they ensured patient comfort throughout the journey. One patient told us she enjoyed listening to a particular radio station and how the PTS crew would always put it on for them in the vehicle if they asked.

- Relatives spoke positively about the attitude of PTS staff, explaining they were always friendly and caring with patients.

Patient understanding and involvement

- Bookings for patient transport were dealt with by the clinic or hospice involved in the patient's care. Patients had to contact their care provider to cancel or change bookings rather than dealing directly with PTS. This process engendered mixed reviews from patients, their relatives and community provider staff; some felt it would be easier for the patient, or their representative, to speak directly with PTS about their requirements.
- Patients told us PTS staff always kept them informed about the length of journey they should expect and if they were picking up any other patients on the way. Patients told us they were not informed if their transport was running late to collect them form home.
- Patient forums were hosted by the trust, during which patients had the opportunity to provide feedback about the PTS and NET service and make suggestions for future improvements. Some patients we spoke with were aware of this forum; all of these patients were regular PTS users.
- Quick question cards were implemented in January 2015 to obtain formal feedback from patients and their families. Out of 56 which were returned, 82% rated PTS five or six out of six in terms of the quality of service provided.

Are patient transport services responsive?

Requires improvement ●

The booking process did not account for the needs of palliative care patients, which meant these vulnerable patients often had long waits for transport. Other care providers also described patients having long waits for transport home. PTS did not proactively inform patients or care providers of delays to their transport.

NET services were not always able to respond to patient collection requests, due to the limited number of vehicles on the road and their geographical distribution at the time. These patients were then collected by emergency vehicles instead.

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Staff told us technology on-board PTS vehicles was outdated, making use of satellite navigation and communication via the personal digital assistant difficult at times.

No support was available during transport journeys for patients with communication difficulties or who did not speak English. Additionally, there was no written information (such as how to make a complaint) for patients on any of the PTS vehicles inspected.

Service planning and delivery to meet the needs of local people

- PTS workloads were planned a day in advance within the control centre, based upon information provided via booking forms. We were told the deadline for a next day booking was 12pm.
- Staff within a hospice setting told us the process of booking over 24 hours in advance did not work well for hospice patients and they frequently had to call and request same day transport. They told us it could be difficult to obtain a crew at a convenient time and the patients often ended up waiting for a long time before being collected.
- Hospice staff showed us a diary of PTS bookings, starting in February 2015, which demonstrated frequent calls made by the hospice to chase delayed transport.
- Ward staff within one community setting told us it was not uncommon for patients to wait over 90 minutes for their transport home to arrive.
- Staff within a podiatry service told us the PTS planning was very good and remained flexible around patient appointment times, which sometimes took longer than expected.
- The number of NET vehicles available ranged from six to 13 each day, depending on the number of NET competent crews working. We were told there were usually eight NET vehicles on the road during the day.
- NET journeys were planned on a task-by-task basis as NET jobs became available within the control centre. Control room staff attempted to keep crews within a certain area to maximise efficiency of the service, but had to remain flexible to accommodate patient need.
- NET crews told us their workload was variable, sometimes picking up two patients in a day and six on other days. The control room staff confirmed it depended upon suitable patients being allocated for NET crews by the emergency control room staff. This sometimes made workload planning difficult.

- If no NET crews were available, emergency vehicles would be sent by the emergency control centre instead.
- Wheelchairs were placed on to every PTS vehicle in 2014. This was as a result of feedback from drivers, who were finding an increasing lack of availability of wheelchairs at pick-up locations.

Meeting people's individual needs

- Patient information was communicated to the PTS and NET crews via PDAs. The PDA required several confirmations from the crew throughout the patient journey; such as when they accepted a job, arrived at a patient's collection address, had the patient on-board, arrived at the patient's destination address and had dropped the patient off.
- The PDA was also used to provide the crew with a satellite navigation system to enable them to travel efficiently between their destinations. The PTS crews told us the software on the PDA was out of date, which led to incorrect routing, causing delays to patient journeys. We also observed the PDA technology 'freezing' on occasion and staff having to use their own mobile phones to assist their journey.
- Referrals to PTS captured important individual information about each patient and also allowed the opportunity to record any special notes the PTS crew might need to know. Information, such as if the patient had poor mobility or was terminally ill, would match the most appropriate type of PTS vehicle and crew to each individual patient.
- A telephone call to each patient was made the day before the transport was due in order to confirm details provided by the referrer. This had been introduced after a number of occasions where incorrect vehicles or crews had been dispatched due to incorrect information being provided by the referrer.
- Some PTS crews were able to support their paramedic colleagues in transporting emergency patients who were unable to travel in a conventional ambulance; such as if they are in a large electric wheelchair or required bariatric equipment.
- Patients travelling with a DNACPR order in place were always transported individually and monitored in the vehicle in case of a difficulty occurring during the journey. Staff told us they would continue onto their destination location if the patient passed away during

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their journey. One crew described a terminally ill patient who passed away on the way back to their home and the crew transferred the patient into their own bed at the request of the family.

- PTS staff were clear on the steps required if a patient passed away during a PTS journey, such as informing the control centre.
- For patients with communication difficulties or who do not speak English, no provision was made to assist their communication throughout their journey. One PTS crew told us they "get by with hand gestures, mimes and a good sense of humour" but communicating could be difficult at times.
- No patient information about the service, such as general information or how to complain, was available in the PTS vehicles we inspected.

Access and flow

- Eligibility criteria for PTS were determined by the organisations which had commissioned the service, based upon on national guidelines for the non-emergency transportation of patients.
- Referrals were received via a computer system, fax form or by telephone. All bookings and changes to bookings were managed via the care providing organisation rather than PTS dealing directly with patients using the service.
- Most patients and staff felt this worked effectively. However we were told of some occasions where PTS staff had arrived to collect a patient when a community provider had cancelled their appointment but the PTS booking had not been cancelled.
- Planners told us they felt KPIs were challenging as they varied for each contract. They said the inconsistency meant that it was difficult to achieve the targets, without it affecting the time patients spent on vehicles.
- PTS control also received bookings for all cases that were not contracted journeys and that needed to be paid for. They received 5 to 25 bookings daily, both for long distance and for inside the London region. Aborted journeys were charged for if the they had begun and were then aborted.
- Patients being transported via the NET service had been assessed by emergency call handlers within the emergency operations centre and determined as being category three or four patients. This meant they required medical care but non-emergency transportation to obtain this care.

- Suitable patients were allocated to the NET call handler who assessed NET vehicle availability and assigned the task to a crew. If no NET crew was available within the required timeframe, the patient was referred back to the emergency service.
- NET control room staff told us their workload management computer system was not compatible with the PDAs and required information to be manually uploaded onto the Meridian system before it could be handed over to the NET crew.
- The PTS did not have any contract to transport patients receiving kidney dialysis.

Learning from complaints and concerns

- Complaints were forwarded to the customer relations managers (CRM) for investigation, either from the LAS complaints team or from community providers which LAS had a contract with.
- One CRM told us that the first task undertaken was to contact the complainant to discuss their concerns and see if the issue could be resolved to their satisfaction locally, while completing a complaint form with them.
- Before any complaint received a response, it went through the patient experience department. They dealt with all complaints and monitored all responses before they were sent to the complainant.
- Learning from complaints was addressed on an individual basis and based on the nature of the complaint, by either the head or deputy head of the department. Senior operational managers collated all complaints to identify themes or issues that may arise. This ensured timelines on actions were followed. These were discussed in senior PTS management meetings.

Are patient transport services well-led?

Requires improvement 🟠

There was demonstrable inconsistency of service oversight within PTS management, such as overseeing day to day tasks, for example, the accurate completion of daily vehicle checks. Incident reporting and response was also variable depending upon the overseeing manager. Staff did not feel PTS had a valued role within the trust.

The PTS management team had a thorough understanding of the diminishing workload PTS was facing and had presented a structured exit plan in early 2015. This had

Patient transport services (PTS)

been presented to the trust board but had yet to receive their approval. There were clear aims for the NET service and senior staff could describe their strategy for its expansion. Staff were positive about the PTS managerial team and their interactions with them.

Vision and strategy for this service

- The most recent PTS strategy paper, produced by the PTS management team and presented to the board in January 2015, outlined the need to plan a managed exit from the PTS market. With the recent decline in the number of PTS contracts secured by the trust, it was anticipated that PTS would cease to function in its current format by April 2016. At the time of our inspection, this proposal had not been approved by the board.
- The Head of PTS was keen to maintain the organisational structure of a traditional PTS in place, so the trust may be in a position to once again bid for contracts in the future.
- Moving forward, the key strategy of PTS was to fully integrate the NET service into a support network for the emergency response colleagues.
- Targets to develop the NET service further included working on identifying appropriate incoming calls more quickly to ensure appropriate allocation of work and maximisation of efficiency.
- Staff were aware of the trust values but told us these had been recently updated and this had failed to be communicated to the PTS part of the organisation until several weeks later.

Governance, risk management and quality measurement

- Senior staff were aware that some daily checks, such as equipment checks, were not occurring effectively on a daily basis. We were told this was dependent on who had oversight of a particular team and that this needed standardising across the trust. Incident reporting and response was also variable depending upon the overseeing manager.
- PTS integrated fully into the wider trust governance structure. PTS was represented by the Head of PTS, the Deputy Head of PTS and the PLM at various governance meetings within the trust such as; corporate health and safety meetings, infection prevention and control, safeguarding committee and motor risk group.

- A PTS risk register was maintained and senior management staff met to discuss and review this on a quarterly basis. The Head of PTS was able to describe items on the register and how they had recently changed.
- Weekly meetings between POMs and senior PTS staff alternated between strategy meetings and operational meetings. Within these, incidents and risks were discussed, including the creation of an action plan and deadlines for these actions.
- The Head of PTS told us of aims to encourage further involvement of the POMs in monitoring service quality.
- Target achievement was monitored by PTS operational managers on a monthly basis and fed back to the senior management team.

Leadership of service

- Three PTS operational managers were responsible for overseeing day-to-day management of PTS across London, including performing spot-checks, monitoring service quality, staff management and incident investigation.
- Four customer relations managers covered contract management and maintained relationships with organisations using PTS.
- Two senior operational managers, who had divided their responsibilities into east and west London, were responsible for overseeing the work completed by the PTS operational managers and customer relations managers.
- The Deputy Head of PTS was responsible for managing the senior operational managers and oversight of the entire service was the responsibility of the Head of PTS.
- A practice learning manager worked across all trust sites to provide clinical leadership and support the training provided by PTS work-based trainers.
- PTS staff spoke positively of their immediate management team and felt able to approach the managers with difficulties and ideas. They described seeing the PTS operation managers at the start or end of most of their shifts and told us they could discuss issues with them then.
- Staff told us they saw the senior management team less frequently and associated seeing them on-site with receiving "bad news", such as the loss of a PTS contract.

Patient transport services (PTS)

- General feedback regarding the trust management team was variable, with some positive comments (such as "the management always remember my name") and some staff commented on the apparent disconnection between trust management and PTS crews.
- Senior management in PTS described how they valued the staff and explained their aim to maintain as many PTS staff within the trust as possible, such as finding PTS drivers roles within other departments, like logistics.

Culture within the service

- Staff told us they felt proud to represent the service and of their work in PTS.However they did not consider they were valued within the organisation, outside of the PTS management team. Staff used the example of the new trust values not being communicated to PTS.
- On more than one occasion, PTS was described by staff as being "the poor relation" when compared to the other work completed by the trust.
- Staff were aware of PTS contracts being lost and described feeling concerned at the prospect of losing their jobs with the trust, despite being able to transfer to the new contractor under Transfer of Undertakings (Protection of Employment) Regulations (2006).
- Senior staff were sensitive to the feelings of PTS crews and told us they could appreciate the impact of uncertainty around job security. They acknowledged the difficulty of maintaining good morale in the current workplace climate.

Public and staff engagement

- Patient forums were hosted by the trust, during which patients had the opportunity to provide feedback about the PTS and NET service and make suggestions for future improvements.
- Quick question cards were instigating to obtain feedback from patients using PTS.
- A series of 'roadshows' were hosted by senior management at various sites across the trust, raising the PTS staff awareness of opportunities within the NET service. PTS staff were positive about this engagement and told us it allowed them opportunities to ask questions about how their post could be transferred.

Innovation, improvement and sustainability

- We were told PTS work had been a reducing service for the trust over the last five years and senior staff explained the trust had recently struggled to be successful in bidding for contracts across London. This had led to the loss of major work streams for the service. Compliance with Agenda for Change terms and conditions alongside large overhead costs meant the trust struggled to price contracts competitively.
- Current contracts were spread across London, making it difficult to use resources effectively, and were due for renewal over the upcoming months, putting the future sustainability of the service in doubt.
- The significant innovation within PTS was the implementation of the NET trial which began in September 2014. NET services facilitate the transportation of non-emergency category three and four patients who need to be taken to receive medical care.
- At the time of our inspection, the service completed 35-45 NET journeys each day (Monday-Friday) and had clear goals for increasing these journeys to 110 journeys per day by July 2015 and 224 per day by January 2016. To support the increase in NET activity, a total of 140 NET staff were planned to be in post by January 2016.
- Senior staff described the 224 journeys per day as being cautious target and told us they felt there would be potential for the service to deliver journeys beyond this number if the assessment and allocation processes they put in place are effective.
- The Head of PTS identified other specialist areas in which he envisaged PTS work may be sustainable and described these as "opportunities to grab with both hands". These ideas were in their infancy and so there was no documentation available to support these concepts at the time of our inspection.

Emergency operations centre

Safe	Requires improvement	●
Effective	Good	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Inadequate	●
Overall	Requires improvement	●

Information about the service

The Emergency Operations Centre (EOC) receives and triages 999 calls from members of the public and other emergency services. It provides advice and dispatches ambulances to the scene as appropriate. The EOC provides assessment and treatment advice to callers who do not need an ambulance response, a service known as 'hear and treat'. Callers may receive advice on how to care for themselves, make an appointment for a general practitioner (GP) or be directed to other services that may be of assistance. The EOC also manages requests by health care professionals, to convey people either between hospitals or from the community into hospital.

The trust has two emergency operations centre; one at the trust's headquarters in Waterloo and the other in Bow. The trust has a single virtual emergency operations centre across their two call centres meaning all calls are routed to the next available operator.

The EOC has three core sections: call takers, dispatchers and a clinical hub. There is also a central support unit, dispatch and distribution support desk, and an intelligence conveyance desk. At Waterloo there is an emergency bed service, helicopter emergency medical service (HEMS) and advanced paramedic practitioner (APP desk). The desk coordination work between the ambulance service and the Metropolitan Police Service. This desk is referred to as METDG and is based at Bow.

The call handlers are responsible for answering and triaging calls in accordance with clinical need. The clinical hub is staffed by clinicians, including specialists such as

paramedics, nurses and mental health nurses. The dispatch team is responsible for allocating calls to vehicle crews in accordance with clinical priority and location of vehicles. The central support unit is responsible for supporting the call handlers with advice for more complex calls, ensuring welfare checks are made (particularly if there is a delay in a vehicle arriving on scene) and providing advice to emergency responders. The emergency bed service also handles safeguarding referrals. The HEMS desk is responsible for dispatching the air ambulance and the METDG desk triaged Metropolitan Police Service calls to determine an accurate priority and facilitate more effective tasking of LAS resources.

There is an incident control room at the Waterloo emergency operation centre with an additional events control room in Bow EOC. Both rooms include a dedicated management suite which are designed to support and manage the tactical command function during incidents and other operations. The event control room is intended to manage pre-planned events, with a capacity to handle the control of large annual events.

The emergency operations centre took nearly 1.9 million calls in 2014/2015. During our inspection we spoke with 82 staff, looked at 17 records, listened in to over 100 calls which included 65 emergency calls, 15 'hear and treat' calls, 7 call backs and 22 radio call to ambulance crews.

We followed up our announced inspection, carried out on the week commencing 1 June 2015, with two additional unannounced visits. We visited the EOC in Waterloo on the evening of 11 June 2015 and the EOC in Bow on the evening of 21 June 2015.

Emergency operations centre

Summary of findings

We found that the emergency operations centre was poorly led and it required improvement across the safe and responsive domains. We also found that staff were caring and the emergency operations centre was effective.

Staff were not provided with feedback in response to incidents reported by them and did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety. There were also limited opportunities for learning from complaints. Patients' complaints were not routinely discussed to prevent future occurrences or improve the quality of service in response. The surge management plan was not implemented effectively and its incorrect use allowed for routine delays in ambulance dispatch and for prolonged response times. There were delays in call backs made to re-assess risk and provide patients and their relatives with an update.

There was no long term strategy for the EOC. There was insufficient operational overview and management of appraisals. Staff reported a bullying culture and told us that the trust did not proactively act to address it. The restructure of the EOC had not been managed well. Staff reported that there had been no staff involvement and that the restructure had been imposed from the top down. There was no effective flagging system for frequent callers, patients with complex needs, learning disabilities as well as for patients from other vulnerable groups.

We also found that calls were monitored for consistency and to ensure advice in line with correct clinical protocols was provided by EOC staff. LAS performed much better for call abandonment than the England average and was best amongst ambulance trusts in England. LAS performed better than all ambulance trusts in the time taken to answer calls. The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust in England. Emergency operations centre services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect.

Is emergency operations centre safe?

Requires improvement ●

Staff were not provided with feedback in response to incidents reported by them. No systematic actions were taken in response to incidents to prevent future occurrence and mitigate risks. Staff did not always assess and respond to patient risk promptly as there was no robust system to monitor call backs in situations when ambulance crew could not be dispatched. Staff participation in the mandatory training, including safeguarding, was low. EOC staff did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety. There were delays in call backs made to re-assess risk and provide patients and their relatives with an update. Major incident protocols had not been amended since July 2012.

Incidents

- The trust reported 47 Incidents resulting in severe harm or death to patients in 2014/2015 (StEIS incidents; Health Strategic Executive Information System). Seven of these related to EOC and were linked to delays in dispatching ambulance crews. In one case the dispatch team did not monitor a vehicle crew which was accidently cancelled from the system. In another incident, a call from a GP who had concerns for the mental health of a patient suffering from depression, was identified as not fulfilling criteria for a 'welfare check'. An ambulance did not attend and the call was closed under 'hear and treat'. The trust assured us that all incidents were fully investigated.

- 26 moderate harm incidents were reported in January 2014 to February 2015 through the national reporting and learning system (NRLS), three of which involved emergency operation centres. Two of these related to access, admission, transfer and discharge, and one to clinical assessment.

- Although the trust operated an incident database, staff were not aware of the system and it was used only by some departments. EOC staff reported incidents on paper forms which needed to be obtained from a senior member of staff. These forms, after initial investigation had been completed by the local manager, were sent to the safety and risk team, who then updated the database with appropriate detail. Staff told us in many cases they were not provided with feedback in response

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to the incident reported by them. It was not clear what systematic actions were taken in response to incidents to prevent future occurrence and mitigate risks. For example no response actions were recorded in a case where staff reported a communication breakdown between the clinical co-ordination desk and a member of a local hospital team, which potentially caused delay in treatment provided to a patient. There were limited opportunities for incidents to be discussed among teams to allow for shared learning.

- The report provided by the trust indicated an increase in the number of incidents in 2014 when comparing with previous years. A total of 1,115 incidents were reported which involved EOC. 23% more than in 2013 and 12% more than in 2012. It included 56 serious incidents, 40% more when compared with 2013. The majority of incidents related to patient experience (761); triage procedure, and calls that were inappropriately categorised (195).

- The investigation and learning from incidents, complaints and claims policy amended in October 2012 was due to be reviewed in June 2015. This policy described a role of the 'learning from experience group'. Its role was to provide a co-ordinated and focused approach to the review of incidents, and to ensure individual teams implemented improvements for patients, carers and staff. Staff we spoke with were unaware of this group which was tasked with facilitating learning and overseeing improvements.

Mandatory training

- Most of the dispatch staff and call handlers confirmed they were up to date with mandatory training. Staff told us they accessed some training through online courses and face to face training as and when this was available.

- The trust had set 100% target for participation in mandatory training. It included learning from serious incidents, health and safety, information governance, emergency preparedness, medical priority dispatch system; priority symptoms and good practice and update training related to the automated dispatch system. Records provided by the trust indicated that 83% of EOC staff completed mandatory training in 2013/ 2014 and 41% in 2014/2015.

- The training strategy group was responsible for determining which training was mandatory for LAS staff and the frequency for delivery of core training.

Safeguarding

- Staff raised safeguarding concerns with the ambulance operations manager or operational control manager. There was an 'emergency bed service' tasked with coordinating and quality assuring the referral process, and communication with local authorities. The trust provided us with contradictory information related to safeguarding referrals. One document stated that sixteen safeguarding alerts were raised with the local authority by the EOC team in 2014.This was higher than number of cases reported in 2013 (11). Another document stated that 355 referrals were made by EOC (concerning 219 adults and 136 children). It seemed that appropriate cases were referred to the safeguarding authorities judging from the examples of referrals we looked at. We spoke with a number of call handlers who told us they had not needed to raise a safeguarding concern for many years. EOC staff did not routinely discuss safeguarding referrals to share learning and increase awareness and patients' safety.

- Senior managers told us call handlers, dispatchers and allocators were provided with online safeguarding training (level1) every twelve months. There was also a two hour session on safeguarding allocated during the annual core skill refresher training. Records indicated only 43% of all EOC staff received designated safeguarding training.

Cleanliness, infection control and hygiene

- Call handlers relayed information related to health associated infections to ambulance crews members and risks were highlighted in the notes section on the patient record if needed. There were up to date protocols which advised staff on special measures and how to respond to diseases such as: rabies, plague, viral haemorrhagic fevers (Lassa virus, Marburg virus, Ebola virus and Crimean-Congo haemorrhagic fever). The service worked in partnership with the high security infectious diseases unit (HSIDU) at the Royal Free Hospital. A coordinated response with the hazardous area response team (HART) would be used for the transfer.

- We found appropriate hand washing and drying facilities available in toilets for staff and visitors.

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Environment and equipment

- Staff had access to equipment required to do their work.They told us it was well maintained and allowed them to do their job. For example there were headsets, IT systems with multiple screens, telephones and radio stations.
- The EOC premises were secure and all areas needed ID access.
- Call handling staff working at the Waterloo EOC complained that the environment they worked in was very dark. The room they were located had very limited amount of day light as it was located on a lower ground floor. They felt it was not suitable for long shifts. Staff of both EOC centres had access to a staff room and a kitchen which was located on the same floor.

Medicines

- We observed call handlers checking with patients whether they were taking any medicines or pain control medication and providing advice accordingly. Call handlers obtained advice from the clinical hub desks if they required clinical support.

Records

- The IT system allowed the flow of information from call handling to dispatch to responders. The service used a computer-aided dispatch (CAD) system to record details about patients who called. Records were initiated at the beginning of a 999 call. The call handlers asked a set of questions to prioritise calls as guided by the medical priority dispatch triage system (MPDS). All answers were recorded appropriately. Staff were able to update the records as more information became available.
- The trust used 'special notes' about patients to share with ambulance crews. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. We observed these were not easily accessible through the command point system used. Staff told us ambulance crews on occasion complained that they could not access documents directly from their mobile data terminals and needed to be instructed over the telephone.

Assessing and responding to patient risk

- The procedure for the dispatch of resources by the EOC was up to date; it provided guidance as to the roles, responsibilities and actions that were required to provide the most appropriate response in an appropriate timescale to meet patients' needs.

- The medical priority dispatch system (MPDS) was used by call handlers to make decisions related to dispatch appropriate aid to medical emergencies.It allowed for systematised caller interrogation and pre-arrival instructions. The Manchester Triage System (MTS) supported decisions made by clinicians working in the 'clinical hub'. Every call received in the dispatch area of EOC was categorised with a priority level linked to it. Often the priority of calls changed at varying points of the call process and the risk was assessed as different information was obtained.
- Mobile data terminals were used by ambulance crews.These devices were connected wirelessly to a central computer at the control centre and were used to pass details of jobs to the crew, and log the time the crew was mobile to a patient, arrived, and left the scene. It helped to locate crews in real time and provided information on their readiness to respond to emergency.
- Staff did not always assess and respond to patient risk promptly. Where demand outstripped available resources with calls being held in the dispatch area due to lack of available resources, contact was supposed to be made with the callers/patients at regular intervals. It helped to ensure callers remained informed of delays and allowed staff to update calls with any additional information or changes to the patient condition. Where appropriate calls were re-prioritised. The team responsible for call backs was guided by set time frames within which calls were supposed to be made. Records indicated they were not always able to meet these targets. In one case where an ambulance was not dispatched within the required eight minutes (life threatening emergency, category Red 2), staff did not follow up with a call back for 37 minutes in order to re-assess risk and provide the patient/ their relative with an update. On another occasion a call back was not made for 131 minutes (category red2). The performance related to call backs was monitored in real time. All EOC staff were aware how many calls were held and of call backs delays at any particular time. However, this information was not used to establish trends and inform actions which would help to prevent further breaches and minimise risk to patients.
- There were approximately 100 'community first responders' (CFR; volunteers trained to attend emergency calls received by the ambulance service and provide care until the ambulance arrives) who worked

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alongside ambulance crews and were able to provide immediate lifesaving support. They were based at home and were dispatched alongside the regular vehicle crews in situations where additional resources were required or if their estimated arrival time was quicker. CFR were instructed over the telephone as they were not equipped with mobile data terminals used to pass details of jobs to the crew.

Staffing

- Staff turnover rate within the emergency operation centre department was 15% in 2014/ 2015. The highest turnover was reported among emergency medical dispatcher level1 staff (EMD) at 28%, and nursing staff at 41%. The lowest turnover was among EMD allocators (5%), managers (7%), and sector controllers (6%).
- There were emergency medicine and critical care nurses who were employed by an external agency. They worked regular hours at the clinical desk while also working for another NHS trust.
- Records indicated low agency staff use within the emergency operation centre in 2014/2015. The percentage of hours worked by trust employed staff when compared with the amount of hours worked by agency staff was at 99.8%. However, 11.5% of all shifts were filled with bank staff (employed by the trust).
- Weekly resourcing performance indicators and daily call handling performance indicators indicated that significantly more staff were booked to handle calls than required. The trust used a management consultancy that used research techniques to support resource planning in the public sector.

Anticipated resource and capacity risks

- Major incident protocols, although following requirements of the Civil Contingencies Act, were not up to date. The document stated that it was to be reviewed at least annually by the department for emergency preparedness, resilience and response. However, it had not been amended since July 2012. The procedure included a description of actions by staff first at the scene and detailed actions which needed to best taken by the emergency operation centre.
- There was an incident control room (ICR) at the Waterloo emergency operation centre with additional events control room in Bow. Both rooms included a dedicated management suite, which was designed to support and manage the tactical command function during incidents and other operations (14 work stations

which allowed for two 'incident Islands' of seven work stations). A senior member of staff had responsibility to ensure that ICR was opened at the earliest opportunity once a serious or major incident had been identified. We were told that the room would be staffed with staff with dispatch experience to manage the incident and normal operations in EOC would be temporarily re-arranged to relocate sufficient staff numbers to ICR to manage the incident. This setting allowed controlling the incident from a single location, communicating with hospitals, perform primary logging duties, paging instruction procedures and allowed for the strategic overview of the incident. All services involved in response were able to communicate via airwave 'talk-groups' used by LAS commanders. There were inter-agency talk-groups available to all airwave users as well as a number of police and other agencies required to provide aid.

- The event control room (ECR) was intended to manage pre-planned events, with capacity to handle the control of large annual events or five smaller events simultaneously (35 work stations). Adjacent to the ECR suite was a dedicated event commander facility for the coordination and command of events. During multiple or protracted incidents, ECR could also be used to control incidents.
- There was a tiered structure of command to be implemented according to the severity of an incident, as determined by the major incident protocol. The command structure was designed to work on three levels: gold, silver and bronze. It specified what decisions need to be taken on operational level and others which needed to move onto tactical or strategic level. Staff we spoke to were aware who was allocated to take operational level decisions. There was a chart with allocated responsibilities for other command levels.

Is emergency operations centre effective?

Good 🟢

Calls were monitored daily for consistency and to ensure staff provided advice in line with agreed clinical protocols. All calls were categorised in line with the national guidance. LAS performed much better for call abandonment than the England average and was best

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amongst ambulance trusts in England. LAS performed better than all ambulance trusts in the time taken to answer calls. The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust in England. There was good coordination with other providers allowing for better patient experience.

Evidence-based care and treatment

- The procedure for the dispatch of resources by EOC was up to date and informed by relevant guidance. The dispatch team managed the allocation and prioritisation of vehicles in accordance with clinical need, and instructed vehicles to attend the scene. The dispatch operators had an overview of where ambulances were, and which call each crew was responding to. They allocated and re-allocated calls as needed, in accordance with clinical priority.

- Principles of professional guidance on the structure and content of ambulance records issued by Health and Social Care Information Centre, NHS England, Royal College of Physicians, and other professional representative groups were followed. It included the triage assessment by the dispatcher that determined the degree of urgency, the time the incident was allocated to the ambulance crew or individual responder, and additional post-dispatch information recorded and communicated by the dispatcher following allocation of the incident. This could include access instructions, such as key code. However, it was not always clear from the record that there was a care plan or similar information held by the patient or held on other health or social care registers. Patient records of significant medical, surgical and mental health history were not easily accessible which mean staff were not always informed of relevant previous diagnoses, problems and issues, procedures or investigations.

- 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.

- There was an agreed process for implementing changes to the triage system, used by call handlers to make decisions related to dispatch appropriate aid to medical emergencies and to provide staff with patient specific

information. However, it was not easily achieved as the software was managed by an external contractor. It was standardised to meet the needs of various providers across a number of countries.

- Staff were given paper sheets containing information they were required to provide patients with, which corresponded with surge levels.These were not included in the triage system. In addition, staff were provided with an exclusion list which was not contained within the triage system used by call handlers. Staff told us occasionally they were required to "circumnavigate the system" and ignore some of the answers provided by patients in order to achieve a desired outcome (i.e. initiate auto dispatch). Staff highlighted that some of the rare conditions/ emergency situations were not included in the triage system and they were required to obtain additional advice in order to make a decision and categorise the call. For example there was no advice card/tab to provide support for oil scalding.

Assessment and planning of care

- All calls were categorised in line with national guidance, for example Red1 calls which required response within eight minutes (classified as immediately life threatening). EOC staff aimed to dispatch any resource available including A&E support (respond to lower category calls and take patients who are in a stable condition to emergency departments) or any other nearest or additional resource allocated through computer-aided dispatch (CAD). There were measures in place to ensure the second vehicle was not cancelled if the A&E support crew arrived on scene before the back-up had been dispatched. A&E support crews formed one of two/three responders sent to these calls.

- Call handlers were supported by clinical staff and were able to transfer calls to the 'clinical hub' if they felt additional assessment was required. Members of the clinical hub had access to a directory of services and were able to guide patients to their nearest specialist or contact a specialist on their behalf. For example a midwife could be arranged for women in the early stages of labour.

Response times

- LAS performed much better for call abandonment (0.4%) than the England average (1.4%) and was best amongst ambulance trusts in England. This indicator

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measures the percentage of 999 callers who have hung up before their call was answered in an emergency control room. We observed that nearly all of the calls had been answered immediately.

- LAS performed better than all ambulance trusts in the time taken to answer calls with 50% of all calls being answered in less than one second and 95% in less than two seconds. 99% of calls answered below 37 seconds which was slightly better than the England average of 48 seconds.

- EOC staff were frequently unable to dispatch crews due to lack of availability of paramedics and general staff shortages. Dispatchers and allocators told us not being able to allocate calls as promptly as required was frustrating and demotivating. Records indicated that staff shortages were experienced daily among members of the ambulance crews, mostly between 18:00 and 05:00. For example in the week commencing 8 June 2015 staffing levels were 21% lower than required with over 30% staff shortage on one night. It also reflected in the proportion of life threatening emergency calls (Red1) responded to within eight minutes with LAS being the worst performing ambulance trust for getting to calls within eight minutes. It had failed to reach the 75% target since May 2014. EOC staff felt they were unable to deliver a good quality service as they were dependant on ambulance crews' availability.

Patient outcomes

- The proportion of emergency calls resolved by telephone advice was much better than for any other ambulance trust from April 2014 to February 2015 (13.3%). The trust performed better than the England average (8%).

- The 'hear and treat' service was provided by paramedics working within the clinical hub and METDG desk. They triaged serious but not immediately life threatening calls (C1 and C2) and non-life-threatening emergencies (C3 and C4). From December 2014 to May 2015, 47% of calls received by clinical hub and METDG were resolved without a need for dispatching an ambulance crew. In addition, 15% of calls initially triaged as life threatening were resolved under hear and treat (Red1, 20%; Red2 10%).

- Calls resolved under 'hear and treat' included 22% call backs for patients to be clinically re-assessed by a member of clinical hub team, and a further 22% re-assessed by the emergency medical dispatcher or a member of staff on the METDG desk.

- At 'surge red' (limited capacity to dispatch ambulance crews) all calls categorised as C4 for patients aged 2 to 69 years were given self-referral advice and then the call was closed at call-taking. The service had been on 'red surge' level (or above) since October 2014 and this potentially increased the percentage of patients recorded as 'treated'.

- LAS had the lowest telephone re-contact rate of patients within 24 hours after discharge of care, at 2% (England average 7.8%).

Competent staff

- The trust used the clinical hub desk (CHUB) to train senior paramedics. They were working at the desk for approximately seven weeks which allowed them to train, gain experience and then mentor the next group of trainees. Paramedics told us they were expected to work 10% of their shifts providing advice to patients over the phone on the clinical desk in order to keep their clinical practice current. They worked alongside agency nurses specialised in emergency medicine and critical care.

- Staff performance was monitored. Call handling staff received monthly feedback from their area controller on how they performed in relation to triaging emergency calls and the average time they spent to conclude a call. It was also monitored how long time it took them to record a patient's address and determine the nature of the complaint. The trust aimed to routinely monitor 1% of calls received by the emergency operation centre with the aim to establish if correct protocols were used and appropriate advice provided to the caller. Members of staff told us they had received feedback after their calls were listened to which allowed them to improve performance when necessary. The quality assurance compliance rate formed part of staff key performance indicators. Individual monthly compliance figures were available to call handlers documenting their compliance figures. Monthly individual and team compliance reports were also distributed to all EOC ambulance operations managers and operational control managers.

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- Records indicated that only 64% of all staff working within EOC had received an appraisal at the time of the inspection. The rate varied between 94% (E Watch) and 29% (C Watch). Only six out of 23 of the senior management team (26%) had their appraisals up to date. The percentage of staff who reported that they were appraised in last 12 months in The NHS staff survey 2014 was 31% and was much lower than the national average of 55%. Only 7% reported having well-structured appraisals in last 12 months (national average 20%).

- Staff handling calls had not received regular training in relation to dealing with abusive callers. Although this subject was included in the initial training provided to newly started employees, there were no updates or additional training provided to long term staff. A manager told us, when dealing with an abusive caller, call handlers would try to ascertain the nature of the emergency and the location to assess the risk and ensure appropriate action was taken in response. Call handlers told us there was no written protocol to provide them with an advice on how to respond to an abusive caller and that they would report it to their area controller.

- 43% of staff completed the Joint Emergency Services Interoperability Programme training (JESIP). This was designed for 'blue light services' to ensure that initial response to major incidents was organised, structured and practised.

Coordination with other providers

- LAS coordinated its response with the Metropolitan Police Service (MPS) by establishing the METDG service. This service helped to close approximately 60-70% of all MPS calls after advice had been provided by a clinician over the telephone. The service's command and control system was linked electronically with the equivalent system for London's Metropolitan Police. Police updates regarding specific jobs were updated directly on the computer-aided dispatch (CAD) log and could be viewed by the EOC which allowed allocating adequate resources to the job.

- Call handlers were provided with information on when to redirect callers to the 111 service (NHS non-emergency number) or transfer calls and how to respond when patients were handed over to LAS from 111. Staff told us they had good working relationship with providers operating 111 services across London.

- Staff gave examples of how they worked with other providers of health and social care such as; pre-alerting A&E departments about patients in a critical condition on their way to hospital, facilitating urgent ambulance transfers for calls made by GPs and other professionals or services who may request urgent ambulance transfers including for patients with mental health conditions or being detained under the Mental Health Act. They had good working relations with providers of emergency alarm monitoring services (personal alarms and tele-care products). There was a clinical co-ordination desk (CCD) which received details of priority patients from operational staff conveying patients to hospital and then passed on those details to the appropriate receiving hospital.

Multidisciplinary working

- EOC staff knew what type of calls should be allocated to the hazardous area response team (HART). It was a specialised small team of staff who have been trained to administer life saving medical care in hostile environments such as industrial accidents, natural disasters, and terrorist incidents among others. Although they were not aware of a protocol which described the type of calls which would routinely be allocated to HART team.

- We observed overall good multidisciplinary team working between the EMDs, clinical advisors and dispatch staff. However there were limited opportunities for cross-team communications with no team meetings arranged.

Access to information

- Staff told us they could access policies, protocols and other information they needed to do their job through the local restricted communications network. There were computer stations available at both EOC sites which could be used by staff.

- The medical priority dispatch system (MPDS) used by call handlers to make decisions on dispatching appropriate aid to medical emergencies, provided staff with patient specific information. It allowed for systematised caller interrogation and providing pre-arrival instructions.

- The Manchester Triage System (MTS) provided staff with information and supported decisions made by clinicians

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working in the 'clinical hub'. It allowed them to select from a range of presentations, and then to seek a limited number of signs and symptoms at each level of clinical priority.

- Community first responders (CFR) were provided with suitable patient specific information over the telephone as they were not equipped with mobile data terminals used to pass details of jobs to the crew.
- LAS emergency ambulances, response cars and other vehicles were fitted with mobile phones, two-way transceiver radios, global positioning systems (GPS) and an automatic vehicle location system (AVLS) through mobile data terminals on each vehicle. Staff working at EOC were able to access information provided by these devices in order to inform decisions related to response and dispatches. They were also supported by the computer-aided dispatch (CAD) system which consolidated emergency response command and control actions and helped bring resources to the scene of emergencies more rapidly and efficiently.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were mental health nurses able to provide advice related to patients with a mental health problem, Mental Health Act, and Mental Capacity Act. However, this service was not routinely provided 24 hours a day with occasional shifts being left uncovered.
- Staff allocating and dispatching vehicles were aware of specific response times and types of vehicles needed for patients being detained / transported under the Mental Health Act.

Is emergency operations centre caring?

Good ●

Emergency operations centre (EOC) services were delivered by caring and compassionate staff. We observed staff talking to people in a compassionate manner and treating them with dignity and respect. The staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress. Staff involved patients or those close to them in making decisions with support where necessary. Staff supported patients to cope emotionally with their care and treatment. The London

Ambulance Service participated in the 'hear and treat' survey for 2013/ 2014. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 321 patients for the London Ambulance Service NHS Trust. Overall the trust was performing similar to other trusts that took part in the survey.

Compassionate care

- Staff spoke to people in a compassionate manner and treated them with dignity and respect. They listened carefully to what was being said and rechecked information when necessary and were sensitive and supportive whilst on the phone.
- The London Ambulance Service participated in the 'hear and treat' survey for 2013/2014. This survey looked at the experiences of over 2,900 people who called an ambulance service in December 2013 or January 2014. Responses were received from 321 patients for the London Ambulance Service NHS Trust.
- People were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question. Overall, the trust performance was comparable to other trusts that took part in the survey.
- The 'hear and treat' survey indicated the trust scored 9.2 out of 10 for patients who felt the call handler listened to what they had to say and 7.9 out of 10 for having confidence in the call handler. The trust scored 9.2 out of 10 for patients who felt the clinical advisor listened to what they had to say and 8.4 out of 10 for having confidence in the clinical advisor. We also noted the trust scored 9.1 out of 10 for patients who felt they were treated with dignity and respect by the call handler and 9.3 out of 10 by the clinical advisor.

Understanding and involvement of patients and those close to them

- Staff demonstrated an understanding of the importance of involving patients and carers in their interactions.
- Clinicians who provided hear and treat services also re-triaged patients using the Manchester Triage System and would upgrade patients so that the ambulance would arrive sooner.
- We saw in the 'hear and treat' survey that the trust scored 8.7 out of 10 for patients who felt that the call handlers understood what they were being told.

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- We saw in the 'hear and treat' survey that the trust scored 8.8 out of 10 for patients who received understandable advice from a clinical advisor when an ambulance was not being sent.
- We saw in the 'hear and treat' survey the trust scored 9.7 out of 10 for patients who spoke to a second person, who understood the instructions about what to do if their situation changed.

Emotional support

- Staff were observed providing emotional support to patients awaiting the arrival of emergency responders by staying on the call until the ambulance crews arrived.
- The 'hear and treat' survey indicated that 7.8 out of 10 for patients who spoke to a second person who had any anxieties or fears, had the opportunity to discuss them with a clinical advisor. The trust scored 8.9 out of 10 for patients felt they were treated with kindness and understanding by the ambulance service.

Supporting people to manage their own health

- Patients were re directed to 111 services by 999 call handlers following triage for low priority calls and when demand escalation plans were in place.
- During 'hear and treat' calls we observed the clinicians discuss treatment options with patients, contact patients general practitioner's(GP's) and make arrangements for the GP to visit.
- Clinicians would also advise patients about managing their own health needs. This also included advising people to contact their GP surgeries.
- Frequent callers were identified with flags on records or against an address and call handlers could sign post patients to other services where appropriate. For example to the mental health crisis intervention team.

Is emergency operations centre responsive?

Requires improvement 🟠

There was no effective flagging system for patients with special and complex needs. 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, it was not effective and did not allow to access important information promptly. There were limited opportunities for learning

from complaints. Patients' complaints were not routinely discussed to prevent future occurrences or improve the quality of the service in response. The surge management plan was not implemented effectively and its incorrect use allowed for routine delays in ambulance dispatch and for prolonged response times potentially increasing risk to those in need of treatment.

Service planning and delivery to meet the needs of local people

- Each year, the Metropolitan Police Service (MPS) requests the LAS to respond to over 124,000 calls. In 2013, the LAS developed two initiatives to tackle demand from the MPS. The first was the provision of fast response vehicles dedicated to responding to MPS calls in specific London boroughs. The second was the METGD which provided clinical telephone advice to patients with minor injuries or medical problems, negating the need to dispatch an ambulance. Establishing the METDG service helped to close approximately 60-70% of all MPS calls after advice had been provided over the telephone.
- The METDG desk located in Bow, did not have permanently allocated staff and was staffed by bank staff working overtime. Staffing levels were irregular with the desk being unstaffed on some days.
- Each of the EOC allocators and dispatchers had a small geographical area allocated to them. They knew well their geographical patches including; main and side roads, bridges, local hospitals, traffic levels and temporary traffic limitation (i.e. road works). They also worked with a limited number of ambulance crews which were allocated to a similar geographical patch which helped, as they told us, to ensure better service, effective communication, and continuity.
- There was a control services surge management plan to ensure that at times of sustained high pressure the EOC provided a consistent service to 999 callers. The plan allowed for seven colour-coded levels of surge, which were imposed to manage crises when resources were stretched at a critical level (listed accordingly to impact, 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 authorised by the on-duty ambulance operations manager. The higher levels could only be authorised by the trust's "gold commander". There had never been a surge black called on record.

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- Staff told us since October 2014 the lowest surge level implemented was the surge red. In addition surge purple and enhanced purple were imposed on average eight times each month. The surge management plan allowed for calls related to patients between 2 and 74 years old to be routinely redirected to 111 service. In addition the surge level should be reviewed 4 hours post implementation then 8 hourly. Local managers told us they were not aware of regular reviews taking place as advised by the plan. Other staff told us there were frequent situations where no calls were held but no de-escalation was considered.A few of them added "red was the new green" as it was now "normal, and the lowest surge level".

Meeting people's individual needs

- A proportion of the trust's income in 2014/2015 was conditional on achieving quality improvement and innovation goals agreed through the Commissioning for Quality and Innovation payment framework (CQUIN). One of the goals set was improving staff awareness and provide training on mental health and dementia with an aim to improve the care for people with mental health needs and people living with dementia. Staff we spoke to felt confident in their ability to provide appropriate support, care and treatment to people living with dementia. However, EOC staff were not routinely provided with dementia training to ensure they were able to recognise when a person may have dementia. They had also not received training on end of life care which would include recognising the wishes of patients regarding their preferred place of death, discussing death and dying, breaking bad news and palliative care emergencies as well as understanding legal and ethical considerations.
- An EOC manger reported approximately 50% of EOC staff attended half day mental health training provided by a charity specialising in providing advice and support to people experiencing a mental health problems. In addition a two hour session on mental health was routinely provided during the annual core skill refresher training. There were mental health nurses available to provide advice relating to patients with a mental health problem, but this service was not routinely provided 24 hours a day.
- Call handlers did not routinely check patients' body mass index. There was no effective flagging system for those who had used specialist bariatric equipment in

the past. Since May 2014 two specialist vehicles were available to dispatchers. Allocators were unable to locate and dispatch them by the system used for other vehicles and were required to instruct crew members over the telephone.
- 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 that the translation service was meeting callers' needs adequately.
- Staff had access to a text service to help people with hearing loss and/or a speech impairment to access the telephone system.
- The proportion of calls from patients for whom a locally agreed frequent caller procedure was in place for LAS was slightly higher (1.6%) than the England average (0.9%) in April 2014 to February 2015. 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, it was not effective and did not allow to access important information promptly. 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 did not always take place.

Access and flow

- The control services function was operated from the emergency operations centre at the trust headquarters and Bow annexe. Both sites acted as one virtual control room with normal working or business as usual. All of the day-to-day control services functions operated at the same time in both EOC sites using a computer-aided call taking and dispatch system. Each control room had call-taking and dispatching facilities which allowed the transfer of any sections of the operation to either site depending on the needs of the service.
- There was an intelligence conveyance desk (ICD) at the Waterloo emergency operation centre to support management of pressures at London emergency departments (ED). The aim was to proactively balance the arrival of ambulances across London trusts to

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reduce the surge of ambulance attendance at busy hospitals. The team was able to monitor the number of ambulances waiting at hospitals and the time spent waiting.

- There was no protocol to advise staff on the critical point when an ambulance should be redirected from one emergency department to another. The information available to staff working on the intelligence conveyance desk did not automatically feed into the system used by dispatch and allocation staff. There was a list of exclusions for patients who required complex care and urgent life threatening conditions.

- The staff working at the intelligence conveyance desk (ICD) told us occasionally patients were taken to busy A&E departments by ambulance crew members despite their advice.

- Records indicated that on the week prior to our inspection (week commencing 25 May 2015) approximately 8.5% of patients were taken to the nearest emergency department contrary to ICD staff advice (crew conveyed to nearest Emergency Department (ED) despite receiving hospital information from the IC desk). However, reasons given by crew members for this included patient choice and technical issues with the messaging process.

- There were personal support plans developed for people who required frequent support. These were available from the clinical hub. Call handlers and vehicle crews did not routinely have access to these documents and were required to obtain it from the clinical hub desk.

- Dispatchers and allocators were responsible for allocating jobs to the hazardous area response team (HART). Although dispatchers and allocators assigned calls accurately they were not aware of a written protocol which specified dispatch criteria. An area controller told us decisions were made on an individual basis and staff used their personal experience and expertise to decide on job suitability. We noted that HART teams were also dispatched to regular calls (category red 1 and red 2) if they were free to respond.

Learning from complaints and concerns

- There was a system for recording complaints and the action taken in response. It distinguished which

complaints related to which team and the overall nature of complaints. However, the system was not used effectively with either no or minimal outcome information recorded.

- Many complaints made in November and December 2014 were unresolved and were still open at the time of inspection. There were 260 complaints recorded in that period and 120 were still open at the time of inspection.

- The trust policy specified that a written response in non-complex cases would be provided within 25 days, with those cases of significant complexity allowed 35 working days' response and the most serious up to 60 working days.

- Most complaints related to delays in ambulance dispatches and long waits; others were from patients who were referred to NHS 111 when they believed their condition was very serious.

- There was limited learning from complaint opportunities for staff. Patient complaints and cases were not shared with staff and they had no information about actions taken by the trust and learning from complaints. Staff told us trends were not discussed and there was no plan to minimise the number of complaints, prevent future occurrences or improve the quality of service in response. Feedback was not routinely provided to individual members of staff when a complaint was raised against them.

- In the NHS staff survey 2014, the percentage of staff who agreed that feedback from patients was used to make informed decisions in their department was much worse than the national average (14% compared to 31%).

Is emergency operations centre well-led?

Inadequate ●

There was no long term strategy for the EOC. There was insufficient operational overview and management of appraisals paired with poor performance and risk monitoring. The risk register was not kept up to date. Staff reported a bullying culture and told us that the trust did not proactively act to address it. The restructure of the EOC had not been managed well. Staff did not feel involved and

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told us changes were imposed from the top down. The service participated in the 'hear and treat' survey but did not proactively seek the views of the patients who used the service.

Vision and strategy for this service

- Three main trust values were; care, clinical excellence and commitment. Some staff advised us the trust's values had changed recently and it was communicated via the trust's staff intranet page: 'Pulse'. Others we spoke to in the EOC were not aware that the values had changed. Senior managers told us they recognised the need to involve staff in the decisions made and establish stronger processes for obtaining staff feedback.It was also one of the quality improvement priorities for 2014/15. However, staff told us they had not been always involved in decisions affecting their work and the trust, including developing the trust's new values.

- Staff in the EOC, including local managers, were not aware of a long term strategy for the EOC or the trust's vision and strategy. There was a business plan designed for control services (2014/2015), which supported the strategic and operational plan for the integrated business. It highlighted short term service delivery objectives, mostly focused on staff restructure, retention and development.

Governance, risk management and quality measurement

- The EOC maintained a risk register. The last risk identified on the register was in April 2013 and had not been regularly updated. We did not see that all risks were listed, for example the failure of the computer based Command Point system in the EOC. The system had failed in May 2015 which resulted in the EOC having to result to paper based systems. Staff told us the system had crashed on more than one occasion.

- Risks and issues were not dealt with in a timely manner. The lack of quality assurance for dispatch had been identified in February 2013 which required additional resources. The risk register showed that in July 2014 additional staff had been obtained but there was still no capacity for quality assurance of dispatch services.

- The trust had an audit team that audited all 999 calls and monitored operational performance against national requirements. All calls were recorded and a proportion was audited on a random basis.

- Call handlers told us 1% of all their calls should be monitored. A call auditor told us they aimed to audit calls of all staff. However, there was no standardised system to ensure this occurred.

- Staff working in the clinical hub advised us that they would undertake daily peer reviews, listening in to each other's calls. Check sheets were used and they would constructively feedback to colleagues.

- There was insufficient operational overview and management of staff appraisals. Managers told us that support received from the human resource department was inadequate which made tackling poor performance and frequent staff absence difficult.

- Staff were not routinely provided with feedback in relation to incidents and complaints received by EOC. There were minimal opportunities for shared learning and using learning to improve the quality of the service. Team meetings were not organised routinely and there were no opportunities for cross-team communication.

Leadership of service

- Staff told us that the restructure of the EOC had not been managed well, with little perceived staff involvement. They perceived that it had been imposed from the top down with the trust announcing in January 2014 the plan to restructure its managment tier by September 2014.

- The trust stated,however, that, in January2014, the Director of Operations had begun an informal consultation with staff over a plan to restructure its management tier. Formal consultation began in October 2014. However the reorganisation of the workforce had not been completed at the time of the inspection in June 2015.

- Staff on family friendly rotas told us they did not have equal opportunities for promotion, training or development. Examples were provided of there being no protected training time allocated to staff working part-time.

- Staff spoke openly about the lack of support from the executive management team and some staff were not aware of the individuals on the executive team. Although the EOC at Waterloo was located in the same building as the head office, staff told us senior managers had not visited them and were not visible.

- Staff turnover rate within the emergency operation centre department was 15% in 2014/2015. The highest turnover was reported among emergency medical

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dispatcher level1 staff (EMD), at 28%. Many staff told us of a culture of bullying from senior management and that some of their colleagues had left the service as they were unhappy with the leadership of the service. At the same time call handlers, allocators and dispatchers told us they felt supported by their direct team leader.

- EOC staff worked under constant severe pressure, often being unable to provide quality support due to delays in response times and lack of availability of ambulance crews. Staff were not routinely offered emotional support or counselling even after they were involved in stressful incidents which could impact on their well being. Many felt there was no recognition from LAS.

Culture within the service

- We found that staff felt that they had an important role. They said they worked well as a team and supported each other. EOC operational staff were focused on providing a good experience for patients. They were patient-focused and aimed to provide a good quality service. We observed that local teams were mostly supportive of one another.

- Many staff told us they felt the culture within the trust needed to improve. Staff were unable to openly challenge each other and they felt the management of the service was not supportive. Others told us some of their colleagues had left the department as they did not feel they were valued by their managers and the trust. A member of staff told us they were planning to leave the trust because of an outstanding dispute with their manager which was not resolved satisfactorily. Staff did not think enough was being done and conflict resolution strategies did not worked well. We were informed of a case where a senior manager had been verbally abusive towards a member of staff. We also noted another example when a manager had been impolite in their response to staff when they requested advice and suggested a solution to a problem. We were approached by other staff who felt that they were intimidated by their managers and felt that they exhausted all avenues available to them in order to resolve the issue.

- There was a discrepancy between staff's views and senior EOC managers' perception of the culture within

the service. Senior managers spoke about staff's positive morale and told us staff were well supported by the trust. They also felt conflict resolution strategies were effective.

- The overall percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver reported in the NHS staff survey 2014 was much lower (50%) than the average (73%). The percentage agreeing that they would feel secure raising concerns about unsafe clinical practice was also lower (43%) that the national average (59%). Only 8% of staff reported good communication between senior management and staff. It was also worse that then national average (17%) and worse than the percentage reported for the trust in 2013. 73% of staff did not feel able to contribute towards improvements at work (national average 56%). There was no action plan for EOC to improve the result and address problems highlighted by staff through the survey.

Public and staff engagement

- The service had participated in the national hear and treat survey and performed similar or better than other trusts.

- 31% of staff across the trust completed the NHS staff survey 2014 survey, which was a reduction from the previous year. The survey showed that the trust rated worse than average in 29 of the 30 findings. Some of the EOC staff told us they were scared to complete the staff survey in case it was traced back to them.

Innovation, improvement and sustainability

- The clinical hub was staffed with paramedics who covered the hub on rotation; registered general nurses (agency) with backgrounds in accident and emergency and intensive care and mental health nurses. The clinical hub provided hear and treat services which resulted in more patients being treated out of hospital.

- The METDG desk re-triaged Metropolitan Police Service calls to determine an accurate priority and facilitate more effective tasking of LAS resources. This service helped to close approximately 60-70% of all MPS calls after advice had been provided by a clinician over the telephone without a need for dispatching a vehicle crew. The service's command and control system was linked electronically with the equivalent system for London's Metropolitan Police.

Resilience planning

Safe	**Inadequate** ●
Effective	**Requires improvement** ●
Caring	**Not sufficient evidence to rate** ●
Responsive	**Not sufficient evidence to rate** ●
Well-led	**Requires improvement** ●
Overall	**Inadequate** ●

Information about the service

London Ambulance Service resilience function was provided trust wide from its Emergency Operation Centre at Waterloo. The trust also had two HART (hazardous area response team) teams, based in the London Boroughs of Hounslow and Tower Hamlets. The team based in Hounslow was the major HART team base. HART provide a specialist team, which is part of the overall ambulance response to an incident involving hazardous materials, or which present hazardous environments, that have occurred as a result of an accident or have been caused deliberately. The HART base contained specialist equipment and a range of vehicles to support the resilience function and included vehicles containing equipment for mass casualty events.

During the inspection we visited both the HART bases and the Emergency Operation Centre at Waterloo. We inspected vehicles and equipment including medical bags and breathing equipment. We spoke with a variety of staff including those working across the wider resilience function, front-line HART paramedics and both junior and senior managers.

We conducted a planned inspection on 17 and 18 June 2015. We were unable to observe direct patient care because the opportunity to accompany a crew to a call-out did not arise.

Summary of findings

Serious concerns were identified about how the trust had been fulfilling their responsibilities to deliver a HART capable service to the NARU specification, because of insufficient paramedics. As a result there was not a safe system of working where an effective HART response could be utilised.

Incidents were recorded in a log book and staff debriefing took place following major incidents. However, some staff did not routinely receive feedback about the incidents they reported.

Several gaps were identified in the overall skill, training and competence of HART paramedics. For example, low numbers of staff had undertaken training in 'confined space' and initial operational response (IOR); and there had been no physical competency assessment of staff in the past two years.

There were appropriate special contingencies for dealing with acts of aggression such as improvised explosive devices (IEDs), aircraft incidents and public disorder. The trust worked with national groups to develop policies and support staff around operational HART guidelines.

When the emergency operations centre (EOC) received a 999 call for an incident that would be suitable for a HART response, the call handler sent the nearest HART resource to the incident. However, there was a sense from staff that the HART service was being under-utilised.

Resilience planning

The trust's overall Emergency Preparedness, Resilience and Response (EPRR) assurance compliance levels, showed that plans and work programmes did not appropriately address one or more of the core standard that the organisation was expected to achieve. The risk register did not list insufficient HART paramedics, when we would have expected it to.The NARU NHS Service Specification 2015/16 for HART teams had not been fully implemented.

Some staff felt supported by colleagues and senior management within HART but others felt undervalued by managers outside of the team.

Is resilience planning services safe?

Inadequate ●

Serious concerns were identified about how the trust had been fulfilling their responsibilities to deliver a HART capable service to the NARU specification, because of insufficient paramedics. On several occasions there was less than the acceptable level of six paramedics on duty. This was not a safe system of working where an effective HART response could be utilised.

Incidents were recorded in a log book and staff debriefing took place following major incidents. However, some staff did not routinely receive feedback about the incidents they reported. The ambulances we inspected were largely found to be clean and tidy. However, the office environment at the Hounslow team base was dirty and overcrowded. Equipment on vehicles was audited periodically. Staff knew how to make safeguarding referrals and how to complete the form.

Incidents

- There was a major incident plan to ensure that the trust was capable of responding to major incidents of any scale in a way that delivered optimum care and assistance to the victims. The plan was prepared in light of guidance from the Department of Health, Home Office and Civil Contingencies Act 2004.
- The London Ambulance Service was tasked by the London Emergency Services Liaison Panel (LESLP) to conduct a structured debrief in to the structural collapse of part of the ceiling at the Apollo Theatre in December 2013 and subsequent declaration of a major incident. The debrief was attended by members of the London Ambulance Service, London Fire Brigade, Metropolitan Police and London Resilience Team.
- Incidents were recorded in a log book and staff debriefing took place following major incidents. However, some staff told us that the never got any feedback about the incidents they reported. The safety and risk team logged incidents on datix (Patient safety and risk management software for healthcare incident reporting and adverse events). However, low staffing numbers (which occurred very often) were not reported as incidents.

Resilience planning

- Lessons were learnt following incidents. For example, following a power switch unit failure at the trust headquarters, risk assessments were upgraded and the unit is now tested more regularly.
- The incident command suite was located in the emergency operations centre. There were systems and plans; clear roles and functions for team members were identified. Pager was tested on a daily basis.
- The medical director attended all elements and phases of major incidents and reviewed and reflected on incidents to ensure lessons were learnt and embedded into practice.

Cleanliness, infection control and hygiene

- We observed the environment and vehicles at the HART bases. Trust policies and procedures make clear that all employees have a duty to prevent and control infection. However, the office environment at Hounslow was dirty as evidenced by thick black dust on nearly all surface areas including consumable items and in vehicles. One staff member told us that this was normal and it had been raised with management.
- The ambulances we inspected were largely found to be clean and tidy, both inside and out.

Environment and equipment

- Each HART site had five emergency vehicles that were available to deploy in the event of a major incident. These were broken down as two HART rapid response vehicles (RRV), one HART command vehicle, one large bulk vehicle and one incident response unit (IRU). There were six serviceable decontamination units available and 316 live powered respirator protective suits (PRPS), which were used for emergency personnel after a chemical or biological incident.
- Equipment on vehicles was audited periodically. We checked the kit and equipment at both the Tower Hamlets and Hounslow sites. There were good audit trails and a very tight and efficient check of the kit on the vehicles. Equipment included, incident equipment boxes, suction machines, oxygen cylinders and defibrillators. The defibrillator we checked on a vehicle in the East team base was fit to be used in an emergency and had pads that were in date.
- One manager described maintenance and replacement of kit and equipment when faulty was a challenge.
- There was a HART command vehicle in an acute NHS hospital in the East of London (Romford), which was being used as an office to support both HART and the acute trust. There was also another mobile EOC vehicle (command vehicle) on station at Cody Road (HART East base), but this had not been operational pending repairs, since May 2015.
- There was one available 'off-road' emergency ambulance, which was located at the Hounslow base.
- One staff member told us that the HART West Team (Hounslow) was overcrowded; having been designed for 42 staff members on rotating shifts but currently supported nearer 80, due to the accommodating the central operations teams. They told us that in the past, this site was able to support HART staff practising their skills in the garage area, but this was no longer possible due to the mass of vehicles. The staff member also highlighted that the staff changing room was given over to the central operations department, therefore staff had nowhere to change as a result. This staff member also told us that the training room that was on site had been handed over to the occupational health department and the new room was too small to practise in.

Medicines

- Paramedic shift-based drug packs were signed out by staff at the start of each shift. All medicines we checked were in date.
- We found that medicines in responder bags had no traceability and salbutamol inhalers were found to be out of date. No records could be found that would allow for an audit trail of these medicines.

Records

- Patient record forms (PRFs) are completed and sent to team leaders for logging. We were told that team leaders audited PRFs.

Safeguarding

- The trust had a safeguarding report form and a reporting mechanism. Staff spoken to at both HART sites knew how to make safeguarding referrals and how to complete the form.

Mandatory training

- The HART function operated within a service specification defined by the National Ambulance Resilience Unit (NARU) which required each HART team to have a whole time equivalent training resource and for one week in seven to be a dedicated training week.

Resilience planning

The trust was achieving this standard, however, we were not assured that each team member attended their training week as rostered, due to leave or other commitments.

Assessing and responding to patient risk

- We spoke with a team of HART paramedics, including team leaders, about assessing and responding to patient risk. We found that there were effective systems in place to manage large events.
- A description of how the trust managed two large mass gather events (Notting Hill carnival and Wimbledon Tennis) was explained.

Staffing

- The NARU's HART Interoperability Standard number 12 states 'The provider must maintain a minimum of six competent HART staff on duty for live deployment at all times. We noted that on regular occasions in a six week period, the HART's staffing resources were below this standard. We found there were fewer than four HART staff available at each site on a number of occasions during this period. There were occasions where there was only one HART member of staff on duty in the East and one on in the West. This was not a safe system of working where an effective HART response could be utilised.
- Shortage of staff was expressed as a major concern by those we spoke with. The overall vacancy rate for staff with an EPPR function was 15.6%. Staff attrition rate was at 10%, an increase from a steady 7.5% and some resilience staff had transferred to the frontline emergency ambulances.
- In May 2015 at Tower Hill, the HART had vacancies for one team leader, 8 operational staff, 31 days were lost during the year due to staff absences as a result of non-work related injury/illnesses. There were 27 shifts during the month where there were less than six HART staff on duty.
- In May 2015 at Hounslow, the HART had vacancies for seven operational staff, 38 days were lost during the year due to staff absences as a result of non-work related injury/illnesses. There were 24 shifts during the month where there were less than six HART staff on duty.
- However, following a request to the trust for further information after the inspection visit, they submitted staffing figures for both East and West HART teams in July 2015. In the East Team, there were 40 occasions

(day and night) when there were fewer than six HART staff available. In the West Team, there were 53 occasions (day and night) when there were fewer than six HART staff available. This regular pattern of staffing the HART teams below the expected number of paramedics was a major concern for us.

- One staff member told us that on occasions, the trust had put all HART personnel on ambulances, effectively removing the HART response from the public. We were also told by one staff member that the trust did not follow the national specification to have two HART paramedics available at all times to be able to respond in two fast response vehicles, which were not to be put under the day to day dispatch systems but could be tasked to local medical emergencies. Instead, managers allocated two members of the HART team to an ambulance under the control of the emergency operations centre, further depleting the already limited resources of the HART teams.
- The number of 'Bronze' staff available was 12 and the number of operative staff available to deploy was 214.
- During our visit in June, we found that there were vacancies for 11 frontline staff in HART. Some staff stated staff were leaving because they felt 'fed up' with not being utilised for HART jobs, but for other operational ambulance calls instead. One staff member stated they had actually asked to return to an operational ambulance job in the emergency and urgent care team because of being under-utilised in HART.
- Voluntary groups were on call in the event of a major incident, which would enhance the staffing complement.
- We were told that the ability for specific teams to support response times was a challenge because of high staff vacancies. However, it was not possible to back fill HART staff shortages with frontline staff on a daily basis due to training and equipment issues.
- Senior managers stated that staffing vacancies was a concern. We were told that the trust was attempting to recruit both internal and external staff to HART, but this was a challenge due to the remuneration package. Senior staff acknowledged that recruitment and retention was a challenge. HART had recruited nine paramedics in the past year, but the process following interview took seven months and there were issues with the occupational health process. As a result three of the appointees withdrew.

Resilience planning

- It was recently agreed to increase the staff in the EOC including staff in the clinical hub from 558 to 652.

Medical staffing

- The medical director told us there were 15 medical consultants who provided 24 hour on-call support to trust staff including those in HART.
- The whole medical team were encouraged to attend large events/incidents.
- All doctors go through the operational commanders' course and then shadow events so that they can gain experience and develop their skills.

Security

- We were told that security at the HART bases was an issue. Staff said that on occasions, they have had to 'chase' trespassers out of their garages. Part of a security fence and catalytic converters from ambulances had also been stolen in the past.

Business continuity management

- We saw the London Ambulance's strategy for business continuity of its resilience function (2014). The purpose of this strategy was to have an effective business continuity management service to meet the organisation's legal and statutory obligations, to ensure that in the event of a business disruption, it could continue to undertake their prioritised activities.
- The director of operations oversaw the trust's emergency preparedness efforts including the business continuity management programme.
- Managers did not receive much business continuity training and an e-learning package was in the process of being developed.
- Business continuity management plans were tested regularly (five times in the past year) and lessons learnt applied. However, we found that business continuity plans for inclement weather such as heavy snowfall had not been tested.

Is resilience planning services effective?

Requires improvement ●

Several gaps were identified in the overall skill, training and competence of HART paramedics. For example, low numbers of staff had undertaken training in 'confined space' and initial operational response (IOR); and there had been no physical competency assessment of staff in the past two years.

There was an emergency preparedness strategy (2010 – 2015), aimed at building and maintaining organisational resilience. The trust worked with national groups to develop policies and support staff around operational HART guidelines. There were appropriate special contingencies for dealing with acts of aggression such as improvised explosive devices (IEDs), aircraft incidents and public disorder.

Some staff received one to one supervision on a six-weekly basis and were meant to be appraised on their performance three-monthly and yearly. However, we were told that many HART paramedics had not had an appraisal.

Multi-agency meetings took place in order to plan and deliver services. For example, there were safety advisory groups with attendees from different London boroughs.

Evidence-based care and treatment

- The trust had an emergency preparedness strategy (2010 – 2015), aimed at building and maintaining organisational resilience. The strategy identified clear pathways and processes to ensure the trust (and the wider health economy) was both well prepared and resilient to disruptive challenges such as major incidents or severe interruption to critical business functions and activities. The strategy also supported the Department of Health's statement of NHS organisations being "individually resilient, collectively robust" in terms of emergency preparedness capabilities.
- The pulse magazine was seen on the HART premises, but we were told that nothing from HART was usually published in it. Some HART information was published in the Emergency, Preparedness, Resilience and Response (EPRR) bulletin.
- Monthly EPRR meetings took place where relevant matters such as the risk register were discussed.
- The resilience command structure was explained to us as Gold (strategic), Silver (tactical), bronze (operational).
- The trust worked with national groups to develop policies and support staff around operational HART guidelines.
- We saw the HART audit (May, 2013). Most of the recommended actions had been completed. However, the implementation of regular physical competence

Resilience planning

assessments to meet the statutory re-certification training and assessment had been delayed until July 2015. Physical competence assessments are the fitness tests required in the NARU specification that should be completed every six months to ensure staff had the required fitness.

- There were appropriate special contingencies for dealing with acts of aggression such as improvised explosive devices (IEDs), aircraft incidents and public disorder.

Competent staff

- HART paramedics could only perform certain medical interventions after having specialist training.
- There was a training week every seven weeks for staff to attend. Some staff told us that although they had been trained in extended skills such as insertion of chest drains, they did not use these skills as they tended to be performed by heli-medics from air ambulances.
- Staff were given learning opportunities and encouraged to developed their careers. Two staff members told us the training provided was very good and they had protected time for it. Resilience training was provided to staff.
- There was a full-time chemical, biological, radiological and nuclear (CBRN) trainer.
- We were told by one member of staff that despite asking for the skill-mix of HART staff to be placed on the risk register, this was not done by their line manager. There were also only seven staff trained in to operate in 'confined space'.However, there were 46 staff trained in urban, search and rescue paramedics (USAR) across the two teams and this was line with the NARU specification.
- There had been no physical competency assessment of staff completed in the past two years. This was not in keeping with the NARU competency standard number 25.
- There was an issue with the very small number of staff who had either received initial operational response (IOR) training or their training had expired (six to seven staff out of the whole of the two HART teams). This was a serious concern. One of the HART training managers was aware of this. They told us they tried to escalate it, but were told not to put it on the risk register by their manager and was having procurement issues in trying to get a course set up.

- There were a number of ambulance technicians, but they were not able to do a range of HART training. This was because, the HART job specification was for staff to be paramedics not technicians, due to the clinical skills required.
- All paramedics in the country were allowed to intubate patients if they had received the appropriate training. We were told that whilst in the past, HART staff were required to intubate patients, the trust had now removed this expectation from their roles.
- Some staff received one to one supervision on a six-weekly basis and were meant to be appraised on their performance three-monthly and yearly. However, we were told that many HART paramedics had not had an appraisal. One senior manager told us that plans were being developed to address this issue.
- Personal issue action cards had been provided to all managers.
- HART staff maintained their skills by working with the EPPR team and undertaking joint training with the frontline operations team.
- Some staff told us that they were sent to work in the EOC to 'floor walk' or carry out 'call backs', but had not been trained to undertake these roles.

Multidisciplinary working and coordination with other agencies

- As part of its major event and EPRR plan, we were told that the trust regularly tested its major incident plan alongside other agencies.
- Multi-agency meetings took place in order to plan and deliver services. For example, there were safety advisory groups with attendees from different London boroughs.
- The computer aided dispatch (CAD) was combined with the metropolitan police, but there were some technical challenges with some elements of the CAD.
- The incident command suite had a live view of Transport for London screens, to identify any transport issues.
- Staff undertook training on managing conflict with the police and we found there were good relationships with all London local authorities.
- Multi-agency team debrief took place prior to events. Debrief was facilitated by the EPRO officer and the medical director attended. Following events, outcomes and actions were reviewed which included informing NHS England.

Resilience planning

• The Metropolitan Police Counter Terrorism Unit held a multi-agency live exercise in the London Borough of Croydon on the 9 February 2014 as part of their responsibilities under the Civil Contingencies Act. The trust provided appropriate resources to ensure the objectives of the exercise were met. The aim was to exercise the first response to a terrorist related incident and to explore the complexities which might arise. The participating agencies were London Ambulance, the Metropolitan Police, Police Explosives Team, London Fire Brigade and London Borough of Croydon.

Seven-day services

• The HART service was on standby and operational 24 hours a day, seven days a week.

Access to information

• Staff described a number of bulletins that were sent out to staff and these were usually displayed on the staff notice board and/or discussed at team meetings.
• Policy guidance documents and other clinical guidance were accessible via the intranet.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

• Staff we spoke with knew about the requirements for patients consent and the Mental capacity Act, 2005.

Is resilience planning services caring?

Not sufficient evidence to rate ●

We were unable to observe HART staff interact with patients during the inspection as the opportunity to attend a call-out did not arise. Therefore we were not able to rate caring.

Compassionate care

• We were unable to observe HART staff interact with patients during the inspection as the opportunity to attend a call-out did not arise.

Understanding and involvement of patients and those close to them

• We were unable to directly observe HART staff interact with patients.

Emotional support

• We were unable to directly observe HART staff interact with patients.

Is resilience planning services responsive?

The service demands and constraints were assessed and a (Resource Escalation Action Plan) REAP level was assigned as required by national practice standards.

When the emergency control room (EOC) received a 999 call for an incident that would be suitable for a HART response, the call handler sent the nearest HART resource to the incident. However, there was a sense that the HART service was being under-utilised.

Service planning and delivery to meet the needs of local people

• The Home Office had commissioned and were funding a two year programme of work to improve the ability of the 'blue light' emergency services of the United Kingdom to work together with the overarching aim of saving as many lives as possible. The project was called the 'Joint Emergency Services Interoperability Programme' or JESIP. This had an objective to train 400 ambulance commanders in the JESIP methodology. The trust had about 372 trained commanders at the time of the inspection.
• Several staff members commented about the under-utilisation of HART. They claimed that this was because the team was not being allocated sufficient jobs by the EOC. Technical resilience was also expressed as a concern by senior staff.
• The service demands and constraints were assessed and a (Resource Escalation Action Plan) REAP level was assigned as required by national practice standards.
• We saw the operational arrangements for the response to industrial action within and/or directly affecting the London Ambulance Service.
• We were told that in the autumn of 2014, all but one of the paramedics in the HART East Team were put on ambulances and the HART West Team had to cover London.

Meeting people's individual needs

• When the emergency control room (EOC) received a 999 call for an incident that would be suitable for a HART response, the call handler sent the nearest HART resource to the incident. The HART vehicle tasked to the

Resilience planning

incident had a call sign and the call handler needed to ensure that they identified their call sign and attach the case to that call sign/vehicle. However, there was a sense that the HART service was being under-utilised.

Learning from complaints and concerns
- We were told that the HART team did not receive many complaints about its function.

Is resilience planning services well-led?

Requires improvement ●

The trust's overall EPRR assurance compliance levels, showed that plans and work programmes did not appropriately address one or more of the core standard that the organisation was expected to achieve. The risk register did not list insufficient HART paramedics as a risk, when we would have expected it to. The NARU NHS Service Specification 2015/16 for HART teams had not been fully implemented.

Senior HART managers were visible and interacted with frontline staff, but senior trust wide managers were less visible.

Some staff felt supported by colleagues and senior management within HART but others stated they felt undervalued by managers outside of the team. Staff felt able to raise their concerns within the HART team but had a negative view of how supported they would be by other managers.

The trust carried out several simulation exercises in order to test the organisation's capability in the event of a major incident.

Governance, risk management and quality measurement
- The trust self-assessed its overall EPRR assurance compliance levels in line with guidance issued by NHS England in July 2014. Compliance level was rated as 'substantial'. This meant that plans and work programmes did not appropriately address one or more of the core standard that the organisation was expected to achieve.
- We saw the organisation's risk register related to emergency preparedness. Insufficient staff was not

listed on the register, but inadequate training of staff and managers in major incident procedures was. We were told that a risk register specific to HART was in the process of being developed.
- Risk registers were communicated through the resilience forums and staff met with the police on a weekly basis to discuss key risks.
- The business continuity and management (BCM) leads met with each other once a quarter. However, it was documented that the BCM disaster recovery group was not sustainable with the current number of attendees.
- There were monthly EPRR business meetings. Topics discussed included updating staff on HART, JESIP and upcoming training exercises.
- Staff told us the trust made quality and safety a priority. For example, events such as the Notting Hill carnival were over-resourced so as to ensure a quality service.
- The medical director worked with the head of the EPPR to risk assess events.
- Resilience data across both HART sites was not replicated. Senior staff explained that whilst it was possible for this to be done, the cost was prohibitive.
- The medical director reviews emerging risks and provides advice for staff.

Leadership of service
- One staff member told us that the NARU NHS Service Specification 2015/16 for HART teams had not been fully implemented in London, with the staff being told that the management were 'considering what was applicable to them'.
- Staff told us senior HART managers were visible and interacted with frontline staff. However, they said other managers from trust were rarely visible.
- Staff told us that their managers had an open door policy.
- We found that the director of operations had a comprehensive knowledge of the utilisation of HART.

Culture within the service
- We spoke with a group of HART paramedics about the culture within HART and across the service. Some staff stated they felt supported by colleagues and senior management within HART. However, some HART team members also stated they felt undervalued by managers outside of the team. They felt able to raise their concerns within the HART team but had a negative view of how supported they will be by other managers.

Resilience planning

- We found staff knew how to ask for advice and support when necessary, but one staff member felt frustrated that HART staff were banded below HART staff in other areas in the country.
- One staff expressed concern that with the recent management restructure, their line manager's post had been deleted and they were waiting to see how this will work out.
- Several staff commented that they wore the same uniform as front line ambulance staff which was not practical for their job. This was believed to be because they would blend in more and if were required to go on a normal ambulance.
- Sickness rates in HART was around 7%, compared to the trust's overall rate of 9% and staff tended to be on sick leave long-term rather than short term.

Innovation, improvement and sustainability

- The trust carried out several simulation exercises in order to test the organisation's capability in the event of a major incident. One such simulation exercise was designed to examine the RAF Kenley Emergency Plan. The exercise consisted of a simulated aircraft crash, using an aircraft fuselage, luggage and wreckage which were placed around the nominated crash site. Fourteen members of the casualty union, with simulated injuries, took on the role of occupants of the civilian aircraft. Mannequins were used to simulate casualties, - one in a glider the other in the open as a dog walker. The aim of the exercise was to demonstrate the trust's first on scene response to an aircraft accident on a small airfield, as per the current major incident plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Develop and implement a detailed and sustained action plan to tackle bullying and harassment and a perceived culture of fear in some parts.
- Recruit sufficient frontline paramedic and other staff to meet patient safety and operational standards requirements.
- Recruit to the required level of HART paramedics to meet its requirements under the National Ambulance Resilience Unit (NARU) specification.
- Improve its medicines management including:
- Formally appoint and name a board director responsible for overseeing medication errors.
- Review the system of code access arrangements for medicine packs to improve security.
- Set up a system of checks and audit to ensure medicines removed from paramedic drug packs have been administered to patients.
- Set up control systems for the issue and safekeeping of medical gas cylinders.
- Improve the system of governance and risk management to ensure that all risks are reported, understood, updated and cleared regularly.
- Ensure staff report all appropriate incidents and are always encouraged to do so.

Action the hospital SHOULD take to improve

- Review and improve trust incident reporting data.
- Ensure all staff understand and can explain what situations need to be reported as safeguarding.
- Review the use of PGDs to support safe and consistent medicines use.
- Improve equipment checks on vehicles and ensure all equipment checks are up to date on specific equipment such as oxygen cylinders.
- Ensure sufficient time for vehicle crews to undertake their daily vehicle checks.
- Ensure consistent standards of cleanliness of vehicles and instigate vehicle cleanliness audits.
- Set up learning to ensure all staff understand Duty of Candour and their responsibilities under it.
- Ensure adequate and ready provision of protective clothing for all ambulance crews.

- Ensure equal provision of ambulance equipment across shifts.
- Improve the blanket exchange system pan London to prevent re-use of blankets before cleaning.
- Ensure full compliance with bare below the elbow requirements.
- Review and improve ambulance station cleaning to ensure full infection, prevention and control in the buildings and in equipment used to daily clean ambulances.
- Set up a system of regular clinical supervision for paramedic and other clinical staff.
- Ensure all staff have sufficient opportunity to complete their mandatory training, including personal alerts and control record system.
- Increase training to address gaps identified in the overall skill, training and competence of HART paramedics.
- Review staff rotas to include time for meal breaks, and administrative time for example for incident reporting.
- Review patient handover recording systems to be more time efficient.
- Provide NICE cognitive assessment training for frontline ambulance staff.
- Improve training for staff on Mental Capacity Act assessment.
- Ensure all staff receive annual appraisals.
- Review development opportunities for staff.
- Improve access to computers at ambulance stations to facilitate e-learning and learning from incidents.
- Review maintenance of ambulances to ensure all are fully operational including heating etc.
- Review arrangements in the event of ambulances becoming faulty at weekends.
- Review and improve patient waiting times for PTS patients.
- Ensure PTS booking procedures account for the needs of palliative care patients.
- Develop operational plans to respond to the growing bariatric population in London.
- Review operational guidelines for managing patients with mental health issues and communicate these to staff.

Outstanding practice and areas for improvement

- Ensure better public and staff communication on how to make a complaint including provision of information in emergency and non emergency ambulances.
- Communicate clearly to all staff the trust's vision and strategy.
- Develop a long term strategy for the Emergency Control Centres (EOCs).
- Increase the visibility and day to day involvement of the trust executive team and board across all departments.
- Review trust equality and diversity and equality of opportunity policies and practice to address the perceptionby ethnic minority staffof discrimination and lack of career advancement and by frontline staff thatrotas are notfamily-friendly .

- Review the capacity and capability of the trust risk and safety team to address the backlog of incidents and to improve incident reporting, investigation, learning and feedback the trust and to frontline staff.

The above list is not exhaustive and the trust should study our reports in full to identify and examine all other areas where it can make improvements.

We issued a Warning Notice to the trust on 1 October 2015, under Section 29A of the Health and Social Care Act 2008, requiring the trust to make significant improvements in the areas of medicines management, good governance and staffing by 30 November 2015.