

London Ambulance Service NHS Trust

London Ambulance Service NHS Trust

Quality Report

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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 known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location

Requires improvement



Emergency and urgent care services

Requires improvement



Emergency operations centre

Requires improvement



Resilience planning

Good



Are acute services at this trust safe?

Requires improvement



Are acute services at this trust effective?

Good



Are acute services at this trust caring?

Outstanding



Are acute services at this trust responsive?

Good



Are acute services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

London Ambulance Service NHS Trust covers the capital city of the United Kingdom, over an area covering approximately 620 square miles. The service is provided to a population of around 8.6 million people, and over 30 million annual visitors. London Ambulance Service NHS Trust (LAS) was established in 1965 from nine previously existing services, and became an NHS Trust on 1 April 1996.

The trust provides an emergency and urgent care (EUC) service to respond to 999 calls, which are received and managed by the trust's emergency operations centre (EOC). Staff working in EOC provide clinical advice over the telephone, and dispatch emergency vehicles where required. The LAS also provides resilience and hazardous area response teams (HART), which all NHS organisations have been required to have since April 2013. LAS plays a crucial role in the national arrangements for emergency preparedness, resilience and response (EPRR), contributing to a co-ordinated and planned response to major incidents through the local health resilience partnerships (LHRPs). There are two LAS Hazardous Area Response Team (HART), one based in Hounslow and the other in Tower Hamlets. In addition, LAS provides a patient transport services (PTS).

Services are managed from the trust's main headquarters in Waterloo, and annexes in Bow and Pocock Street. The trust also offers the following services: First Aid Training to organisations and the public, and Community First Responders (volunteers trained by LAS to provide life-saving treatment).

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

The trust had previously been inspected in June 2015, where we rated Emergency and Urgent Care (EUC) and Resilience Planning as inadequate. The Emergency Operations Centre was rated as requires improvement. A follow up inspection undertaken in August 2016 found progress had been made with regard to the requirements we had set out in a warning notice issued as a result of

the June 2015 inspection. We did not rate the August 2016 inspection because we did not consider all of the key lines of enquiry due to the focused approach of the inspection.

We inspected LAS as part of our planned, comprehensive inspection programme. Our inspection took place on 7, 8 & 9 February 2017, with unannounced visits on 17, 24 & 25 February 2017. We looked at three core services: access via Emergency Operations Centres (EOC), EUC, and the Emergency Preparedness, Resilience and Response (EPRR), which included its two hazardous area response teams (HART). The 111 service provided by the trust had been inspected recently, and we included the ratings from that inspection in our overall aggregation of the service.

We did not inspect the patient transport services on this occasion. The commercial training services were not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC)

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

Overall, we rated this trust as requires improvement.

We rated the trust as being good for delivering an effective and responsive service to the needs of the population it serves.

We rated safety and the well-led domain as requires improvement.

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

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

Summary of findings

Our key findings were as follows:

Safety:

- Whilst there had been improved mechanisms for identifying, reporting and investigating incidents, there remained a level of inconsistency in staffs perception of what constituted an incident and the reporting of such in all three services. As a result the trust was not always able to capture important data, which could identify trends and common themes across the organisation.
- Learning from incidents had improved but, was happening in an ad-hoc way, and as a result was not yet fully embedded in practice across all areas of the service. Whilst the executive team had clear methods for communicating learning, staff reported they did not always have time to read updates.
- Mandatory safety training was not meeting the trusts own targets, and as a result, there was a risk of staff not being updated with regard to the latest safety practices.
- The systems and processes for safeguarding people who were vulnerable as a result of their circumstances were clearly set out, and staff we spoke with were aware of safeguarding and how to recognise and report abuse or neglect.
- Infection prevention and control measures had been established. Despite this, standards of compliance with protocols varied across the organisation. This was compounded further by the lack of staff awareness of standards, possibly attributed to non-completion of required training, and a lack of basic essential items to support practices.
- A number of ambulance vehicles needed internal repair, which prevented a good level of cleanliness from being achieved.
- There was some inconsistency in undertaking the required safety checks of vehicles and equipment, some of which was attributed to time factors at the start of shifts.
- Significant improvement in medicine management had been achieved over the past few months. There remained an issue related to the tracking and tracing of medicines, which was still not sufficiently robust with regard to safe storage and tracking.

- Whilst significant work had been undertaken to increase front-line ambulance staff, we were not assured all ambulance crew were allocated to response vehicles appropriately. Inexperienced crew were sometimes paired together and solo first responders were not always paramedics. As a result patient care and treatment was delayed when backup support was required.

- Patient records provided detailed information to support handover at local hospitals, as well as an audit trail from call handler on-wards. Records were accurately kept and stored securely.

Effective:

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

However,

Summary of findings

- The trust was not meeting the national performance targets for highest priority calls attended to by emergency and urgent care crew. Although outside factors of handover delays at emergency departments, and increased activity contributed towards this, patient safety was at risk due to delayed treatment and non-conveyancing to hospital.

- The EUC ambulance crews experienced significant problems with handover delays at hospitals, resulting in stacked ambulances and crew being unable to attend emergency calls.

- Many staff did not have a clear understanding of the Mental Health Act. Although this had improved for staff working in emergency 999 services.

Caring:

- Staff across all services were caring, compassionate and treated patients with dignity and respect the majority of time.

- Patients who spoke with us were very positive about the service they received and the way they were treated by staff. Formal written information from patients to the trust demonstrated high levels of satisfaction.

- The emotional needs of patients and their relatives were addressed by staff providing information, treatment and care. Staff used a range of skills to provide empathy, support and reassurance when dealing with patients who were anxious or distressed.

- Ambulance staff explained treatment and care options in a way which patients were able to understand, and involved them and their relatives in decisions about whether it was appropriate to take them to hospital or not.

- Call handlers took their time to provide information and advice in a manner which was understood. They were patient, respectful and kind.

- Patients could receive advice from experts and clinicians in order to manage their own health. Clinicians provided information to patients about managing worsening symptoms and were able to advise patients of alternative services, such as none-emergency services, their GP or local urgent care centres.

- A small number of ambulance crew who were waiting with patients to hand them over to nursing staff in emergency departments did not on occasion demonstrate considered attention to the patient.

Responsive:

- There was effective and collaborative working between emergency operations centres, ambulance crews and the resilience staff, as well as external agencies. The services were co-ordinated to support seamless care, admission avoidance and alternative care pathways.

- The service was able to cope with different levels of demand, and was accessible via a number of routes. Systems for reporting to the National Ambulance Resilience Unit (NARU) and NHS England about the Hazardous Area Response Teams capacity had improved; formal arrangements were in place to report staffing on a shift by shift basis to NARU.

- Patients with complex needs could be met by the staff, and they had access to an interpretation service when required.

However,

- Attendance rates for equality, diversity and human rights training was relatively low.

- There was more work to do in relation to developing a comprehensive business continuity plan, which would include all aspects of service delivery, including control services demand management systems, and rolling out the business impact assessment procedure to all part of the service. It was estimated this would be completed within 12-24 months.

- The complaints process was clearly defined and the process for responding to complaints was robust. There was however, limited evidence of learning from complaints and concerns.

Well-led:

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

Summary of findings

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

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

• Although the trust were in the process of reviewing current rosters and breaks, the current system was a contentious issues among staff. Staff told us there was an inconsistent and inflexible approach across the organisation and this was a source of frustration with them. Additionally, there was variation in how sickness absence was managed at departmental level, which caused a degree of unrest.

• The trust had placed a great deal of emphasis on tackling bullying and harassment, despite this there remained a perception from some staff of issues remaining of this nature, and of discrimination. The variation in the local management of stations was linked to this.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

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

In addition the trust should:

- Continue to develop a culture which empowers staff to recognise and report incidents. This should include reporting of low harm and near-miss incidents.
- The trust needs to do more to ensure they meet the national performance targets for highest priority calls.

Summary of findings

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

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	Requires improvement 	• Staff felt disconnected from the main executive team. Staff were not fully engaged with the trusts vision, core values and overall strategy. The constant changes within the executive team unsettled staff. They wanted more stability. • The trust was not meeting the national targets for highest priority calls. Although outside factors of increased activity and handover delays at emergency departments contributed towards this, patient safety was at risk due to delayed treatment and non-conveyancing to hospital. Most ambulance trust across the country were not meeting the national target. • There were significant problems with access and flow across the organisation. Handover delays at hospital were a huge problem. Ambulance vehicles were often stacked outside hospitals and ambulance crews were left waiting in emergency departments or in their vehicles. This meant they were unable to attend emergency calls. • We were not assured all ambulance crew were appropriately allocated to response vehicles. Solo responders were not always paramedics and inexperienced crew were paired together. Patient treatment was delayed when backup support was requested. As a result this meant not all patients received effective care and treatment. • Paramedics were not trained to the required safeguarding children level expected for them to perform their role. The safeguarding training for staff was not in line with the Safeguarding Children and Young Peoples: Roles and Competencies for Health Care Staff Intercollegiate document: March 2014. We were informed paramedics were trained to safeguarding level two.

Summary of findings

- Staff did not always report minor and moderate incidents. Not all staff understood the importance of reporting incidents of all severities. Therefore, the trust was not effectively capturing data which could identify trends and common themes, and which could help lead to quality improvements within the service.
- Standards of infection prevention and control (IPC) were varied across the organisation. Some ambulance vehicles were not clean and we found several vehicles were in need of internal repair which prevented a good level of IPC.
- Although there had been significant improvement in medicine management, the tracking and tracing of medicines was still not sufficiently robust. Better systems were required to ensure medicines were safely stored and tracked.
- Staff rarely received a rest break. This meant they could work 12 hour shifts without having adequate rest. The lack of sufficient rest breaks posed a health and safety risk to staff.
- Staff were not happy with the current management of rosters and sick leave. This was contentious issue amongst staff. Staff told us there was an inconsistent and inflexible approach across the organisation and this was a source of frustration with them. The trust were in the process of reviewing current rosters.
- Staff told us they did not always complete the full vehicle and equipment checks before their shift as the allocated 10 minutes they were given was not sufficient. They became available to attend calls within this time and, often staff said would not complete the full checks.
- There were still elements of bullying and harassment within the organisation. Although the service had made strides in

Summary of findings

tackling such issues, there was still more work to be done in this area. We found pockets of the service where staff were still afraid to speak up for fear of intimidation.

However:

- Staff were kind, compassionate and treated patients with dignity and respect. We observed ambulance crew offer high levels of patient care and treatment during our inspection.
- The trust had worked hard to make quality improvements since our last inspection. Medicine management had improved and although there was more work to be completed in this area, staff were able comment on the improvements.
 - The trust had recruited international paramedics to meet demand and there had been an increase in patient-facing hours as a result.
 - The trust had a clinical strategy, which recognised and understood the problems they faced with growing demand and increased activity. They were quality plans in place to improve clinical outcomes.
- We saw assessments of patient care were in place and staff followed the Joint Royal College's Ambulance Liaison Committee (JRCALC) and Health Care Professions Council (HCPC) standards. There were pathways of care to assess and respond to deteriorating patients. These included suspected stroke, chest pain, and trauma. Staff were fully engaged in using the appropriate care pathways.
- The trust worked well with commissioners and local stakeholders to meet the needs of the local communities. Patients were supported to manage their own health through non-emergency services such as local alternative care pathways; GP's or urgent care centres.
- The trust had made an effort to improve staff development. Over 75% of staff had received an appraisal. Staff were able to take on

Summary of findings

		additional responsibilities through expanded roles, such as clinical team leader and advanced paramedic. The introduction of the in-house Academy provided an opportunity for staff to progress to the paramedic role. • The trust supported patients with mental health issues. They had employed mental health nurses at their clinical hub to provide expert opinion and assistance to frontline staff when they treated patients. A maternity education programme meant staff had been provided with extra training and support when providing care and treatment to those patients. Staff were issued with maternity pre-screening tools and action plans to help treat maternity cases. Staff said they had been a useful tool when providing care and treatment.
Emergency operations centre	Requires improvement 	• There was limited evidence of staff acquiring measurable learning from incidents both within the EOC service and across the trust. • Some staff reported confusion over the definition of an incident and what to report as an incident. • All staff were not trained to an appropriate level in both adults and children's safeguarding. This meant staff may not have had the knowledge and skills to recognise and act on safeguarding risks to callers and patients. • We found 86% of staff had elements of mandatory and statutory training which was not up to date. This meant there was a risk that staff may not have the most up to date skills and knowledge to perform their roles. • Most EOC Watch shifts were not meeting the trust response times target of 75% for Category A, immediate or life threatening, calls reached within eight minutes. • All sectors were failing to meet the trust response times target of 93% of Category C1, serious but not immediately life threatening, calls reached within 20 minutes.

Summary of findings

- All sectors were failing to meet the trust response times target of 93% of C2, serious but not immediately life threatening, calls reached within 30 minutes.
- Between July 2015 and October 2016, the proportion of patients who re-contacted the service within 24 hours following discharge by telephone, was worse than the England average throughout this time period.
- Patients were informed of how to complain, but staff thought complaints handling processes could be improved.
 - Some staff felt there was a 'top down' approach to management and staff did not feel fully consulted and engaged in the trust change agenda.

However:

- Staff followed guidance on providing medicines advice to patients.
 - The trust had made environmental improvements to both Waterloo and Bow EOCs and staff could identify potential infection control risks to crews.
- Records were appropriately stored on an electronic system and special notes were available for patients who had specific individual requirements.
 - The trust were in the process of comprehensively reviewing their systems and processes in response to major incidents following a New Year's Eve outage of the computer aided dispatch (CAD) system.
- Staff used evidence-based systems to provide care, advice and treatment to patients.
- The clinical hub team (CHUB) could assess and discuss care and treatment with patients.
- Clinicians worked to national guidance and standards such as National Institute for Health and Care Excellence (NICE) when providing advice over the phone.
- The trust took part in national audits and we saw actions and learning from these.

Summary of findings

- Both Waterloo and Bow EOC's worked effectively with other emergency services.
 - Staff were compassionate and caring towards patients and callers. Staff treated patients with dignity and respect including those in mental health crisis. Staff recognised when patients and callers needed further support to understand their treatment and care and this was provided.
- The service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.
 - The service had a number of different clinical specialist services designed to meet the needs of the local population. This included the metropolitan police desk (METDG) and community first responders (CFR).
- The service had a surge management plan to cope with different levels of demand on the service.
 - Staff identified where patients had additional needs including interpreting services for patients whose first language was not English.
- The service had systems and processes in place for frequent callers and patients with complex needs.
- The EOC service had a strategy that was in consultation with managers prior to being ratified and implemented.
- There was a clear governance structure with accountable roles for staff and managers.
- There were frameworks in place to manage risk and quality assurance. Managers and knew the key risks to the service.
 - The new deputy director of operations for EOC was popular amongst frontline staff and managers. Both EOCs reported improvements in the culture of the EOCs, with the trust having taken action to intervene where there were reports of staff bullying and harassment.

Summary of findings

Resilience planning

Good



- Since the 2015 inspection much progress had been made to ensure the service met national standards and LAS was able to provide an effective and timely response to planned events and catastrophic incidents.
- The number of paramedics in the HARTs had increased and was line with NARU guidance.
- There had been a significant improvement in attendance at specific training for HARTs.
 - Response times were now in line with national standards.
 - Security at the HART sites had been improved and action taken to mitigate risk.
 - The uptake of appraisals was much improved and staff were positive about the training they had attended.
- There was effective partnership working with organisations across London for major events along with multi-agency training.
 - Staff were using evidence based practice and working to national guidance for HART/ CBRN/MTFA.
- Although unable to observe EPRR providing care, LAS provided us with examples of positive feedback from patients/public about care provided by staff.
 - Improvements since the 2015 inspection meant the EPRR were able to respond more effectively to severe or catastrophic disruptions to normal activities in the community.
 - HARTs were meeting national response times.
- There was a clear leadership structure and staff were aware of the structure.
- Staff were positive about their immediate line and local managers but, some still felt more could be done to improve communication and taking action in response to feedback from staff.
- Systems to monitor the quality and safety of services were in place and there was some feedback at local level.

However:

Summary of findings

- Learning from significant events attended by EPRR staff was shared but learning from incidents in other areas was not so well developed.
- The HARTs were still using leased vehicles at the time of the inspection but, permanent HART specific vehicles were on order and due to be delivered in May 2017.
- The trust business continuity plan needed to be aligned with other trust policies/plans.

Overall rating:

Requires improvement



London Ambulance Service NHS Trust

Detailed findings

Services we looked at

Emergency and urgent care; Emergency operations centre (EOC); Resilience;

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 and over 30 million annual visitors. The trust employs around 5000 whole time equivalent (WTE) staff.

London Ambulance Service provides an emergency and urgent care service to respond to 999 calls; an NHS 111 service for when medical help is needed but it is not a 999 emergency, and a patient transport service (PTS), for non-emergency patients between provided locations or

their home address. They also provide clinical advice and dispatching of emergency vehicles if required from its operation centres (EOC), where 999 and NHS 111 calls are received. There is a Resilience and Hazardous Area Response Team (HART). This team provides NHS standard Paramedic care to any persons within a hazardous environment that would otherwise be beyond the reach of NHS care. This includes the provision of NHS care within the inner cordon or 'hot zone' of incidents.

We would like to thank all the staff and patients for sharing their time, views and experiences of the care provided by London Ambulance NHS Trust.

Our inspection team

Our inspection team was led by:

Chair: Shelagh O'Leary

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission

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

How we carried out this inspection

We referred to information provided by London Ambulance Service NHS Trust in advance of the inspection. This was analysed and used within the planning process. In addition, we considered a range of information, which came through our national reporting

centre from members of the public and employees of LAS. We engaged with representatives of the clinical commissioning group and other stakeholders, including the Patients Forum and Healthwatch England to capture their feedback.

Detailed findings

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

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

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

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

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

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

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

Facts and data about London Ambulance Service NHS Trust

Demographics:

The area is made up of:

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

London Activity:

Between August 2016 and March 2017 the trust:

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

Resources and teams include:

- 248 fast response vehicles
- 420 ambulances
- 4 advanced paramedic practitioner vehicles
- 22 motorcycle response units
- 84 vehicles to support the emergency preparedness, resilience and response (EPRR) service
- Two emergency operation centres located at Waterloo and Bow
- 70 ambulance stations and two Hazardous Area Response Teams (HART)
- The trust has a budgeted establishment of 5,200 wholetime equivalent staff. At the time of inspection, there were 4,934.4 wte staff in post (5.1% total vacancy rate)

Frontline staffing

- Paramedics: 2,088.5 establishment with 1,896.2 in post (9.2% vacancy rate)
- Apprentice paramedics: 85 establishment with 99.1 in post (-16.6% vacancy rate)

Detailed findings

- Emergency ambulance crew (EAC)/trainee EAC (TEAC): 773.2 establishment with 799 in post (-3.3% vacancy rate)
- Emergency medical technicians (EMT) and support technicians: 426 establishment with 357.1 in post (16.2% vacancy rate)

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

Other staff

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

Emergency operations centre staffing

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires improvement	Requires improvement	Outstanding	Requires improvement	Requires improvement	Requires improvement
Emergency operations centre	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Resilience planning	Good	Good	Not rated	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Good	Requires improvement	Requires improvement

Emergency and urgent care services

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

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. Almost 1.6 million calls are handled across London every year, and ambulance staff attend more than one million incidents. Staff record each 999 call, and use information about the nature of the patient's illness or injury to ensure they are sent the right medical help.

Call-handlers known as emergency medical dispatchers use computer software to put the call into a particular category, based on its urgency. Calls are categorised as either; A, immediately life threatening or C, not serious or life threatening.

The 999 service provided by LAS is commissioned by clinical commissioning groups, and performance is monitored by NHS England. A trust board, made up of a non-executive chairman, seven non-executive directors and five executive directors, including the chief executive lead the service.

The LAS emergency and urgent care service has nearly 3000 qualified ambulance staff including; paramedics and emergency ambulance crew (EAC's), working on front line services. The trust also has advanced paramedic practitioners (APP), who had received extended training to treat and discharge patients.

The trust has three locations which make up its headquarters, the main one being based in Waterloo, and

others in Bow and Pocock Street. There are 70 ambulance stations of varying size, situated within 26 local operational areas known as complexes. Emergency and urgent care services are provided to more than eight million people who live and work in the London area.

LAS operates across an area of approximately 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south. Accident and emergency services are split into five operational sectors: North west, north central, north east, south east and south west. Each is managed by an assistant director of operations, and each group ambulance station is managed by a group station manager.

The service has a fleet of around 900 emergency vehicles, which include emergency ambulances, fast/rapid response cars, motorcycles, and bicycles.

During the inspection, we visited 24 ambulance stations across London, and spoke with approximately 200 staff. These staff included paramedics, emergency ambulance crew members (EACS) trainee emergency ambulance crew members (TEAC), trainee paramedic students, clinical team leaders, general station managers, and senior managers. We also conducted focus group sessions with frontline ambulance staff, administrative staff and senior managers. We spoke with over 50 patients and relatives who used the service, either in their own homes or in emergency departments. We also observed patient care at handovers at emergency departments.

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We inspected approximately 30 ambulances and reviewed patient records. We visited 16 hospitals in the London region, where we observed patient care and interaction between London Ambulance staff and hospital emergency department staff.

Summary of findings

We rated this service as requires improvement because:

- There remained a disconnect between the executive team and frontline staff. Staff were not fully engaged with the trust's strategy, vision, and core values. The trust recognised more work was needed to be done in this area.
- Staff were unsettled with the constant changes within the executive team, and said they wanted more stability.
- The trust was not meeting the national performance targets for highest priority calls. Although outside factors of handover delays at emergency departments, and increased activity contributed towards this, patient safety was at risk due to delayed treatment and non-conveyancing to hospital. Most ambulance trusts across the country were not meeting the national target.
- There were significant problems with access and flow across the organisation. Handover delays at hospitals were a major problem. Ambulance vehicles were often stacked and crew were left waiting in emergency departments or in their vehicles. This meant they were unable to attend emergency calls.
- We were not assured all ambulance crew were allocated to response vehicles appropriately. Inexperienced crew were sometimes paired together and solo first responders were not always paramedics. This meant patient care and treatment was delayed when backup support was required.
- Paramedics were not trained to the required safeguarding children level expected for them to perform their role. The safeguarding training for staff was not in line with the Safeguarding Children and Young Peoples: Roles and Competencies for Health Care Staff Intercollegiate document: March 2014. We were informed paramedics were trained to safeguarding level two.
- Staff did not robustly report minor and moderate incidents. There was a lack of understanding of the importance of reporting incidents of all severities. Therefore, the trust was not effectively capturing

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important data, which could identify trends and common themes across the organisation which could lead to quality improvements within the service.

- Standards of infection prevention and control (IPC) were varied across the organisation. There was a lack of basic essential items, such as black sacks and tissues and some ambulance vehicles were not clean. We found several vehicles were in need of internal repair which prevented a good level of IPC.
- Although there had been significant improvement in medicine management, the tracking and tracing of medicines was still not sufficiently robust. Better systems were required to ensure medicines were safely stored and tracked.
- Rosters and sick leave were contentious issues amongst staff. They were not happy with current policy. Staff told us there was an inconsistent and inflexible approach across the organisation and this was a source of frustration with them. The trust were in the process of reviewing current rosters.
- Staff were unhappy with the allocated 10 minutes they were given to check their vehicles before their shift. They became available to attend calls within this time and, often staff said would not complete the full checks.
- There were still elements of bullying and harassment within the organisation. Although the service had made strides in tackling such issues, there was still more work to be done in this area. We found pockets of the service where staff were still afraid to speak up for fear of intimidation.

However:

- Staff were compassionate, kind and treated patients with dignity and respect. We saw ambulance crew offer outstanding levels of patient care and treatment during our inspection.
- The trust had worked hard to improve the quality of the service since our last inspection. Medicine management had improved and although there was more work to be completed in this area, staff were able to comment on the improvements.
- The trust had recruited international paramedics to meet demand and there had been an increase in patient-facing hours as a result.

- The trust had a clinical strategy, which recognised and understood the problems they faced with growing demand and increased activity. They had quality plans in place to improve clinical outcomes.
- We saw assessments of patient care were in place and staff followed the Joint Royal College's Ambulance Liaison Committee (JRCALC) and Health Care Professions Council (HCPC) standards. There were pathways of care to assess and respond to deteriorating patients. These included suspected stroke, chest pain, and trauma. Staff were fully engaged in using the appropriate care pathways.
- The trust worked well with commissioners and local stakeholders to meet the needs of the local communities. Patients were supported to manage their own health through non-emergency services such as local alternative care pathways; GP's or urgent care centres.
- The trust had made an effort to improve staff development. Over 75% of staff had received an appraisal. Staff were able to take on additional responsibilities through expanded roles, such as clinical team leader and advanced paramedic practitioner. The introduction of the in-house Academy provided an opportunity for staff to progress to the paramedic role.
- The trust supported patients with mental health issues. They had employed mental health nurses at their clinical hub to provide expert opinion and assistance to frontline staff when they treated patients with mental health concerns.
- A maternity education programme meant staff had been provided with extra training and support when providing care and treatment to those patients. Staff were issued with maternity pre-screening tools and action plans to help treat maternity cases. Staff said they had been a useful tool when providing care and treatment.

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Are emergency and urgent care services safe?

Requires improvement



We rated safe as requires improvement because:

- Although we had seen an improvement on the reporting of incidents, we were not assured all staff understood the importance of reporting incidents of all severities. Staff were good at reporting serious incidents but there was lack of understanding on the reporting of minor incidents, and how the information was important to the trust. There was still some way to go with the developing of communicating processes and lessons learnt.
- Although there were problems with the trust's electronic system in how mandatory training was uploaded and configured, the trust acknowledged this was an area for improvement. As a result mandatory training was not managed effectively and compliance figures were poor. There was a reliance on staff to complete mandatory training in their own time and most staff we spoke with had not done so.
- We were not assured temporary bank staff had competently trained in safeguarding.
- We saw inconsistencies with infection control procedures. We did not see all staff washing their hands at the appropriate expected times after treating patients.
- We found several vehicles in need of internal repair and this posed a risk in terms of cross infection, as staff were unable to clean the vehicles well. Several of the patient's trolleys and stretchers were dirty with dust.
- Although we had seen significant improvement with medicine management, the system was still not robust enough to allow for medicine diversion. We found compliance was poor with staff signing in and out station based medicines, such as paracetamol, and these were not reported as incidents.
- There were inconsistencies with the skill mix of staff on vehicles. We were told of occasions when newly qualified paramedics would be teamed with newly-trained emergency crew. Not all first responders were paramedics. They were not able to administer certain drugs, such as morphine and we were therefore, not assured patient care and treatment was effective.

However:

- The trust had recruited 972 frontline staff. They were able to provide more patient-facing vehicle hours as result.
- The trust had worked hard to improve the reporting of incidents. LAS were now the second highest reporter of serious incidents across UK ambulance services for 2015 to 2016.
- Staff were now able to use a dedicated telephone line, which was available on a 24/7 basis for the reporting of incidents. Staff said this had made the reporting of incidents easier.
- Staff we spoke with demonstrated a good understanding of safeguarding concerns and were able to describe safeguarding incidents and the steps they would take to report them.
- There had been a lot of work undertaken to improve the management of medicines throughout the whole organisation and staff feedback there were much better systems in place. Staff said they had received good information on medicines from their managers.
- We saw assessments of patient care were in place and staff followed the Joint Royal College's Ambulance Liaison Committee (JRCALC) and Health Care Professions Council (HCPC) standards.
- There were good pathways for assessing and responding to deteriorating patients. This included suspected stroke, chest pain, and trauma. We saw the correct pathways used by staff for the majority of cases.
- The trust had major incident policy and plans in place. We were given good evidence of how the plans worked well, for example with the Croydon tram derailment in 2016. Good local command ensured patients were treated as quickly as possible.

Incidents

- The trust had an Incident Reporting and Investigation policy, and used an electronic incident reporting system. The majority of staff we spoke with were clear about the reporting system and knew how to access it. Although knowledge of the telephone reporting system was less widespread.
- Between January 2016 and December 2016, the trust reported no incidents, which were classified as Never Events for Emergency and Urgent Care. Never Events are patient safety incidents that should not happen if healthcare providers follow national guidance on how

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to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- In accordance with the Serious Incident Framework 2015, the Emergency and Urgent Care service reported 46 serious incidents (SIs) which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these, the most common type of incident reported was diagnostic incident including delay meeting SI criteria (including ambulance delay).
- Since April 2016, LAS had met the target of reporting 100% of serious incidents within 48 hours of being declared.
- During the first three quarters of 2016-2017, 62 SI were raised compared to 43 over the same period in 2015-2016, which was an increase of 44%. The LAS was now the second highest reporter of SI across UK ambulance services for 2015-2016.
- The investigation and feedback loop was led by the work of the quality, governance, and assurance managers (QGAM). Clinical team leaders and QGAM provided the feedback to incident reporters.
- In November 2016, the organisation launched 'Insight', a new learning from experience magazine. This highlighted learning, which happened as a result of reviews from serious incidents, risks and complaints. The magazine was circulated through the service and we saw copies at every station we visited. We saw examples of case studies undertaken following the reporting of serious incidents and the key learning shared from investigations. The magazine was clear and easy to read and provided good examples of root cause analysis and actions taken as a result.
- From the organisations embargoed staff survey there had been several improvements identified with the reporting of serious incidents. Results showed that in 2016, 80% of staff compared to 66% in 2015 felt the organisation encouraged the reporting of errors. In 2016, 43% of staff compared to 31% in 2015, indicated that staff were given feedback about changes made in response to the reporting of errors.
- Through communication and internal publicity, staff told us they were more aware of reporting of incidents and the importance of doing so.
- Staff were able to report incidents through the 'single point of access team', a team dedicated to inputting incidents reported by front line staff into the

organisations electronic reporting system. Staff were able to call the team from the ambulance, report the incident and the team would then place this into the electronic system. Staff told us this had made the system of reporting incidents quicker and smoother. From June 2016, the operational hours of this line were extended to 24 hours a day. However, staff we spoke with during the inspection reported the dedicated line was sometimes busy and they therefore had forgotten about the incident by the end of their shift.

- From the launch of the electronic reporting system from May 2016 to November 2016, 3973 incidents had been reported on the system. This compared to 2687 incidents reported in the same period in 2015, which showed an increase of 48%.
- With the implementation of the electronic system, the percentage of patient safety incidents reported within four days of the incident occurring had increased from around 20% to 94% in November 2016, against a target of 85%.
- We found there was a general apathy and under reporting of minor and moderate incidents across the locations visited. The threshold for reporting varied, and staff told us they were less likely to report any near misses or incidents that did not result in harm. This was because they did not have time to complete the electronic system at the end of the shift. The majority of staff we spoke with told us they did not report all incidents and that "nothing changed" as a result of raising a report. We were not assured that all staff had a good understanding of the importance of reporting incidents of all severities. There was disparity between staff on what they classed as an incident. Therefore, although the trust had made good headway in improving the reporting of incidents it was not necessarily embedded into the organisation and important information was not yet fully captured.
- Although staff were able to contact the 'single point of access team' to report incidents, the biggest concern for staff was completing or reporting incidents at the end of their shift. Most staff did not want to report incidents after a long working day.
- Injuries which occurred to staff during their working hours were reported as incidents on paper form. However, most of the staff we spoke with said they did not feel confident incidents of this nature were

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investigated thoroughly. Several staff members said when enquiring about incidents they had reported, the incident had been closed before being investigated. We did not see evidence to corroborate this.

- Private ambulance providers who were subcontracted by the LAS completed the trusts incident reporting forms and these were forwarded to the trust for investigation. A provision of the contract was for private ambulance providers to train their staff on reporting procedures expected at the trust.
- Staff received feedback on incident outcomes via e-mail and through one to one discussions with their clinical team leader.
- For January 2017, there were 11 reported incidents on the electronic incident reporting system relating to missing equipment. This would indicate there was an under reporting of this type of incident, as staff we spoke with during the inspection said equipment frequently was missing or damaged. When we asked staff if they reported this as an incident, most commented they did not, either because they did not have the time or felt nothing would be done about it.
- Manual handling incidents were the largest single category of reported incidents affecting staff. Following research to address the issue of manual handling incidents involving carry chairs, the organisation implemented the use of a new carry chair in January and February 2015. Staff were trained in using the chair and analysis was undertaken, which demonstrated the implementation of the new type of carry chair had reduced the instances of harm occurring to staff.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide reasonable support to that person’s
- The LAS duty of candour policy was recently updated in September 2016 and set out the responsibilities at all levels throughout the trust. DoC required the trust staff to be open and honest with patients, or their families when something went wrong, that appeared to have caused or could lead to significant harm in the future. We saw evidence that four incidents had met the threshold for DoC, and letters had been written to those

individuals concerned. In addition, we noted the trust recorded where they had attempted to contact individuals but they refused communications, as well as those who received a verbal apology. e

- All incidents were reviewed by either the QGAM, or the Serious Incident Group depending on the severity of the incident. Any incident which required the trust to be honest and open with the families, had a DOC champion assigned, who arranged in person to notify the family of the suspected or actual notifiable safety incident.
- Recently the trust had launched a ‘Speak Up’ campaign, which sought to remind staff and managers of their obligations to apply DOC in their roles.
- DoC training for clinical staff was included as part of core skills refresher (CSR) training in 2015/16 for which 92% of front line operational staff attended. This was an e-learning session designed to increase awareness and requirements of the duty and to test staff members understanding of harm levels.
- For DoC champions and family liaison officers (FLO's) appointed, they had undertaken classroom courses either as part of serious incident lead investigator training or as targeted sessions. Over 45 members of staff had attended these sessions. For those FLOs new to the role, a buddy arrangement was provided, whereby an experienced member of the Governance and Assurance Department accompanied them to meet with patients and their families.
- Staff we spoke with on the front line were aware of the DoC and were able to describe the training they had received and the finer details associated with the DoC.

Mandatory training

- As part of the Quality Improvement Plan, the trust had been working to improve their statutory, mandatory and essential training and e-learning systems, as well as their ability to store and easily retrieve training data. As part of this improvement they had invested in a single learning management system to record and track training completed. The system was a module of the electronic staff record (ESR), which captured compliance against individual members of staff. At the time of our inspection the data was being uploaded into the new system structures.
- A number of the statutory, mandatory and essential training records from April to October 2016 had been migrated from the old system into the new structures, and the dashboard information only reflected data

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completed from April 2016. The training had not been correctly recorded and therefore we were not provided with an accurate overall compliance figure. The trust acknowledged this was an area they were currently working on within their human resources directorate.

- However data provided showed mandatory training rates were poor within the trust and the trust acknowledged this was an area that required improvement. The trust set a mandatory training target of 85% for completion by October 2016. In October 2016, the trust reported that 16.1% of staff had completed mandatory training.
- Topics covered in mandatory training included pathways revalidation, resuscitation level 3 immediate life support, counter fraud, duty of candour, infection prevention and control level 1 and 2, moving and handling level 1 and 2.
- Many staff said they had not completed mandatory training, as there was no protected time offered other than the three days for core skills refresher training (CSR). Staff said they accessed training through e-learning modules and face-to-face training.
- The organisation had three days of protected time built into their rosters to provide them with time to complete statutory and mandatory training. The two core skills refresher training courses in 2016 had 95% and 96% attendance respectively. Topics covered, included, Mental Capacity Act, medicines management, major incidents, safeguarding including PREVENT, manual handling, information governance, infection prevention control and advanced life support training. We saw further courses for 2017 included annual mandatory training subjects.
- Staff we spoke with during the inspection, complimented the CSR days and could provide details of their learning.
- Driving training was covered through induction with instructors trained under the national framework, which included five weeks of driver training. The current LAS policy which was consistent with national benchmark, required all staff driving a vehicle to complete a driving programme. To support their driving programmes, the trust used external providers to deliver and assess their courses.
- Further training was provided to those drivers who had been in an accident and when further training was recommended.

- With the exception of the international paramedics, all of the clinical education programmes included a full accredited emergency response vehicle driving programme and, therefore, all staff had valid driving training at the point at which they started operational shifts.
- Australian and New Zealand recruits could not attend the blue light driving course until they had completed the C1 course, a licence they can only do once they are in UK and have a permanent residence. It took approximately six months for this process to occur, so the trust booked their driving programme for approximately month six of their employment. The staff worked 'Attend Only' until that point.

Safeguarding

- We spoke with the lead person responsible for safeguarding, who told us they were trained to level 4/5 in safeguarding. The safeguarding lead sat on the safeguarding boards for London, and they reported to the executive lead for safeguarding in the trust.
- Reporting into the safeguarding lead were two separate teams, one for children and one for adult safeguarding. The children's team had been trained to level 3 or 4, which was in line with the most recent intercollegiate document.
- The safeguarding lead met as part of a national safeguarding group four times per year to discuss issues, share cases and any learning.
- Training of staff in the area of safeguarding was said by the safeguarding lead to be delivered face to face in a two-hour session. This was attended yearly by paramedics and technicians. There had been a number of staff trained in delivering training, which enabled a cascade process.
- We were informed that paramedic safeguarding training did not meet the intercollegiate guidance, as they were not trained to level 3. However, we were told 93% of front-line staff received safeguarding training last year. Advanced urgent care paramedics, who will be based at GP surgeries, would be trained to level 3.
- We saw a copy of the pocket guide on safeguarding, which was given to staff, as well as a pen with information on the The Mental Capacity Act (MCA) 2005, and the Care Act 2014.
- During December 2016, the trust had focused on people who were vulnerable as a result of their circumstances with their staff and a safeguarding campaign had been

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run. We saw a note card with relevant information had been sent to staff with their pay slip. In addition, we saw safeguarding posters and other material, which had been produced and made available to staff with a focus on such matters as youth violence, gang culture, and domestic abuse.

- Safeguarding information had, until recently, been received via fax, but this was now communicated via the electronic incident reporting system, (started September 2016). Initial referrals of potential concern were being telephoned in by paramedics or via a paper record to the designated team between the hours of 8am and 8pm for adults, and 24/7 for children. The call receiver completed this referral in the electronic system and raised the referral to the safeguarding team.
- The safeguarding lead acknowledged that staff had not been very good at linking with the police where a safeguarding matter may have been something for consideration. The system did not currently have an alert flag or similar to prompt the notification of the police. However, work was being done to improve this engagement with the police.
- The trust had a non-executive director (NED) representing the safeguarding elements of the service and they were described as being “very good and supportive”.
- We reviewed the safeguarding annual report 2015/16. This detailed the level of partnership engagement across the boroughs. Engagement included participation in safeguarding children and adults boards, sub-group meetings, multi-agency safeguarding hub and risk assessment conferences, rapid response meetings, domestic homicide reviews, serious case reviews and other safeguarding meetings. Overall, LAS participated in 308 of these activities during this time scale.
- The chief quality officer was the accountable executive director lead for safeguarding.
- The head of safeguarding provided a safeguarding report to the Clinical Safety and Standards Committee. This included progress with regard to serious case reviews, action plan progress, as well as legislation and safeguarding activity within the trust.
- The report indicated 120 child deaths were sent for serious incident consideration, two of which were declared.
- LAS provided a report for 13 children’s serious case reviews in 2015/16, none of which identified any issues related to the trust.
- Eight adult cases were referred for serious incident review, one of which was declared. There were 10 safeguarding adult reviews in the same period, six of which involved LAS. We could not identify from the report if any learning from these was required, although the report indicated learning was fed back to individual staff and trust-wide into safeguarding training.
- The safeguarding action plan contained within the annual report indicated completion rates (as of 20/05/16): 24 completed, nine partially and five outstanding. An update on the progress was provided, which indicated of the nine partially completed actions, three had since been completed, with the remaining six included within the 2016/17 Safeguarding Action Plan.
- We saw copies of an easy read version of an information document, which helped individuals to understand abuse and how to report it. This was informative and provided clear contact details for additional help.
- Staff were able to provide examples of when they raised a safeguarding concern and felt the core skills refresher training (CSR) they had received had been good.
- Ambulance crew told us they were confident to report safeguarding concerns and provided feedback that the current system for escalating safeguarding issues worked well. Staff were able to contact the emergency direct line, which operated seven days a week, 24 hours a day for the reporting of children safeguarding concerns. Some staff did comment, they did not receive feedback on incidents they reported.
- Part of the CSR training from December 2016 to March 2017 included PREVENT, which related to safeguarding training of protecting people and communities from the threat of terrorism. PREVENT is one of the four elements of CONTEST, the Government’s counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.
- We viewed minutes of the safeguarding committee meeting of October 2016 and saw discussion had taken place on concerns regarding ensuring bank staff had received safeguarding training and how it was recorded. We did not see any further evidence to say what processes were in place for safeguarding training for bank staff. Further, the action plan did not identify anything specific related to bank staff training.

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- We saw in the safeguarding committee meeting minutes, there was gap in safeguarding reporting of youth violence. This had been raised as a risk and sent to the risk and compliance group. Actions taken included a reminder to all staff through the internal organisations staff magazine.
- We saw information relating to youth violence shared to staff through the clinical update magazine in November 2016. There was a good clear guidance for staff to follow.

Cleanliness, infection control and hygiene

- There was a designated infection prevention and control (IPC) lead, who reported to the director of infection prevention and control (DIPC), with oversight from the chief quality officer. The DIPC was newly appointed in January this year. The trust had an IPC committee, which met four times per year. This committee provided scrutiny of the delivery of IPC and assurances to the board through key performance indicators that services were provided in a clean and safe environment.
- The IPC lead told us their day-to-day responsibilities included ensuring the practical application of IPC standards, as well as having an administrative, strategic, and operational role. We were told 19 staff had recently been trained as IPC champions by the IPC lead.
- We were provided with information, which indicated that all new staff attended induction training where they were signposted to the contact details of the infection prevention control team and the main sources of information. The latter was mainly held on the IPC page on the Pulse (Intranet). All new non-patient facing staff were directed to an e-learning IPC module on LAS Live, and the content of the course was equivalent to Core Skills Level 1 (with a requirement for three yearly refreshers).
- In addition to a one and a quarter hour IPC session on the induction, we were told by the IPC lead IPC was part of mandatory safety training, and was based on key skills levels one and two. The target for IPC training was 90%, although we were told the capture of training data was not accurate, which made it difficult to know if this was achieved. Mandatory training figures provided by the trust showed for January 2017 that 23% of all trust staff had completed level 2 IPC training and 32% had completed level one.
- We saw documentary information outlining the content of CSR modular training, which included IPC in module three. We noted however, within information provided to us by the IPC lead practical hand hygiene and aseptic non-touch techniques were not included in the induction training. These areas were covered in the intravenous cannulation training only. There was a risk therefore that unless staff attended this specific training they did not have practical hand hygiene training.
- The IPC lead had a responsibility for ensuring the respective audits were up to the required national standards.
- Station staff undertook most IPC audits. However, the IPC lead told us there were inconsistencies across the units as to what was expected and accepted. For example, the cleanliness of areas at stations used for storage of equipment. We were shown pictorial evidence of poor standards of cleanliness, which staff had not recognised as unacceptable.
- We saw in the annual report of the DIPC 2015/16 there was variation in the upload of audit information by group station managers, with particular mention of lower submission since August to the end of quarter four. There were five audits expected including observed hand hygiene practices, six weekly vehicles deep cleans, monthly premises cleanliness, and a quarterly IPC audit.
- Validation audits were carried out by the IPC lead, and they told us they had completed nine elements in 53% of stations. A mystery shopper audit had also been undertaken.
- They were procedures in place for how stations should be cleaned. The procedures involved responsibilities, frequency of cleaning, colour coded equipment to be used in accordance with each area, and the monitoring of cleanliness of stations.
- The IPC audit of September 2016 showed most stations had achieved the compliance target of 90%, with most of these stations achieving above 90%. Only two stations were below the target. We were told actions taken had included communication of findings to staff and more rigorous monitoring by the GSM.
- The IPC audit of October 2016 showed one of the stations had improved their target and were now reaching the accepted IPC compliance rate. The other station still had not reached the target, although they had made a slight improvement from the previous month.
- We did not have any concerns regarding IPC at the stations we visited. Toilet facilities sluice, and kitchen

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areas were clean and tidy and the appropriate colour coded equipment was being used, which was in line with The National Patient Safety Agency (NPSA) guidelines. This was a recommendation for all NHS organisations to adopt this code as standard in order to improve the safety of cleaning, to ensure consistency and provide clarity for staff.

- We saw audits for Croydon station from October 2016, which showed areas of non-compliance (for example, the mess room, and linen management.) These areas of non-compliance had been rectified by the time of our inspection. We did not see areas of IPC concerns at Croydon Station.
- Over the past year the trusts focus for IPC had been on, reinforcing bare below the elbows requirements from ambulance crew. Bare below the elbows is a way of minimising cross infection, as it enables staff to thoroughly wash and dry their hands and wrists. The trust had updated their uniform policy to reflect this. The requirements for bare below the elbow had been communicated to all staff. The clinical team leaders had the responsibility of observing and ensuring staff adhered to this practice. Bare below the elbows was also monitored through the IPC hand hygiene audits. Out of the 10 group stations covered in the December audit, eight scored 100%, one scored 98%, and one scored 88%. Follow up actions were taken up with the group station with the low score, through more communication and face-to-face conversations with staff.
- We observed there was inconsistency with staff compliance with hand washing. Hand sanitizing gel was available and used by most staff. We also observed some staff using the hand washing facilities within emergency departments. However, not all staff followed best practice. This perhaps could link back to those staff who had not received training regarding intravenous cannulation, and therefore, would not have been provided with training on practical hand hygiene and aseptic non-touch techniques.
- Personal protective equipment (PPE) such as gloves was available for staff to use. We saw staff wearing gloves at the appropriate times when treating patients. Staff disposed of used gloves into the clinical waste bins inside the vehicles.
- Staff we observed had long hair tied back from their face and wore a clean uniform and appropriate heavy toe protected boots supplied by the trust.
- During the inspection, we inspected vehicles for their cleanliness. We found several vehicles were in need of internal repair. For example, we saw rust patches adjacent to the driver's compartment, a plastic window in the rear compartment was cracked, and the plastic floor trim was broken. It would have been impossible for ambulance crew to clean the vehicle to acceptable standards due to the defects.
- We saw ambulance crew cleaning the patient stretchers, equipment and surfaces with clinical wipes in-between patients. Although we observed staff cleaning in-between patients, some staff said they did not always have the appropriate time to do so due to operational pressures.
- At one station, crew did not have sufficient black bags for non-clinical waste and therefore had no option but to use orange clinical waste bags. This caused confusion during the shift we inspected as the clinical and non-clinical waste bins were side by side in the vehicles. We were told there had not been sufficient black bags for almost three weeks. This was not in accordance with HTM-07-01 guidance (Health Technical Memorandum 07-01: Safe management of healthcare waste), however this was an isolated incident we found during the inspection.
- Clinical waste bins at stations were stored appropriately and the majority were locked. For those that were not locked, they were stored in enclosed containers in a secure environment with CCTV surveillance.
- The trust had a Make Ready team who were responsible for cleaning, checking and re-stocking vehicles. The Make Ready team were provided by a private contractor. Staff felt the service was good in terms of IPC.
- Ambulance vehicles were deep cleaned every six weeks or earlier if heavily contaminated. Stickers at the front of the vehicles indicated when the deep clean had taken place. Not all vehicles had the stickers. We viewed the IPC audit for October 2016. All stations apart from one had achieved the target of 95%. The one station that had not had reached a target of 93%. On a few vehicles we inspected we observed the deep clean certification was out of date and had not been updated. One vehicle displayed the date of 27 June 2016.
- If a vehicle became heavily contaminated during duty, staff would contact EOC and a replacement vehicle would be found. However, some staff told us there were occasions this had not happened on their shifts, but we did not see any evidence to corroborate this.

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- Not all sharps bins on vehicles had been signed and dated.

Environment and equipment

- Each ambulance was laid out the same way, including the equipment of stretcher, chair, equipment for taking blood pressure and internal cupboards, fixings and consumables.
- Some ambulance vehicles were old and although visibly clean, needed replacement. The mileage on several vehicles we inspected was over 200,000 miles.
- We were told NHS Improvement had agreed a plan for the replacement of 140 double crew vehicles for 2017. The finance and investment committee were due to consider the business case for purchasing 29 further motorcycle response units.
- The phasing of 60 new cars for the fast response unit team was taking place at the time of our inspection.
- Ambulance crew told us some of the vehicles were unreliable due to the fact they were old and had high mileage. This was a cause of concern with staff.
- Each vehicle was prepared to the same standard by the Make Ready team. Since the introduction of the Make Ready programme in a number of hubs across the trust, they had seen a reduction in the variability of out of service (OOS-Vehicle and equipment related) particularly from July to September 2016 when compared to the previous year. 100% of available vehicles were made ready with essential equipment in the North East area pilot for this period..
- For the period of December 2016, which included peak times when the trust normally expected an increase in OOS due to demand, winter related pressures and Christmas, they had actually seen a reduction in missing equipment by 69% and 'no vehicle' at start of shift reduced by 32.5%.
- Currently the trust had five gold standard and four silver level vehicle preparation hubs. We were told all sites would be of a gold standard by July 2017. A gold standard meant all vehicle preparation activities took place at the hub with the vehicles ferried in from satellite sites. There were more vehicle preparation operatives working at the hub site during the night and a specialist deep clean team was established at each gold hub site.
- Staff were allocated 10 minutes at the start of their shift to check their vehicles in terms of equipment and serviceability. However, most told us as they became available for calls within the 10 minutes and on most occasions they were called out before they were able to make the full checks. Although EOC could place the call on a delay, crew said this placed an immense amount of pressure for them to quickly attend the patient. Some staff said they felt guilty if they delayed the call to ensure sufficient checks had been made. A lot of crew arrived and completed checks before the 10 minutes.
- For some of the vehicles we observed, there was no documented evidence to show crew the vehicle was ready. Although we were assured the Make Ready team had completed checks and had prepared the vehicle for use, the crews therefore, carried out their own checks to equipment before becoming available to respond. This was an unnecessary check, which we observed several times during the inspection.
- We saw good a level of sterile consumable stock in sealed packaging at each station we visited. They were laid out neatly and easily accessible to crew. The logistics team regularly visited stations to make stock checks and provide supply of stock.
- The staff survey results of 2016 showed 40% of staff said they had the adequate materials, supplies and equipment to do their work, an increase from 32% in 2015. However, this was still a relatively low figure.
- Staff did tell us they sometimes had to borrow equipment from other available vehicles at the start of their shift, due to shortages. However this equipment was sometimes borrowed from other vehicles which had been checked by the Make Ready team. This then effectively cancelled the checks they had made, as equipment which they had marked as complete and ready was now not available on that vehicle.
- There were an additional 15,000 red blankets distributed from October 2016 to December 2016. An extra 50,000 disposable blankets were in distribution over the past year. There were formal discussions taking place with hospital laundries to formalise the use of hospital blankets. The result would lead to crew being able to swap blankets on a one to one basis at hospitals.
- Blankets was a contentious issue amongst staff. During our observations, we noted crews already used hospital blankets when they attended emergency departments. Feedback was not positive on the single use blankets, as staff said they were too thin and did not appropriately keep patients warm.

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- Staff told us, on occasions when they had not had enough blankets, patients took their own coverings to keep warm. They also on occasion re-used blankets that were not soiled to keep patients warm. This posed a risk of cross infection.
- In November 2016, 91% of shifts started with the minimum of four blankets. This was under target of 95%; however, this was the first month above 90% and represented a significant improvement from the start of 2015/6, where it was closer to 60%.
- During our inspection, we found various faults within vehicles and lack of basic materials. For example, the heater did not work in one vehicle; there were no black bags and no tissues available at one station for all their vehicles. Staff told us there was a lack of equipment such as paediatric saturation probes, which is a non-invasive device used to measure a child's blood-oxygen saturation level and pulse rate. There was lack of fluids on one ambulance and crew reported, they had only one bag of fluids for a number of days because there was no stock in the station.
- We saw dirty linen placed on the floor of vehicles as no laundry bags were available.
- We saw the use of a child safety harness for transporting an infant in the ambulance.
- All ambulance crews were responsible for their own equipment bag, which they ensured was stocked and ready for each shift. We saw evidence of restocking of equipment bags during the inspection.
- Some equipment had stickers on to indicate they had recently had an electrical safety test. There were a few pieces of equipment we found, for example a suction unit which should have been serviced in April 2016 but this had not been done. We asked crew members if they would report these as incidents and were told they would not.
- We saw a patient trolley on one vehicle had a service tag indicating the trolley was due for a service in April 2016. We spoke to a staff member who looked at the electronic fleet system and was unable to locate a service record relating to this trolley.
- Paediatric advanced life support equipment (PALS) was available during our observations and crew did not report problems with this equipment.
- In the older type ambulance vehicles, medical gases were not secured in internal cupboards. We saw staff had 'padded' internal cupboards with blankets to stop the medical gases from rolling inside.
- Tail lift tests were carried out on vehicle tail lifts at six monthly intervals. The inspection was performed by an external contractor. We saw two sample certificates to confirm the necessary checks had been made.
- Each vehicle was equipped with a mobile data terminal, which supplied information to staff when they attended to calls, such as patient information, maps, routes.
- Each staff member had a hand held radio and if they did not work, they had the chance to go back to their station for a replacement.
- We spoke to a motorcycle operative, who told us that the equipment carried was broadly similar to that carried in a fast response car with the exception of 12 lead electrocardiogram machines (ECG) capacity.
- Although some of the stations we visited were old, they were visibly clean and tidy and fit for purpose. The larger stations we visited were secure and had CCTV monitoring secure keypad systems for entry. The smaller sub stations we visited were also secure and entry was accessed via a keypad system. All keys for vehicles were locked in cupboards with keypad access. However prior to the inspection, some staff said there were occasions the smaller stations had been left unlocked.
- All stations had a sluice area, bathroom facilities a kitchen area and a mess room. Some of the larger stations had separate offices for meetings.
- Some of the sluice areas at the stations were new and had recently been implemented. The appropriate colour coded cleaning equipment was close by and the relevant notices of infection control were placed above the sluice area.
- The kitchen areas and mess rooms were clean and tidy. Staff told us they had been recently cleaned prior to our inspection.
- Notice boards were visible throughout each station and hub. Information relating to clinical updates, health and safety notices, and local information was displayed neatly for staff to see.
- Bathroom facilities were clean and tidy at all stations we visited.
- Some stations only had one airline pump used to check the pressure of tyres. Staff told us at the beginning of a shift there were occasions when several staff were 'queueing' to use the pump. This fed into their 10 minute vehicle and equipment pre-checks which added pressure to complete the checks on time.

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- One crew member did not use their safety seat belt when conveying a patient. They were not undertaking any lifesaving treatment at the time to claim exemption.
- Ambulance crew told us of their concerns with the security of the vehicle while they attended patients. For example, when attending a GP surgery the tail lift was left open leaving the rear of the ambulance insecure, while they collected the patient. However these concerns were not being formally reported. We observed this several times throughout the inspection at emergency departments. This posed a security risk as emergency equipment and medicines were easily accessible and not secure.
- The fleet was serviced by 12 workshops within the confines of the M25. All scheduled and unscheduled maintenance was managed through the fleet support department. We saw individual service sheets, which were produced for all LAS vehicles and serviceable equipment, which gave details of all the serviceable items to be checked.
- Due to the nature of responding to emergencies, the vehicles operated at a level which exceeded the vehicles standard operating limits and as such, vehicles were serviced and parts replaced every 12 weeks.
- The trust had 24 hour cover in place for roadside recovery. Staff told us the services usually came to attend breakdown within an hour.
- There was an electronic recall system to ensure each vehicle received the 12-week service and had a valid Ministry of Transport (MOT) certificate.
- We were told there was discussion to trial vehicles belonging to an ambulance station rather than a flexi system where no individual station had control of any vehicle. Most staff said they would prefer the option of station based vehicles as they felt staff would take ownership of the vehicle and there would be more respect for equipment and ensuring the vehicle was maintained.
- The LAS logistic department were responsible for the ordering, storage, repackaging, distribution, and disposal of any medicines used by the clinical staff.
- We observed the security of medicines at the logistic department had significantly improved since our last inspection, with coded access to storage areas for medicines including drug packs. The trust had also launched a number of campaigns and staff engagement programmes with the aim to improve drug security and medicines safety. They had also recruited a full time pharmacist.
- An electronic system had been implemented to track the flow of medicines ordered from the logistic department onto distribution to different ambulance stations. This consisted of two digital medicines tracking system apps; Kit Prep, which recorded the signing in and out of general and paramedic drug packs, and Perfect Ward, which was used mainly by the clinical team leaders for auditing on hand held devices. We saw the Kit Prep system in use at some ambulance stations for scanning in and out of drug packs, as well as electronic recording when station based drugs were removed. However, the system had not been fully rolled out to all ambulance stations and significant number of stations did not yet have the system. Paramedics at one of the stations we visited (West Ham Station) had not even heard of the new system.
- Some staff expressed concern that they felt the new Kit Prep system, whilst it was an improvement, did not go far enough to ensure the safe use of drugs. The drugs were still freely available within the cabinets they were stored in. There was no CCTV or ID scanning required, so drugs could still be removed without using the KitPrep tablet and their removal would not have been logged.
- Staff feedback that a swipe system for medicine management would be the most effective way of tracking and auditing medicines. The new current system still allowed for diversion of medicines. Staff told us even with the introduction of the I-Pad system, this would not stop medicines being taken and not accounted for. Staff reported to us that availability of drug packs had significantly improved since the introduction of bar codes to paramedic and general drug packs, as this had provided a tracking system for drug packs, which were scanned when taken or returned. Each station had a minimum stock level of

Medicines

- Staff told us the biggest improvements they had seen since our last inspection was medicine management.
- The trust had reviewed all their processes and policies relating to medicines management since the last CQC inspection, and recently updated its policy and procedure for the use of medicines by LAS staff including controlled drugs.

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drug packs, and were no longer replaced one for one by the logistics team. Since 800 new drug packs had been placed in circulation, and staff told us the availability of drug packs was not an issue anymore.

- Medical gases were stored appropriately in locked containers. A gas supplier replaced empty cylinders with full cylinders several times a week. Ambulance stations did not record when cylinders were taken out or how many were replaced. The medicines safety officer (MSO) told us of plans to barcode medical gases so the cylinders could be scanned out when taken into an ambulance vehicle.
- Schedule 2 controlled drugs (CD) were stored appropriately. Records from some stations we visited (Romford and Homerton station) showed that on some occasions there was no witness signatures when morphine sulphate injection was signed out. Station managers stated these were followed up with the paramedics involved. All other records reviewed were completed as expected.
- Staff showed us how they utilised the drug usage form (DUF) inside the drug packs, and how these were linked to individual patient review forms (PRF) forms. The completed forms were sent to the quality assurance and governance department for review and feedback was given to staff or station managers if any concerns were noted.
- A new electronic drug monitoring portal, 'MedMan' had been designed and implemented to help reconcile drug usage forms from the paramedic drug bags with completed patient report forms (PRF). The trust executives demonstrated to us how this was operated. This new system allowed the management team to search and match medicines taken from the drug packs and tracked their administration to patients. We saw how this was used to track dosage of medicines used by patients, as well as any incomplete fields on the PRF. There were also facilities to investigate and track medicines usage by clinicians; the MSO said that this has been very helpful especially when investigating high usage of controlled drugs such as morphine and benzodiazepines, enabling appropriate action and response to be taken as well as prevent CD diversion. However, station managers did not have access to this system.
- Some stations were still using stock books for station based medicines such as paracetamol tablets, ibuprofen tablets, paracetamol injection, and salbutamol nebulas. Paramedics were supposed to sign out each time a drug was taken. However, we noted that compliance was quite poor. At one of the stations we visited, records showed the team leaders had made stock corrections for six medicines in the last week. We asked if these were reported as incidents and followed up and was told no.
- At Homerton station, we noted some security risks to medicines particularly paramedic drug bags being left out in open spaces when returned to base station, with limited number of medicines and intravenous fluids. One ambulance vehicle was unlocked and contained some medicines in the personal grab bags, some of which had expired. The management team informed us there were plans to phase out personal owned grab bags to be replaced with specific drug modular pouches designed for specific clinical conditions. We were told these would be going out for trial in March 2017.
- We saw some returned and out of date medicines at ambulance stations waiting for destruction. Staff said these would be returned to the logistic department for destruction; however, we did not see any documentation process to account for what had been destroyed.
- The trust had a dedicated clinical audit team who had carried out a number of clinical audits in several specialist areas with recommendations and actions implemented; helping to inform staff training needs and improve patient care.
- In January 2016, the clinical audit and research unit (CARU) added an aspect of care to the general documentation clinical performance Indicator (CPI), whereby clinicians had to record the full drug pack code on the PRF when administering a drug from a drug pack. Compliance remained high throughout 2016, with most recent data showing a drug pack code was recorded on 98% of applicable PRFs (December 2016).
- The advanced paramedic practitioner (APP) role allowed selected practitioners with enhanced knowledge to provide clinical interventions beyond standard paramedic practice. Such clinical interventions included the administration of ketamine (KET) and midazolam (MDZ) given under LAS patient group directions (PGDs). The trust conducted a clinical audit which determined whether the new drugs were being administered appropriately and safely. A panel of clinicians utilised a standardised data extraction form to review PRF's for all cases where an APP administered

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KET or MDZ from 1st May to 30th September 2015.

Reviewers assessed indications for and appropriateness of administration, and identification and management of adverse events.

- The use of KET and MDZ in the context of an APP service with high levels of additional education, procedural experience and selective targeting to emergency calls appeared safe and effective. Where adverse events occurred following midazolam administration, these were transient and managed appropriately.
- Incident Response Officers (IRO) currently undertook additional spot-check medicines management audits to supplement those performed by station group management teams. These audits were carried out using standardised criteria and recorded on a purpose designed audit form. Forms were received by the medicines management group, reviewed, red, amber, green (RAG) rated and archived. Depending on findings at the time of the audit, the IRO may escalate concerns directly to the relevant group station management team. Themes such as CD book checks, CD count incorrect, medical gas cabinets not locked, medicine stock balance not reconciled and drug pack checks of expiry dates were audited. Those stations who did not perform well were given direct feedback and further training.
- We observed ambulance crews implementing good medicine management by cross checking medicines with other crew members when administering medication to a patient. We saw staff complete the correct documentation.
- Some paramedics confirmed they carried their own prescription only medication (POMS) within their own personal bag. A clinical team leader confirmed this should not be happening and was not inline with the organisations policy. However, we found this was a common occurrence amongst paramedics.
- The number of PRF records, which included a drug pack code following drug administration, was at 98% since April 2016.
- The trust were now able to track usage by clinicians and investigate and take action as a result of prescribing patterns and medicine usage. One practitioner who was an outlier in terms of administration of diazepam was identified through the new tracking system. This resulted in further support for the staff member regarding their clinical practice.
- Access codes for drug cupboards were changed on a regular basis and were checked by incident response officers and quality and assurance managers. However, the different codes proved a source of frustration for staff. Sometimes there were up to four different codes within a station to access drugs and they had not always received notification when the codes were changed. Some staff told us post-it-notes with the codes were placed on the outside of the locked cupboards so staff could have access. This posed a security and safety risk.
- Although the management of medicines had improved, ambulance crew told us they sometimes took their drug packs home at the end of a shift and brought it back in the morning before the checking of medicines had taken place.
- We saw evidence of medicines related incident reporting and how learning from these was used to improve patient care. For example, a number of incidents reported, related to incorrect administration of adrenaline 1:1000 being either via wrong route or wrong dose. Further investigation by the LAS showed a possible confusion in doses outlined in the Association of Ambulance Chief Executive (AACE) pocket guide that most likely led to human administration errors. The team had introduced labels to prompt staff on route of administration. A new guidance had also been issued to all paramedics and LAS medicines safety officer (MSO) also contacted the AACE to suggest that the “Age per page “ pocket book guidelines was altered to make it clearer the different doses for cardiac arrest and anaphylaxis. We saw that learning from incidents was shared widely with staff through publications such as medicine management bulletins and clinical insight magazine.
- Each station had their own local way of effectively communicating to staff medicine updates, through either notice boards or local Facebook pages and e-mails.

Records

- Patient record forms (PRF) we viewed were clear and legible. They followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Patient details, medical history, and medication were recorded. Continual patient assessments were carried out which included patients’ vital signs such as respiration, pulse, blood pressure, heart rate monitoring were all recorded on the PRF.

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- Completed PRF records were kept within brown envelopes with ambulance crew in the front of the cabin of the vehicle.
- We viewed over 30 PRF records during the inspection and found staff had completed them well. All relevant information to the assessment of patient care had been completed.
- At the end of their shift, ambulance crew placed the completed PRF records in locked secure boxes kept at the stations. These forms were scanned into electronic patient records.
- Within the records, there were clear pathways for assessing and responding to patients involved in trauma and for patients suffering from chest pain or suspected stroke.
- A copy of the PRF was provided to the receiving hospital in the form of a carbon copy and the top record sheet was then retained by the ambulance crew. Hospital staff told us they found information content of a good standard, although the carbon copy sometimes made the information difficult to read.
- The back of the PRF form provided ambulance crew with information on the Mental Capacity Act 2005, pain assessment scores table, and disclosure of patient details. There was also a patient non-conveyance checklist staff could complete and space for patients to sign if they refused to wear a seatbelt.
- The service were able to scrutinize information on the clinical operation of the service from the PRF records. The automated system audited the delivery of patient records to Management Information (MI). Data monitored included how many patients were referred through the correct pathway of care, what medicines were administered, and whether staff were providing the best clinical treatment of care for the patient. The collection of this information took the form of clinical performance indicators (CPI) and took place on a monthly basis.
- We saw from the CPI monthly report, information such as mental health conditions, medicines management, severe sepsis, cardiac arrest, and general documentation were monitored. The GSM received monthly copies of the audits and shared this amongst staff. Staff we spoke with were aware of this information.
- However, it was noted that staff who submitted a PRF without an illness code prevented the system from monitoring the clinical risk.
- PRF records were audited locally for staff performance on completion of records. Staff were individually given a compliance target of 95% in making sure they had competently completed records. Individual staff members were given feedback and necessary training if they had not reached their target.
- Information indicated 96% of staff had attended information governance as part of the core skills refresher training.
- There were confidential waste bins in stations we visited.

Assessing and responding to patient risk

- Staff followed the Joint Royal College's Ambulance Liaison Committee (JRCALC) and Health and Care Professions Council (HCPC) guidelines and standards when assessing patients. We saw there were clear pathways for assessing and responding to patients, which included suspected stroke, trauma and chest pain. We saw most staff following the correct pathways of care.
- Staff we spoke with were confident in escalation procedures and understood processes for requesting additional resources through the control centre and senior staff. Staff recorded physiological observations and early warning scores. They had access to point of care testing and electrocardiograph and cardiorespiratory monitoring.
- Staff were able to contact the clinical hub based within EOC, for advice and support. Staff said this system worked well and was readily available when required. For example, registered nurses with mental health skills were based at the hub to provide clinical assistance to staff assessing and tending to patients at the scene.
- Service contractors were also able to contact the clinical hub for advice and support if required.
- A clinical audit for sepsis conducted in 2015, concluded more training and work needed to be undertaken to ensure patients received the best assessment and care. An adult sepsis screening tool was issued to all staff to help assess, identify, and respond to patients. Sepsis was now monitored monthly as part of clinical performance indicators, whereby PRF records were audited to ensure staff had followed the correct pathway of care. Staff were able to show us the sepsis screening tool during the inspection. We saw sepsis pathways posters displayed at stations. Staff we spoke

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with were able to clarify the steps they would take with sepsis patients and said there had been a focus from the organisation in highlighting assessment of care for patients with sepsis.

- Staff monitored patient's vital signs regularly at the scene. We saw ambulance crew attending to patients, monitoring, and recording their vital signs, which included respiratory rates, blood pressure, temperature, pain score, and cardiac rhythms. Staffs observations and recordings were monitored as part of local PRF auditing. Patient observations were recorded for all records we reviewed.
- Staff were competent in managing deteriorating patients. They were able to describe the national early warning scores (NEWS), which is a guide used by medical services to quickly determine the degree of illness of a patient.
- We saw good evidence of staff providing clear clinical advice to patients at the scene. For example, a patient who could be treated at the scene was given clinical advice on their condition and what to do if they felt they needed further assistance. The staff were able to communicate with the patients GP and arrange the necessary medication. An appointment was made with the patients GP and staff were able to speak to the GP to give an update and arrange the appropriate pathway of care.
- We observed staff speak to mental health advisors regarding a patient they were treating at the scene. The staff stayed with the patient, monitored and assessed their risk and took the appropriate action when it became clear the patient had deteriorated and required emergency treatment. The crew members were able to contact the emergency department ahead of them arriving with the patient.
- We observed over 30 handovers at emergency departments. Ambulance crew provided details of the patients present medical condition, medical history, allergies and observations of care.
- Community first responders worked within the scope of their role and did not attend emergency acute patients.
- First responders who assessed patients and made the necessary escalation of requesting further assistance told of the delays they had encountered. Some staff said they had to wait for more than an hour for an ambulance vehicle to convey the patient to emergency care. Although we were never provided with cases where the patients safety had been compromised, staff

told us it was a matter of time before this happened.

Staff said they often felt they were placed at the back of the queue when requesting further assistance, due to operational pressures and capacity issues.

- The IPC team had developed specific guidance related to patient and staff safety with regard to Viral Haemorrhagic Fever, a copy of which we were provided with. This was based on national guidance and contained a risk assessment, with RAG rating and associated flow chart for staff to follow in such circumstances. On scene, assessment included specific guidance for minimising risk of infection transmission.
- Staff told us they were frustrated with the volume of inappropriate calls they were made to attend. They felt the triage system did not work well. We had reports of crew attending emergency calls for patients whose symptoms varied from a patient with an itchy scalp and a child with a nose bleed. Staff said they often felt they were a transport service rather than an emergency service.

Staffing

- Between April 2015 and December 2016, the trust had recruited 972 frontline staff. The trust had seen an increased number of patient-facing vehicle hours available to care for patients. When compared with June 2015, the trust had achieved a 175 increase in patient-facing vehicle hours.
- In December 2016, the trust reported a vacancy rate of 16.7 % in Emergency and Urgent Care with a whole number of 567.3 full time equivalent (FTE) vacancies. The overall vacancy rate for front line staff had increased from 7.1% to 7.2%. The vacancy rate for front line paramedics had improved from 11.5% to 9.8%.
- Between October 2015 and September 2016, the trust reported a turnover rate of 7.9 % in Emergency and Urgent Care with a whole number of 233.7 FTE staff. Of the 316 staff groups, 197 were reported as having no vacancy. Vacancy rates in the remaining 119 groups ranged from 1.5% (paramedics, Wimbledon ambulance station) to 66.7% (emergency medical technicians at Bounds Green and Feltham ambulance stations).
- From the Integrated Performance report November 2016, we saw the front line turnover had improved from 8.9% to 8.7%. Frontline paramedic turnover had improved from 8.6% to 8.2%.

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- The staff we spoke with said they had noticed the positive impacts of having more front line staff, but they did not necessarily feel the full impact due to increased demand.
- The trust had developed a three-year recruitment plan, which took into account expected leavers. Part of the plan included engagement with students and UK paramedic graduates to promote LAS as a prospective employer. The introduction of 'keep intouch' sessions led by clinical tutors based with four partnership universities to build relationships with paramedics.
- Other plans included building relationships with Australian universities to support future recruitment plans.
- There were inconsistencies with the skill mix on vehicles. Some ambulance vehicles had no paramedics and were manned by an emergency ambulance crew member or trainee. We were told when this happened these staff would not attend high acuity calls. However, staff said this did not always happen. Some of the FRU were not paramedics and gave examples when they had attended emergency calls and could not treat the patient, as they did not have the correct skills or equipment. They then had to request emergency backup for assistance.
- However, there were no audits or records available to confirm how many times this happened. We were not provided with any information to corroborate adverse patient outcomes.
- There were operational workforce plans in place, which monitored future demand in the service against recruitment of new staff. The trust recognised they needed to recruit more paramedics for 2017 and 2018, to reach full establishment. Part of the plans in place involved retention of staff.
- Plans of areas the trust had targeted to improve retention included increasing CTL to provide support to front line staff. However, the trust still had some way to go in ensuring the role was functioning effectively.
- Clinical career structures in place included the creation of the LAS Academy. The Academy provided training and support for non-registered clinical staff to become paramedics in the future. However, staff told us there were only 12 places available in the last cohort trained by the Academy and these positions only came round once every two years. Some staff we spoke with felt the waiting list for these positions were too long and it was "pointless" to apply.
- The trust had negotiated funding from CCG's to create a Band 6 paramedic role across London. Currently paramedics were Band 5. The trust acknowledged the introduction of Band 6 would help retain staff.
- The trust had worked with Health Education England to pilot a new Band 7 urgent paramedic role.
- Non-payment benefits were introduced which included the introduction of lease cars and cycle scheme. 87 staff had taken up the opportunity of lease cars and 338 have participated in the cycle scheme.

Sickness

- As of November 2016, the front line sickness rate was 5.4%.
- From October 2015 to September 2016, the days lost due to sickness was 90,000 and the average number of days sickness per employee totalled 18. Within the last year, 33% of staff had no reports of sick leave.
- Between October 2015 and September 2016, the trust reported a long-term sickness rate of 71.5 % among front line staff in Twickenham ambulance station, and 53% for the same staff group at Tolworth ambulance station. Seven other ambulance stations reported long-term sickness rates of between 20% and 30% in this period, of which five were for emergency medical technicians (Streatham, Ruislip, Greenford, Coulsdon, and Beckenham), one for apprentice paramedics (Barnehurst), and one for administrative and clerical staff (Bromley). Twickenham also reported a long-term sickness rate of 21.9% for its paramedics. The highest short-term rate of sickness during this period was 10.3%, reported by Hayes ambulance station among its emergency medical technicians.

Retention

- The trust had seen a reduction in front line staff, with a turnover across the service down from 15.3% in April 2015 to 8.7% in February 2017.
- Although there was a retention strategy and plan in place, staff expressed concerns with staff retention. They were concerned that many of the new Australian recruits would return home after two years and constant recruitment would lead to an inexperienced workforce.

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- Anxiety, stress, depression and fatigue accounted for 28% of long term sickness, and injury accounted for 21%.

Rosters

- Staff shifts were varied at each station with most staff conducting 10 and 12 hour shifts. Rosters were managed locally. Staff told us there was inconsistency from managers with their flexibility with rosters across stations.
- Some front line staff reported they were unhappy with the inflexibility of their current rosters. The trust had started a roster review at eight selected stations. Potential shift patterns had been discussed with staff at these stations and at the time of our inspection, staff groups were still in discussion with the trust regarding the reviews.
- Staff were concerned with late finishing. Most staff said they did not finish on time and this was a source of frustration. Staff told us they often ran over their finish time by at least a couple of hours. This had a negative impact on their work/life balance.
- From staff feedback relief staff said they were unhappy with having to move from station to station while carrying heavy kit and on occasion during times when public transport was limited. The trust was in the process of reviewing existing procedures and policies for relief staff to determine whether these were fit for purpose. Initial meetings had taken place with relief staff to determine whether they were fit for purpose. Ideas and potential solutions from staff meetings had been identified and agreeing actions were currently being reviewed.
- At the time of our inspection the trust were in discussion with staff groups and managers on revising current rostering for staff.

Rest breaks

- A new rest break policy had been drafted. A schedule of meetings were due to take place at the time of our inspection with management due to meet union and human resources representatives to negotiate the new policy. There was a clear stated expectation that a new rest place policy would be in place. Rest breaks were a contentious issue amongst staff. Staff who spoke with us said they hoped it would be handled with sensitivity.
- Currently if staff did not have a rest break during their shift, they were afforded half an hour protected time at the end of their shift and a £10 allowance. This meant

crew could not be called for an emergency call within the half hour. Therefore, there was a greater chance for staff to complete their shift on time. This was a popular scheme amongst staff. However, the trust recognised they had an obligation as an employer to ensure their staffs well being was considered during their working shift, and that an adequate rest break was taken by staff.

- However, this caused operational difficulties with staff availability at the crucial time of handover between shifts, but most staff did not receive a rest break due to operational demand anyhow.
- We observed ambulance crew complete 12 hour shifts without an assigned rest break. Allocated meal breaks were cancelled due to operational demand and most ambulance crew had to carry their lunch with them and eat this throughout the day.
- For those that were provided with a rest break, they had to attend the nearest station and this could take additional time to get to. Therefore, rest breaks often meant staff were unavailable for longer than expected.
- Most staff we spoke with said due to late finish times they did not receive adequate rest time in-between shifts. We did not have any actual figures to confirm this.
- Staff in FRU had to request to stand down in order to use the toilet. These staff members did not usually attend emergency departments where other crew would have the opportunity to use the facilities. Staff requests for stand down times were reviewed and discussed with staff, Staff felt they were being penalised for using the toilet once in a 12 hours shift

Anticipated resource and capacity risks

- The trust had a Resources Escalation Action Plan (REAP) policy. This reflected the level of pressure the service was operating under any given time, and provided an escalation framework to help mitigate the level of pressure the organisation was operating under.
- This revised structure came into operation in May 2016 in line with the national recommendation from the National Ambulance Resilience Unit (NARU). The purpose of this revision was to align the process for all UK Ambulance Trusts using the Joint Decision Model.
- In line with the NARU, four levels of escalation were used, which aimed to help ambulance services integrate into the wider NHS surge or escalation framework.
- All ambulance service providers (as Category 1 responders) must ensure they embrace best practice national guidance. The new REAP provides a consistent

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and co-ordinated approach to the management of ambulance trusts during times of pressure/excessive demand. It also supports capacity management across the emergency and urgent care divisions. It was developed by NARU and signed off by the National Directors of Operations (NDOG) in November 2015 for implementation.

- In the new REAP structure; there were four levels of escalation, which aimed to aid ambulance services to integrate into the wider NHS surge/escalation framework. These levels are used to determine what actions are necessary to protect core services and supply the best possible level of service with the resources available. REAP is reported nationally as well as utilised within the Trust to guide escalation planning.
- The REAP policy identified a wide range of factors that could affect the performance of the operation, including demand for Red 1 or Red 2 calls, changes in capacity, disruption of staffing levels, security threat, hospital issues and external factors such as the weather.
- REAP levels were assessed on a weekly basis by the Service Delivery Group.
- From May 2016 to November 2016, the trust had remained at REAP 2, which is moderate, and was at level 2 during our inspection.
- For REAP 2 considerations taken into account, included, the use of all patient facing staff including clinical team leaders aligned with operational frameworks. Profiling additional resources from non-emergency, voluntary, and private resources to undertake low acuity work. Targeting IRO to the most challenged emergency departments to manage turnaround times, and considering the re-planning selective non-mandatory and non-statutory training.
- For December 2016 and January 2017, certain elements of REAP 3 were utilised to assist with increased demand over the winter period. Staff were offered overtime bonuses over the Christmas period. Trained staff in solo response vehicles were sent to emergency calls to make initial assessments and the deployment of additional PAS/VAS were utilised. We were told from one service provider they had been asked to increase their additional vehicle cover from four to six daily in December 2016.

- Managers used the real time resource-planning tool to effectively manage capacity. This tool used information from the previous year, such as the weather forecast and large events taking place across London and could predict likely surges in activity.

Response to major incidents

- There was a major incident response plan which was reviewed annually and had been approved in September 2016. The trust also had business continuity plans in place in the event of incidents to ensure the service ran as smoothly as possible.
- The trust had a Hazardous Area Response Team (HART). This was a specialist team of service staff who had been trained to provide life-saving medical care in hostile environments such as industrial accidents and natural disasters. There were two teams based in the east and west of London.
- Reporting systems were in place to notify NHS England, NHS Improvement, The national Ambulance Resilience Unit, the London Fire Brigade, and the Metropolitan Police Service when the two HART teams were not fully staffed.
- Participation in Exercise Unified Response with other emergency response agencies to test the capital's preparedness in the event of a major incident, such as Exercise Strong Tower relating to marauding terrorist firearms attack.
- The trusts REAP policy triggered specific measures when the trust was operating at significant levels of increased activity.
- During our inspection, we spoke with staff who had been involved in offering emergency care for the Croydon tram derailment incident in 2016. Staff from the Croydon station were the first to arrive at the scene. We spoke with the GSM who told us of the plans they put in place to deal with the emergency. There was collaborative working with the EOC team who despatched extra crews to the scene. The GSM spoke of staff that had just completed shifts, volunteering to assist and attended the scene to provide patient care.
- The GSM plans involved collaborating with a local school to arrange a meeting place for a cold brief after the incident had finished. Staff from different emergency services, including the Fire Brigade and Police Force attended the meeting.
- Staff said the incident was managed well locally with support from the EOC. There was high praise for the

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GSM who took command and followed appropriate procedures when dealing with the major incident. Staff said they knew the scope of their role within the incident and who they took command from.

- On News Years day 2017 there was an un-planned outage of the computer aided dispatch (CAD) system used by the trust. This system electronically received and triaged 999 emergency calls and then dispatched the appropriate resources. Every 999 call received initiated a transaction into the CAD and used it to record details of the patient by the call handlers.
- LAS business continuity plans were implemented and the use of paper based processes were used to record details and radios were used to transfer information to ambulance crew. As paper based systems were less efficient this resulted in longer recording and processing times and patients experienced delays.
- An independent review concluded LAS followed the appropriate processes to mitigate the impact; however, it was acknowledged the system became stretched due to the quantity of calls and backlog caused by the outage. Lessons learnt and ongoing reviews were still being undertaken at the time of our inspection.
- Major incident training was part of the core skills refresher training programme in 2016, which received a 96% staff attendance.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement



We rated effective as requires improvement because:

- The trust was not meeting national performance targets for the red highest priority calls. This was similar to other ambulance services across the country. Increased activity and handover delays meant patients were put at risk through delays in conveying patients to hospital and providing treatment at the scene.
- First responders told of the lengthy delays they had encountered when they had requested support, in the form of back up vehicles. Non-paramedic staff did not always have the appropriate equipment, such as

medication to provide the best care for patients.

Therefore, we were not assured ambulance crew had been allocated to response calls and vehicles appropriately.

- The trust was not meeting the national target for patients receiving the appropriate care bundle for ST segment elevation myocardial infarction (STEMI), or heart attack.
- The proportion of patients, who re-contacted the service following treatment and discharge at the scene within 24 hours, was worse than the England average.
- There was inconsistency with staff on their approach with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process, although there was guidance at each station and training had been provided.
- We were not assured international recruits had been provided with the appropriate amount of training. Training hours had been reduced from 600 hours to 300 hours. Staff feedback the training was too short and felt this had been done to meet operational requirements.
- The scope of clinical team leader (CTL) role required further attention. Not all CTL were able to provide the clinical support to frontline staff, due to operational requirements. Some CTL wanted more supervision/managerial training to effectively carry out their duties.
- Staff were not happy with the sickness policy and the way this was managed. They said it was unfair.
- The management of rosters and rest breaks was a contentious issue amongst staff. Most staff did not receive a rest break during their shift and the management of rosters was inconsistent across the organisation.

However:

- The trust worked well with external organisations such as commissioners and hospital emergency departments. The trust was pro-active and understood the importance of collaborative working.
- The trust performed well for patients receiving primary angioplasty within 150 minutes and was better than the England average.
- The proportion of patients discharged from hospital alive following a cardiac arrest was better than the England average. During 2015/16, the trust attended 10,116 patients in out-of-hospital cardiac arrest and attempted to resuscitate 4,389 of these. Survival rates

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remained consistent with the previous year with 9.0% of all patients where resuscitation was attempted surviving to hospital discharge and 31.5% surviving amongst the Utstein comparator group.

- Most staff used the appropriate pathways of care with the assessment and planning of care for patients.
- Staff appraisal rates had improved and most staff had received a personal development plan from their immediate manager. Over 75% of staff had received an appraisal.
- Staff gained consent from patients before they offered treatment of care.

Evidence-based care and treatment

- Care and treatment was provided and staff followed national guidelines, which included the Joint Royal Colleges Ambulances Liaison Committee (JRCALC) clinical practice guidelines. There was a pocket-sized version of the guidelines, which staff could keep with them at all time. Staff told us they found them useful to refer to before administering medication. We saw evidence of staff following National Institute of Health and Care Excellence (NICE) guidance during our observations of care provided to a patient with shortness of breath and chest pains.
- Care pathways and care bundles were developed in line with NICE. Care bundles were used as a structured way of improving the treatment and management of patients who presented with certain risk factors.
- Care pathways were used for stroke and, ST-Elevation Myocardial Infarction (STEMI.) STEMI is a very serious type of heart attack. Most staff were aware of the pathways and felt comfortable using them.
- Clinical updates and NICE guidelines were shared to frontline staff through electronic bulletins and quarterly news bulletins, such as 'Insight', which was a new learning from, experience casebook. Insight provided examples of real life incidents, and gave key learning information to staff on best practice guidelines to follow and what tools staff could use to provide good care to patients. We saw examples of information relating to maternity and spinal injuries and the best action and screening tools staff should use.
- The clinical update newsletter distributed to staff gave examples of incidents and the best triage aids available for staff to use. Such tools included the falls decisions tool and major trauma decision tools.
- Staff had been provided with NICE cognitive assessment training that enabled them to identify patients who may have had diabetes or chest disease.
- Record audits were routinely completed to ensure staff were following the correct pathway of care and using the correct decision tools to ensure patients received the correct treatment. Clinical Performance Indicator (CPI) monthly reports for each region showed audits were carried out to check for compliance with mental health, cardiac arrest, severe sepsis, and difficulty in breathing patients. For example, we viewed the CPI monthly report for December 2016. Areas audited included severe sepsis and whether high oxygen flow was delivered and intravenous fluids administered. For difficulty in breathing patients, the audit checked compliance as to whether the correct pathway had been followed in administering, oxygen, salbutamol, atrovent, adrenaline, and hydrocortisone. From the monthly audits, the trust was able to detect those stations that were non-compliant and from the records the staff member could be identified and training opportunities provided for improvement.
- At a local level, stations such as Croydon were working within the community to provide local community pathways of care for patients, especially for those patients with mental health problems.
- Care pathways were displayed on posters in stations we inspected. Clear pathway guidance was displayed for stroke, STEMI, sepsis, asthma, hypoglycaemic, and sickle cell.
- The trust was and is still involved with the new London section 136 pathway launched in December 2016, to devise a better PAN London pathway of care for those patients with mental health issues. The trust was working together with other NHS hospitals, police, mental health and social services to launch a new set of standards to improve the care of vulnerable London patients.
- The managing of conveyance policy and procedure provided clear protocols for staff on managing section 136 of the Mental Health Act with the cooperation of the police.

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- The maternity pre-hospital screening and action tool was devised and complimented the JRCALC clinical practice guidelines.
- We saw from the weekly distributed Routine Bulletin Board (RIB) updates of policies and procedures were shared with staff. From the 17 January 2017 issue, the revised safe haven policy and procedure was explained to staff with information on how staff could gain further information on the policy.

Assessment and planning of care

- The trust had a managing the conveyance of patients policy and procedure in place. The policy provided clear guidelines to define the process for managing the conveyance/non-conveyance of patients. The policy provided protocols staff should follow for paediatric patients, major trauma, hyperacute stroke, obstetrics, minor injury units, and referred to another health care professional.
- Staff adhered to relevant national and local clinical guidance and protocols for their role, when assessing and providing care for patients of all ages, including children.
- Staff were able to contact a clinical support team based at head office. The team were able to provide clinical support in the form of guidance and best practice for staff to follow if they required support when assessing a patient. Staff we spoke with during the inspection were complimentary of the clinical support team.
- Ambulance staff were prompted by assessment guidance and pathways when assessing patients to determine the best provision of care. Set protocols were provided for staff to follow and during the inspection, we observed staff using and following the correct processes and documentation. Ambulance crew were able to explain the different pathways available when assessing patients. However, they did explain that some of the pathways, particularly those for patients with mental health conditions did not always work due to the limited access to mental health centres.
- Ambulance crew were able to explain how they treated a lot of patients at the scene ('see and treat') rather than take them to hospital ('see and convey'), however most of their cases involved conveying the patient to hospital. We did observe good 'see and treat' cases during our inspection, whereby staff were able to utilise their skills and experience when providing care and treatment. A good example, involved the ambulance crew conversing with the patients GP to get required treatment plan in place for the patient.
- We observed the majority of staff following the protocols when assessing and treating patients during the inspection.
- Staff we observed followed best practice in the assessment and planning of care for those patients with mental health conditions. However, we were told by staff that the pathway of care for mental health patients did not work, due to the lack of available and suitable centres to treat those patients. Although staff followed the correct procedures when assessing the patient, for the majority of time staff had to take the patient to the accident and emergency department, which was not always the best pathway of care for the patient.
- During our inspection, we observed frontline staff provide and follow the correct pathway of care for a patient who suffered mental health issues. On this occasion, staff were able to get the correct assessment of care from a suitably qualified health professional and the patient was taken to the appropriate place for treatment of care.
- There were also local protocols for patients having a heart attack or stroke to make sure patients received the right treatment of care at the right location quickly. For example, stroke patients being taken to a specialist stroke centre and heart attack patients being taken to a centre where they could receive urgent artery unblocking treatment.
- Staff were able to use PAN London pathway of care for the different types of cardiac conditions. Pathways provided information on actions to take for patients with known Kawasaki disease, emergency arrhythmia centres, hyper acute stroke units, STEMI confirmed by 12 lead ECG and major trauma units.
- At hospitals, ambulance crews discharged patients to clinically qualified hospital staff and recorded the destination code on the patient record.
- First responders had been trained to be the first person on the scene at an incident. They were deployed to support emergency response. We were told by some FRU, they had to wait for an extended period of time for further assistance from ambulance staff to convey the patient to hospital. This was a concern for staff as they felt they were unable to provide the appropriate care for patients. For those FRU who were not paramedic

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trained, meant they were unable to administer controlled drugs to the patient, particularly morphine to help those patients in chronic pain. One FRU told us they had waited for over 4 hours for an ambulance, which meant the effect of the drugs they had, administered to the patient had worn off.

- There was a maternity prehospital screening and action tool staff carried, which gave clear guidance when dealing with emergency maternity cases. Staff told us they had received good information from the trust regarding emergency maternity situations and the trust had employed a part time consultant midwife to support and guide staff.
- Sick cell management was part of the core skills refresher training in 2016. There was a 96% staff attendance. Staff we spoke with said the sickle cell pathway did not work well and more work was required to improve this pathway of care. The trust had provided good clinical information for staff for sickle cell management in their November 2016 clinical update magazine.

Response times

- The Department of Health requires that ambulance services reach 75% of category A (life threatening) calls within eight minutes. If onward transport is required, a suitable vehicle should arrive on scene within 19 minutes.
- The number of category A calls that result in an emergency response rose from 2.5 million in 2011/12 to just under 3.4 million in 2015/16, an increase of 33%.
- For Category A calls, this indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly. Category A, Red 1 (Cat A8 – Red 1): incidents may be immediately life threatening and should receive an emergency response within 8 minutes in 75% of cases. Category A, Red 2 (Cat A8 – Red 2): incidents may be life threatening but less time-critical and should receive an emergency response within 8 minutes in 75% of cases.
- Data from NHS England showed the trust did not meet the national Ambulance Quality Indicators (AQI) A8 target for the percentage of Category A Red 1 (most time critical) calls reached within 8 minutes. Between July

2016 to October 2016, the trust reached 68.3% for July, 68.7% for August, and 70.1%, for September against the national target of 75%. The trust was ranked fourth place out of eight ambulance trusts across England.

- The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes was below the national target of 75%. For July 2016 the rate was 63.6%, August 67.4% and September 63.3%.
- The trust performed better for the percentage of category A calls reached within 19 minutes. For July 2016 they reached 93.1%, August 94% and September 92.9% against a national standard target of 95%. The trust was the second highest ranked ambulance service for July and August and third in September for this quality indicator.
- The five second call answering indicator, which measured all 999 calls answered within five seconds for October 2016, was 95.1%, which was higher than the national target of 95%.
- There were problems with service provision for ambulances waiting outside emergency departments, especially in the winter months when emergency departments were at their busiest.
- Information we viewed from the Quality Improvement Programme progress report of October 2016, showed over a period of 10 weeks before October, 26.11% (2,679 hours) of the total time lost for the trust (10,262 hours) was for handover of 15 minutes. Handover being between ambulance crew and emergency department staff. Ambulance crew should be ready to accept new calls within 15 minutes and no longer than 60 minutes.
- The average time spent with a patient was averaged at 42 minutes and 42 seconds.
- Ambulance crew told us the 8 minute response time did not take into account the distance the crew needed to travel to get to the scene, so they felt the target times were not a true representation of their work. For example, crew told us, within eight minutes they may have to attend a scene that was five miles away or 12 miles away. Regardless of blue lights, getting access in narrow streets and to travel across London in heavy traffic made reaching the eight-minute response time even more difficult.
- The trust did not have to formally report on Category C calls (not serious or life threatening). Information we received from The Patients Forum indicated for CAT C

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calls the response was low with 65% of ambulances failing to arrive within the target time (20 minutes, for 90% of Cat C1 calls). This was information they had received directly from the trust.

Pain relief

- There were protocols and guidance available for ambulance staff on managing patients' pain. The guidance for pain assessment and the administering of pain relief was in accordance with NICE guidelines.
- We observed staff asking patient's about their level of pain and administering pain relief to patients to good effect. Staff recorded the pain score on the patient report form and re-checked this during the journey to hospital. Staff managed the patient's pain within their scope of practice, defined by the framework in which they worked.
- A few of the FRU who were not paramedics were concerned that they were not able to administer stronger pain relief for those patients they attended to first at the scene. Sometimes it took time for an ambulance to arrive to convey the patient to hospital. They were concerned they were unable to help the patient until the ambulance arrived. Therefore, we were not assured all patients received the appropriate pain relief at the scene.
- Staff were able to use a pain assessment tool, which graded pain from 0-10, with 10 being the worse pain. Pain was assessed during the observations and recorded on the PRF records.

Patient outcomes

- NHS England collected and published statistics on ambulance service indicators.
- Heart attack, or ST segment elevation myocardial infarction (STEMI), is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention. In addition to these primary treatments, patients with STEMI needed to be managed in the correct way, including the administration of an appropriate care bundle; that is, a package of clinical interventions that are known to benefit the health outcomes of patients. For example, patients should be administered pain relief medicines to help alleviate their ongoing discomfort. Early access

to reperfusion (the restoration of blood flow) or thrombolysis and other assessment and care interventions is associated with reductions in STEMI mortality and morbidity.

- This indicator reflects the three key interventions undertaken by ambulance services for these patients that are known to influence outcome: the indicator will define those patients who receive the appropriate care bundle, those who have timely delivery to the cardiac catheter lab for intervention, and those who have timely thrombolysis.
- The most recent data for June 2016 indicated there were 97 patients with definite STEMI who received primary angioplasty within 150 minutes of the emergency call being connected to the ambulance service. This gave a proportion of 92.4% of patients, which was higher than the England average of 87.2%.
- The most recent data available for June 2016 (published November 2016) indicated 68.2% of patients received the appropriate care bundle for STEMI, which was worse than the England average of 76.9%.
- Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. The return of spontaneous circulation is calculated for two patient groups, ROSC overall and ROSC Utstein comparator group.
- The ROSC overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The most recent data for June 2016 indicated there were 342 patients who had resuscitation commenced and continued by ambulance service following a cardiac arrest. Of these 114 had return of spontaneous circulation on arrival at hospital, following resuscitation. This gave a proportion of 33.3% of patients, which was higher than the England average of 29.7%.
- ROSC Utstein comparator group. 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

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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.

- In the Utstein comparator group, 25.5% of patients were discharged from hospital alive, which was the same as the England average.
- Using the Utstein comparator group, the trust was mainly similar to the England average between August 2015 and July 2016. In both the Utstein comparator group and the overall for August 2015, the percentage was higher than the rest of the time period. In the rest of the period, the trust followed a similar pattern to the England average.
- 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.
- Stroke was recognised as the chief complaint at the 999 call for just under half of patients.
- The trust attended 12,251 patients between the 1st April 2015 and 31st March 2016 who presented with symptoms of stroke as identified by the Face, Arm, and Speech Test (FAST).
- As part of the on-scene assessment, LAS staff will provide the essential elements of pre-hospital care for suspected stroke patients which consists of performing the FAST, and measuring the blood pressure and blood glucose. Together, they constitute a pre-hospital stroke-care bundle.
- The stroke care bundle is one of the NHS England mandated Ambulance Quality Indicators (AQIs) designed to measure and compare the quality of care provided by ambulance services across the country.
- The majority of patients (97%) received a complete pre-hospital stroke care bundle consisting of FAST, blood glucose measurement and blood pressure assessment.
- The provision of blood glucose assessment, which had proved to be the most challenging element of the stroke care bundle, had improved from 96.7% (in 2012-13) to 99.5 %.
- The majority of stroke patients (99%) had the onset of symptoms time recorded or it was documented that the onset time could not be determined.
- Almost all stroke patients (99.1 %,) were conveyed to the most appropriate destination for their condition, in compliance with the London stroke pathway.
- The percentage of stroke patients, who received a complete pre-hospital care bundle, was 97%. Initiatives such as staff being provided with personal-issue blood glucose monitoring kits, staff being invited to attend a one- day stroke education event run by the LAS in conjunction with the stroke networks have helped improve care for patients.
- The National Ambulance Service Clinical Quality Group (NASCQG) introduced National Clinical Performance Indicators (CPIs) in 2008. The National CPIs allow comparison of clinical performance between ambulance trusts which enables improvements in care to be driven forward across England.
- These CPI audits compare the LAS performance to other ambulance services across the country in four clinical areas; asthma, single limb fracture, febrile convulsions and elderly fallers. Twice a year, 300 LAS PRFs relating to each national CPI, over a month's period are audited against aspects of care.
- For asthma the trust saw for improvements for the level of care provided to patients; particularly recording a respiratory rate and administering oxygen when required. They also performed well administering Beta-2 agonists (types of drugs used to treat asthma), to these patients when indicated. However, the trust needed to improve on recording a peak flow. The peak flow reading can determine the severity of the patient's asthma episode and be used as a benchmark to demonstrate the patient's improvement or deterioration.
- For single limb fractures LAS was the worst performing ambulance service out of 11 ambulance services for this CPI. The two aspects of care the trust needed to improve on were immobilisation and assessing circulation distal to the fracture site. We saw the trust had conveyed the message to staff of what codes to use on the PRF records to show this aspect of care had been completed.
- For febrile convulsions the trust were doing well at administering anticonvulsants, but more often than not were ranked in last place for the care provided to these patients. The report indicated the areas where drastic improvements were needed: taking a blood glucose reading; recording SpO2 (which is an estimation of the

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oxygen saturation level), before oxygen administration, and management of the patient's temperature. We saw the trust had highlighted this message to staff by distributing the report's findings.

- For elderly falls, results showed overall, the trust was placed in the middle of the national picture. The areas they struggled with were recording whether the patient had a recent falls history, assessing their mobility, and making a direct referral.
- In 2015 the LAS conducted a clinical audit for the of the diagnosis, management, and treatment of sepsis. 200 PRF records were clinically audited to determine the level of care provided to patients with suspected sepsis. The audit showed most patients (87%) had the observations recorded needed to identify sepsis. However, for only one patient did the clinicians acknowledge these met the systemic inflammatory response syndrome(SIRS) criteria. A review of systems was conducted and clinical evidence of an infection was identified for 44% of patients.
- The findings of the report showed work was needed to ensure staff were accurately identifying and recording the observations of sepsis. Much work was done through 2016 as a result of the clinical review and a set of recommendations was produced and completed. Such actions included updated clinical articles, posters at stations and a new sepsis-screening tool, which staff are able to carry with them. Staff were able to show the sepsis-screening tool they used during the inspection.
- Staff had received one hour of sepsis training as part of their core skills refresher training. Staff we spoke with during the inspection were able to tell us of the steps they would take with patients with sepsis and spoke of the added focus the trust had placed on sepsis and the additional information and training they had provided.
- A new code was introduced for the PRF records so the trust could monitor whether staff were carrying out the correct assessments for sepsis. Managers were able to monitor the sepsis assessments through the monthly clinical performance indicators (CPI). The trust now had a breakdown of monthly sepsis assessments for each station. They were able to track the PRF records back to the staff member involved, so extra training could be provided if necessary. We saw evidence that sepsis was monitored in the monthly CPI audits.

- Between July 2015 and October 2016, the proportion of patients who re-contacted following treatment and discharge at the scene, within 24 hours was worse than the England average. The trust remained consistently worse than the England average for the time period.

Competent staff

- The trusts emergency and urgent care service comprised a mixture of paramedics, emergency ambulance crew (EAC), emergency medical technicians (EMT), clinical team leader (CLT), incident response officer (IRO), and specialist paramedics.
- All paramedics were registered with the Health and Care Professionals Council (HCPC) and had completed an approved qualification in paramedic science. Paramedics were required to revalidate their registration as part of their continuing registration with HCPC.
- Paramedics were required to revalidate their registration every two years. They were required to receive clinical supervision as part of the revalidation.
- We saw job descriptions were in place for all roles with specific responsibilities and duties, Job descriptions included maintaining professional registrations and specific criteria essential to their role.
- We viewed 10 staff records and found them to be incomplete. More than half had missing references, right-to-work checks and photo identification. However, the files did have almost full completion of disclosure and barring service (DBS) checks, qualifications and professional registrations where necessary.
- There was a corporate induction for new starters, followed by local induction dependant on the scope of role. Managers were given an induction checklist to ensure all relevant areas were covered.
- We were told the training for Australian staff had been reduced from 600 core hours to 300 hours and this had an impact on competency of staff. Some Australian staff felt they would have benefited from further training with their mentor.
- We were told there were a few international recruits, although qualified with a paramedic degree that had not had any patient facing experience. Therefore, some crew reported they were concerned with the level of competency and support they had received from the trust, especially for those who had only received 300 hours of training. Staff told us they felt the training had been reduced to meet operational demands. However,

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the trust told us the competency assessments were the same and if a staff member did not pass the necessary tests they were given additional time to complete the training.

- We were told each international paramedic underwent a series of competency tests, which they had to pass before they were allowed to operate on their own. They were paired with a mentor who was an experienced paramedic. The mentors we spoke with said they were allowed to voice concerns if they felt the crewmember needed further training. The international crew we spoke with said they had been well supported during their training.
- Staff had received training on how to manage maternity medical emergencies. Most staff we spoke with said the training had been invaluable. Staff carried a maternity pre-hospital action and screening tool, which provided guidance on how to manage emergency maternity cases.
- The advanced paramedic practitioner role was developed to provide enhanced on the scene care allowing for less patient conveyance to emergency departments.
- Community first responders received regular key training.
- Information provided by the trust showed as of January 2017, 72.93% of staff had received an appraisal. Appraisals required were 2874 and so far, 2096 had been completed. The appraisal year ran from April 2016 to April 2017.
- Most staff we spoke with said they had received an appraisal in the form of a personal development review (PDR). Some staff told us they had not received an appraisal for almost three years. One staff member told us they had not received an appraisal in over seven years. Some staff said the PDR was a 'tick box' session and they did not think any personal development opportunities would be actioned.
- The IPC lead told us paramedics undertook IPC training related to their clinical skills, such as cannulation. Clinical skills refresher training was said to be undertaken in quarterly intervals, with an aim of getting 3,000 staff through quarter one.
- The safeguarding lead was very proud of the work undertaken to improve dementia care. We were told there were four core elements to the focus 'Dementia care matters in the ambulance service.' Part of the work

had resulted in the production of a multi-lingual pre-hospital communication guide, which we viewed. We were told this was now in use by seven other services, although we did not corroborate this.

- Staff had received paediatric basic and advanced life support training through the core skills refresher courses.
- Emergency ambulance crew (EAC) had the opportunity to undertake paramedic science degrees through the trusts Academy. We had a varied response from staff regarding the academy. We spoke to a staff member who had the opportunity to develop through the academy and told us the training and support they had received was good. However, other staff told of their frustration at the lengthy waiting times to attend a course, through the academy.
- Clinical supervision for frontline staff was managed by CTL. There were plans in place for CTL to monitor staff through 'ride outs'. However, this was not always happening due to operational demand and pressure.
- Bursaries funding was available for staff to help with their continual professional development and training. Bursary funding was available on application. To date in 2016/17 a total of £216,299 University funding had been granted.

Co-ordination with other providers

- There were agreed pathways of care staff followed to ensure patients received effective care and treatment for the best outcomes. Some pathways of care worked better than others. For example a pathway of care for mental health patients was virtually non-existent due to the limited capacity and access to the appropriate centres. This was beyond the trusts control; and they were taking appropriate alternative action having employed mental health nurses in their call centres to help deliver 'hear and treat' for those patients with mental health conditions. They also provided vital information to frontline staff.
- Other pathways of care worked extremely well. For example, the stroke pathway of care meant that last year 99.1% of patients were referred to a hyper-acute stroke unit; ensuring patients received appropriate care and treatment immediately.
- From our observations, we noted staff worked well with external organisations such as emergency departments, police and fire service

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- We observed several handovers within the emergency department where staff explained in detail treatment and information relevant to the patients care. A copy of the PRF was left with staff for their records.
 - Emergency department staff spoke of the good working relationships they had with staff. We observed good co-ordination of care between ambulance staff and nursing staff when they conveyed a patient. The patient was always included in conversations that took place on their care and treatment.
 - There were systems to monitor the effectiveness of contracted providers. Audits and spot checks were carried out by LAS staff to ensure standards were met. There were also regular service provider meetings where quality and governance issues were discussed. We saw minutes of meetings with one service provider where audit compliance was discussed.
 - The trust engaged well with local CCG's through local and development groups.
 - The trust had developed a number of pathways with local providers, which ambulance clinicians could access to provide care for patients with long-term conditions in the community. These included direct access to community wards and admission avoidance teams, specifically for patients with chronic conditions such as diabetes, mental health conditions, and COPD.
 - The trust worked with 'Co-ordinate My Care', and was the first ambulance trust to use the system to identify end of life patients with care plans in place, which specifically detailed preferred place of death and ceilings of care. Registered clinicians based within emergency operations had access to the system.
- Multidisciplinary working**
- We observed good multidisciplinary working between crews and other NHS staff within the emergency departments in hospitals. We observed handovers, where information relevant to the patient was explained in detail to the receiving emergency department staff and a copy of the patient record was left with the staff for their records.
 - Staff we spoke to at eight acute hospitals in London were positive of their teamwork with London Ambulance staff and recognised the pressures they faced on a daily basis. They spoke of the professionalism and caring nature of staff. They were happy with the quality of information they received from the handovers and were confident the staff had provided good care and treatment for the patient.
 - We saw good interworking relationships between the fire stations and London Ambulance Service. At Croydon station, they had an agreement with their local fire station to shelter their new motorbike.
 - Ambulance crews worked well with the police, and we observed good interaction when dealing with a patient who had collapsed. The police and ambulance crew communicated well together and the whole process of care for the patient went smoothly.
 - Some of the measures to reduce hospital admissions included increasing the number of single responder vehicles to double crewed ambulances so that, where appropriate, a clinician could make a quick, informed decision about whether or not the patient needed to be conveyed to hospital.
 - The trust had introduced the advanced paramedic role, which provided more skills for the paramedic to treat the patient at the scene, rather than convey to hospital.
 - Staff participated on the driving scheme 'Safe Drive', where they attended schools with other professionals from the police, fire brigade and local councils to provide young people with speed awareness information.
 - During our inspection, we observed good communication and interaction between a GP and the ambulance crew for a patient they conveyed to hospital. There was good clinical assessments undertaken and verbal consent was obtained from the crew. The ambulance crew were able to pre-alert the emergency department of the hospital they conveyed the patient to.
 - There was a disconnect between frontline staff and staff who worked within emergency operations centre. We were told there was a 'them and us' mentality. Frontline staff who had attended EOC either by shadowing or had worked within the department highly recommended more interaction and shadowing by either department. However, most frontline staff we spoke with appreciated the immense operational pressure EOC staff faced on a daily basis.

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Access to information

- Information for staff was generally accessed through the 'Pulse' intranet from computers, which were accessible at stations. Pulse contained updates to medical information and updated policies and procedures.
- Other information on clinical updates was available through the 'Clinical Update' magazine, and the new learning from experience casebook Insight. This was a new magazine, which gave real life cases of incidents and the key learning from each incident as well as clinical information. Staff gave positive feedback on Insight and they felt the cases were relevant and realistic to their role.
- A weekly Routine Information Bulletin (RIB) was produced by the trust, which provided information on trust wide issues and events, education and development and policies and procedures.
- We observed from the trust's intranet page that there was a great deal of IPC information available to staff. The IPC team was identifiable, along with the new IPC champions for the stations. Videos, which were related to the donning and doffing of personal protective equipment (PPE), were played as soon as the page was accessed, to facilitate easy access to new training materials and information.
- We noted staff had access to policies and procedures, which reflected current best practices. Other information related to IPC was easily accessible on the intranet.
- At each station we visited staff were able to access information relating to a number of treatments, for example, capacity to consent to treatment, information following bereavement and parental agreement to the investigation of a child or young person.
- Information was also available to each local area. We saw the North East Area Quality matters newsletter, which provided information on medicine management, duty of candour, learning from incidents and easy ways to improve compliance.
- Information from the emergency operations centre (EOC) was relayed to front line crews via the vehicles mobile data system. This allowed crew to receive information on the calls they were responding to. We observed crews using the system to obtain information on the patient they were responding to.
- The crew used a satellite navigation system to gain access for the best routes to follow when conveying patients. Staff did inform us that the satellite systems

were sometimes unreliable and did not operate effectively. However when they did work they were an important tool and were used a great deal during their operational shifts.

- Staff had access to guidance on pathways of care via pocket sized information tools, which they kept with them at all times. The tools allowed staff to update and add information.
- Staff had access to a clinical support team, who gave advice and support for clinical issues and decisions. Access was available seven days a week, 24 hours a day.
- The trust recognised they needed to work collaboratively with CCG's to influence, develop, and utilise appropriate pathways of care based on patient need. It was widely accepted amongst frontline staff that each sector within LAS had different community pathways of care and some were more developed than others. This proved to be difficult for the trust to provide consistent care for the patient. Some CCG's were better at providing local pathways of care than others, for example, falls groups within certain sectors of London were more advanced than others.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a Mental Capacity Act (MCA) and consent to treatment policy, which provided staff with guidance and processes to follow to gain consent from a patient. The policy was detailed in providing information to staff on intervention for patients with mental health concerns for life sustaining situations and when to act to prevent a serious deterioration to their condition.
- There was a good practice guide on recording consent, mental capacity, and best interest decisions in healthcare settings. The guide gave clear protocols for staff to follow and we saw the capacity to consent to treatment and course of action records staff used to record their findings.
- During our inspection, we observed staff follow the correct guidelines in obtaining consent when dealing with a patient with mental health concerns. They followed the assessment to capacity and were able to explain to the patient clearly the treatment options and plan of care. The staff members were patient, explained their actions clearly, and followed the correct pathway of care for the patient.
- Frontline staff received training in the Mental Capacity Act 2005 as part of their induction and mandatory

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training. This was in the form of e-learning modules. Core skills refresher (CSR) training was additional training, which included statutory and mandatory training as well as clinical refresher training. Staff had three days per annum of this training and MCA was included in the 2016/7 CSR.

- The majority of staff we spoke with had attended the CSR training on MCA which included additional information and guidance on Do Not Attempt Cardiopulmonary Resuscitation (DNCPR).
- We found there was a good understanding of the MCA, and staff had a mental capacity aide memoir, which gave guidance on diagnostic tests, functional tests, best interest checklists and the five key principles of the MCA.
- Staff we spoke with during the inspection had an understanding in relation to 'reasonable restraint' allowed by the MCA during conveying a patient. Ambulance staff trained and skilled in de-escalation and the use of equipment, straps and gentle holds to prevent patients from harm.
- Staff told us they had seen an increase in dealing with mental health patients and felt frustrated when they were unable to access the correct pathway of care. This was due to limited access to the correct centres, either because they had no capacity and there simply was not enough support centres.
- The trust had employed five mental health nurses with a whole time equivalent of 3.5. Each nurse was the allocated link to a particular mental health trust in London and they liaised with the crisis teams, dealt with adverse concerns, and had joint training and support. There were plans to expand the team.
- National funding had been secured for a patient experience programme with mental health patients with personality disorders, using co-production to improve the patient experience and improve LAS systems. This work was to coincide with the work undertaken in 2016 with their mental health patient reference group and dementia patients and their families.
- The Non-Emergency Transport Service (NETS) primarily dealt with patients who were assessed by social care workers and doctors to determine whether they should be detained under the Mental Health Act. NETS vehicles were pre-booked which meant they arrived on time.

- The NETS development was a good example, whereby the trust worked well with the Patient Forum who assisted with NETS development and were included in conference calls to determine the effectiveness of the service.
- Between April 2015 to March 2016, the service took 5961 calls, 16.0% (954) calls which were managed with the 'hear and treat' response.
- When speaking to staff we found there was a variation with the DNCPR process. For example, the scenario presented to staff was if DNCPR documentation was locked in a care home manager's office and they were not there to obtain the DNCPR, would they accept the authorisation from the registered nurse without having seen the DNCPR documentation. Some staff said they would, when others said they would not. Therefore, patients would not necessarily receive consistent care from staff when following DNCPR protocols. However, at each station we visited there were clear guidelines for staff to follow concerning DNCPR.
- We observed patients being asked for verbal consent to be treated and ambulance crews explaining the care and treatment they were receiving.
- Staff were able to explain the Fraser guidelines and Gillick competency used within the service. These are guidelines to help balance children's rights and keep them safe from harm. The Mental Capacity Act 2005 guidelines on the back of the PRF records was a useful tool staff used when gaining consent for children. There were four set of principles staff followed, which they used to assess if the patient lacked capacity.

Are emergency and urgent care services caring?

Outstanding



We rated caring as outstanding because:

- Patient care was at the heart of frontline staff. Staff were kind, compassionate, and treated patients with dignity and respect. Staff adopted a person centred approach.
- We saw ambulance crew deliver care and treatment above and beyond what was expected of them. There were many stories from patients who were appreciative of the care and grateful of the treatment and attention they had received.

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- Patients we spoke with during the inspection highly praised staff for the compassion and the respect they had received. They all said how caring and understanding they had been.
- Staff were fully committed in ensuring patients were empowered and encouraged to make decisions about their care. They worked in partnership with non-emergency services, for example, GP's, to ensure patients were supported to manage their own health.
- Staff listened to patients and were kind to relatives and carers. They were able to diffuse distressing and emotional situations in a calm manner and offered the necessary support to relatives, carers, and people who were close to patients. We saw patients and those close to them received emotional support and were provided with reassurance and assistance throughout the patient's pathway of care.

Compassionate care

- During the inspection, we observed staff consistently treating patients kindly and compassionately. There were many occasions we saw staff deliver care and treatment far above what was expected of them. Patients told us stories of the care and treatment they had received from the ambulance crew. Such comments included "exceptional staff, they have all been so warm and caring".
- Other comments from patients included 'they are so professional and I felt reassured.' 'I recognise they are so busy, but they are so lovely and kind when they have seen me.'
- We observed many occasions when staff offered care and compassion to the patient in sometimes difficult environments. For example, we observed a crew member lie on the floor next to an elderly patient who had fallen, so they were able to speak to the patient on the same level, held the elderly persons hand offering comforting words as well as explaining clearly what their next actions were. It was clear the patients comfort and care was at the heart of the staff members concern. This care continued when the patient was conveyed to hospital.
- We saw evidence of staff treating a patient with mental health issues kindly and with dignity. The staff were professional when dealing with the patients relatives who were upset and emotional. Staff spoke with kindness to the relatives but also with clarity to explain treatment and to provide dignity for the patient. They were patient and sensitive but on occasion staff had to be firm but fair to the relatives in order to provide the correct and best treatment for the patient. The incident was handled in a sensitive and professional manner.
- We observed ambulance crew attend a small child who had swallowed a coin. They were able to assess the plan of care in a calm and professional manner, were friendly and kind to the child, and made them feel at ease. They handled the parents compassionately, reassured them, and included them in every step of the child's treatment and care plan. They were able to distract the child, which made the atmosphere relaxed and calm.
- Staff had a good way of communicating to all patients, finding a common ground so they were able to talk to them and make them feel comfortable.
- We observed outstanding care and treatment provided to patients in their home and in the ambulance during transport to the emergency departments. Staff were professional yet compassionate in the manner they applied appropriate levels of assessment for the location and the condition of the patient.
- We saw many examples when staff showed a positive, sensitive, and encouraging manner to patients and their relatives or carers. One patient who had used the service twice within a month spoke of the "exceptional" treatment they had received from the crew. The crew were able to support the patient and engaged with other non-emergency services to make sure the patient was able to be involved in their plan of care. Crew spoke with the patients GP, were able to arrange an appointment for that day, which suited the patient and their carer.
- The crew divided their roles determined by the setting and the requirement of the patient and those present. The crew assured and assisted upset and concerned relatives and friends, and ensured the patient was always prioritised. Crew worked consistently to find common ground for discussion when treating patients. We observed a patient who was concerned about the welfare of their pet dog when they would be away attending hospital. The crew were supportive and reassuring with the patient and assisted the patient to contact someone who could look after the dog.
- We observed the interactions between a crew and a member of the public who had been assaulted during a

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night out. The crew treated the distressed patient with outstanding support and empathy. They treated the injuries swiftly and efficiently whilst engaging the patient in jovial conversation to lighten the mood.

- We observed ambulance crew caring for patients in public places. They maintained the dignity of patients by covering them with blankets when they were transported in either wheelchairs or stretchers. We heard ambulance crew ask patients if they felt warm and comfortable. We observed staff making sure an elderly patient had socks placed on their feet before they were placed in the ambulance
- We saw staff using their initiative to adapt in difficult environments to care for the patient. For example, we saw ambulance crew having to adapt equipment in a small restricted environment to place a patient on the stretcher. Staff took their time to ensure the patient was comfortable and there was no potential risk of harm to the patient when moving them.
- All the interactions we observed by ambulance crew were non-judgmental and patients were treated as individuals. When staff treated an obese patient, they were kind and non-judgmental and the patient was able to confide other external lifestyle factors, which had an impact on their health. The crew provided helpline numbers and supportive advice which the patient was grateful for. They described the crew as “non-patronising. They completely understand my problems they took time to listen and they are so nice and kind”.
- Ambulance crew were kind and reassuring to relatives and carers. They involved them in the patient’s pathway of care. They explained clearly in a calm manner what actions were being taken. They offered support and reassurance to those relatives and carers who were distressed. We observed crew attend and care for a relative of a patient who was upset. They took them to another area from where the patient was being treated, sat down with them, gave encouragement and reassurance in an empathetic and kind manner.
- We heard ambulance crew ask patients if they were in pain and offered pain relief if patients said they were.
- Ambulance crew we spoke with during the inspection said there were support systems in place by the trust if patients or members of the public were abusive to them. Most staff told us they did not encounter abusive situations, but felt confident how to handle such situations if they arose.

- We observed a crew member interacting with a patient who did not speak English well. They spoke to the patient slowly and clearly and were kind at all times. They were able to use the language line, the organisations translation system, and had access to a language phrase book.
- However, we observed a few isolated incidents, whereby patients were left alone during handover at hospital. Ambulance crew were either on their mobile phones or speaking to other crew members who had arrived at the emergency department.

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so they understood their care, treatment, and condition. For example, ambulance crew treating a patient with mental health concerns ensured the patient was fully understanding of the actions they wished to take. The ambulance crew made sure the relatives were provided with details on how to find further information and ask questions about their care and treatment. Staff gave patients time to ask questions and answered these clearly and thoroughly.
- Relatives and carers told us ambulance crew explained what they were doing and the options available in terms of treatment for the patient. We saw ambulance crew explain to relatives and carers what actions they were taking, such as conveying them to hospital and the reasons why.
- We heard ambulance crew ask relatives and carers if they wanted to accompany the patient if they were conveyed to hospital. During the journey, the crew reassured relatives and carers and we saw good examples of kind and sensitive care.
- During conveying patients to hospital ambulance crew provided reassurance and care for the patient. We saw crew members hold the hand of patients to offer them reassurance and they explained what hospital they would take them to and the care and treatment they would be offered.
- Hospital staff we spoke with were complimentary about the crew. They told us crew were always co-operative and had full confidence in the care and treatment they had provided the patient. They said the handover information was always detailed and informative. Hospital staff said crew had always built up a rapport with the patient by the time they handed them over for

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care. We were told this greatly helped them to provide treatment to the patient, as most of the time the patient was relaxed and had been informed what was going to happen to them.

- We attended one emergency call to a patient who was unable to verbally communicate clearly. Crew then asked the patient to squeeze their hand if they agreed or confirmed the actions they were going to take.
- We heard ambulance crew introduce themselves and ask relatives and carers how they would like to be addressed. We observed staff modifying their language, tone, and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.
- We observed staff provide further information of care to relatives and patients. For example, ambulance crew treating an elderly patient were able to arrange with the patient's GP a prescription, which was sent straight to the patient's local pharmacist for collection. While the relative went to collect the prescription, the ambulance crew stayed with the patient to observe them and provide reassurance.
- Relatives and carers gave feedback on the ambulance crew, with comments such as "Absolutely fantastic staff" and "they have been so supportive and understanding, I really don't know how they do their job".

Emotional support

- The feedback we received from patients was that ambulance crew were reassuring and they provided emotional support throughout their care. Comments such as "they made me feel comfortable by talking about everyday things and took an interest in me as an individual".
- We saw staff offer support to relatives who were emotional and upset. For example, while one ambulance crew member treated the patient, another was tending to an upset relative. They made the relative a cup of tea and we observed the crew member speak kindly and offering words of comfort and support. The crew member also provided further information for the relative on who they could contact for further support.
- Ambulance staff supported confused and anxious patients. We observed staff ensure an anxious older person's house was tidied up before they conveyed them to hospital. They asked the patient if they had any pets that needed looking after and were able to contact

a relative to provide support and reassurance to the patient. They made sure the patient's feet were kept warm before they took them outside, even though they were covered in a blanket.

- Ambulance crew were able to explain how they dealt with bereavement situations and the support they would offer the family. They said they would stay with the family until they felt it was appropriate to do so. We saw a bereavement booklet that ambulance crew provided to families. The booklet provided supportive helpline numbers for family members to use.

Supporting people to manage their own health

- The trust had a frequent caller's policy in place. The policy explained the actions the trust took when dealing with those patients who called frequently. Such actions included the management and provision of appropriate clinical services.
- Frequent caller procedures were determined by the individual patient needs and were agreed with the individual and the main care provider (e.g. GP, Mental Health Service). The EOC staff were able to monitor and manage frequent callers.
- The EOC were able to advise the crew about the frequent caller before they attended the patient and signpost the patient to the appropriate services before the crew arrived.
- The trust had 30 patients in the frequent caller's database that were flagged as having a care plan in place. The trust was working with CCG's on developing the depth of detail and the capture of activity to the wider frequent caller cohort.
- We observed staff promote patient health and wellbeing verbally during interactions, including offering advice on how to access information about wellbeing advice. We observed ambulance crew give health advice to a young patient who smoked. They provided details of support lines to help them stop smoking. Staff were able to treat a patient and offer the appropriate pathway of care by involving the patient's GP. This meant the patient was not conveyed to the hospital emergency department.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

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Requires improvement



We rated responsive as requires improvement because:

- There were problems with access and flow of patients throughout London as a result of increased demand and pressures on health services. Delays in patient handovers at acute hospitals meant ambulances were often stacked and crew were left waiting in the emergency departments or their vehicles. This meant other emergency calls could not be attended to.
- There were a lack of sufficient facilities for bariatric patients to provide effective care and treatment, and the trust recognised they needed to do more.
- The pathway of care for patients with mental health concerns was insufficient and required review with other external agents for it to be responsive.

However:

- The trust were developing their 'hear and treat' and 'see and treat' processes to improve patient care. Staff were being encouraged to treat and manage patient's care and treatment without having to convey them to emergency centres.
- The trust employed mental health nurses at their clinical hubs to help assist frontline staff in providing effective care and treatment for those patients with mental health concerns.
- LAS had a maternity education programme in place with midwives across London. Staff were issued with maternity pre-screening tools and action plans to help treat maternity cases. Staff said they had been a useful tool when providing care and treatment.

Service planning and delivery to meet the needs of local people

- We saw from quality reports and minutes of board meetings the operational plans for the service, planning, and delivery were discussed and proved to be challenging.
- A review of activity trends highlighted the following areas that were influencing demand: demand for LAS services was growing faster than population growth; the demand from elderly patients was growing as a proportion of total activity. Demand from patients over the age of 75 was growing at the fastest rate; demand from elderly patients was greater in outer London CCG's.

- Demand had exceeded contracted levels by 3.4%. The contract for 2016/17 included growth of 2.2%, overall and 4.0% for Category A calls. Overall, this meant Category A activity had grown by 7.8% on the previous year.
- CCG's in outer London were busier with Category A activity for elderly people. Six CCG's had significant activity and growth in activity for the elderly population. The biggest demand and increase fell within Camden, Bexley, Hounslow Hammersmith and Fulham, Enfield and Bromley.
- Within the London region, the trust covered 32 CCG's.
- Externally, in conjunction with CCG's, the trust was focusing on the following to reduce demand: management of frequent callers, calls received from care homes, community treatment teams, and handover delays in hospitals.
- The trust was assisting the CCG's by providing enhanced demand data to support their understanding of patient demand, as well as the development of clinical pathways to improve care.
- The trust aligned to the London Sustainability and Transformation Plans (STP), which is an NHS development of proposals to make improvements to health and care across London. These proposals, called sustainability and transformation plans (STPs), were place-based, and built around the needs of the local population.
- The trust had worked in partnership with commissioners to develop urgent and emergency priorities for London STPs, and their operational management structures had been restructured to align to the five STPs so they were locally responsive.
- In addition, the trust had a number mechanisms to manage demand and resources for the most seriously or life threatened patients, including the EOC operating a 'hear and treat' service which resolved around 2,400 calls a week allowing resources to be sent to higher acuity calls. They had a dedicated desk, which reviewed all police calls and provided clinical assessments before an ambulance was dispatched. This provided greater support to the Police and 50% of these calls were now managed on scene. They also utilised the National Resourcing, Escalatory Action Plan (REAP) when demand outstripped capacity on a sustained level.

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Additionally they used surge management when there were spikes in demand, which were addressed through re-allocation of resources and the ability to refer lower acuity calls through to NHS 111.

- We saw the trusts computer system showed clearly, where there were ambulances stacked at various hospitals. The system let managers know where there were problems and how long each ambulance crew had been waiting in emergency departments.

Meeting people's individual needs

- London Ambulance staff took the needs of different people into account when providing care. There was shared understanding between staff that every patient had individual needs.
- The trust commissioned two vehicles specifically equipped for bariatric patients and these were operated by one of their service providers. However, when speaking to staff, some said there were occasions when they had conveyed bariatric patients to emergency departments and those hospitals did not have the appropriate equipment. They described the process as somewhat undignified for the patient. We were told the patient stretchers were able to accommodate bariatric patients. The hazardous area response team (HART) would also be utilised to accommodate those patients who required specialist support.
- We noted Bariatric training was part of CSR training for 2017.
- The trust acknowledged they needed to do more for bariatric patients, due to the growing demand for this service. A bariatric working group was set up which included a patient representative who reviewed the bariatric requirements of the service. New bariatric clinical training had been incorporated into the CSR training for 2017/18. This was still a work in progress at the time of our inspection.
- For patients with learning difficulties, staff carried a communications assistance pocket booklet, which gave guidance on how to communicate and pictorial aids to help patients communicate.
- A range of lifting and chair aids were available for those patients with physical disabilities. On occasions, patients with motorised scooters were allowed to take them on board vehicles if they wished to do so.
- Mental health nurses based within the emergency operations centre (EOC) were able to offer support to ambulance crew and to patients who made contact through the telephone system.
- The trust was the first ambulance service to “spotlight on maternity” and had taken the following actions. They currently have joint maternity education in progress with midwives across the capital. They have established a maternity risk summit, which meets every six weeks and has a focus on maternity safety, which identified the following themes: recognising deterioration in pregnancy, management of preterm delivery and managing temperature in newborns.
- Following an investigation of a maternal death, all frontline staff were issued with a maternity prehospital screening & action tool along with specific guidance, which detailed the responsibilities of both ambulance services clinicians and midwives within maternity units in London.
- A translation service was available for staff to use. There was also a multilingual booklet staff were able to refer to for patients who spoke little English.
- Consistent delays in gaining access to some hospital emergency and urgent care departments meant patients sometimes waited over two hours to be seen. Patients were ‘queued’ in corridors, which meant patient dignity, and privacy was poor. This was beyond the trusts control; however staff we spoke with fed back their concerns with regards to patient care and risk to patient outcomes. Sometimes these patients did not receive the clinical observations required by hospital staff during this time. Ambulance crew were demoralised with the queuing system. Certain staff told us they were stressed at the delays in handover to hospitals. We observed crew waiting to handover the patient at a hospital. During this time they had received several broadcasts for ambulance resources due to outstanding emergencies
- The trust had established the appropriate care pathways group which was chaired by a consultant paramedic who together with managers and clinicians helped develop pathways in a central forum. The idea was to share good practice and develop a suite of pathways able to meet the needs of patients.
- The trust embarked on a pilot scheme, which introduced up to 12 Advanced Paramedic Practitioners (APP) from January 2017. The role of the APP was to work rotationally in other practice settings to develop

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an understanding of the wider system as well as clinical competencies, which to enhance their ability to manage patients in the community. These practitioners held an advanced scope of practice in urgent care and were able to provide see and treat services to a wider range of patients, including those with chronic conditions, end of life care needs and minor injuries. This system was in the very early stages of implementation at the time of our inspection.

- The trust had developed a number of pathways with local providers which ambulance clinicians were able to access to provide care for patients with long-term conditions in the community. These included direct access to community wards and admission avoidance teams, specifically for patients with chronic conditions such as diabetes, mental health, and chronic obstructive pulmonary disease (COPD). However, staff informed us the mental health pathways did not work, due to the strains on the mental health service. Therefore, the pathways did not work well for mental health patients.
- The trust worked closely with Co-ordinate My Care (CMC) and was the first UK ambulance trust to begin using this system to identify end of life patients, with care plans in place specifically detailing preferred place of death and ceilings of care. Registered clinicians based within the emergency operations centre had direct access to this system, and were able discuss the case with the attending crew, so all relevant information was available to the crew, so they were able to support the patient to make a decision, or to make a best interests decision if the patient lacked capacity.
- The trust had a system for flagging patient's addresses if they required care outside of normal guidelines. For example, this may be for a patient with a long-term condition, requiring specialist treatment or support. Plans, which did not appear, on CMC were written in conjunction with the patient's lead clinician, and were reviewed yearly.
- The trust provided information to bereaved relatives or carers. Support telephone lines were supplied along with information of when a person should seek help.
- Most staff we spoke with had received training to care for patients with dementia. They had also received training for The Mental Capacity Act 2005. Training was in the form of core skills refresher training, which most staff said they had attended in 2016. During our inspection, we observed good interactions of care for

patients with dementia. We were told London Ambulance community involvement officers worked closely with care homes to make sure unnecessary calls were not being made to the service. Sometimes the patient was better cared for in a familiar environment than a hospital. However, we found involvement for community involvement officers was varied dependant on each station and region within the service.

- Staff told us when they had to convey a patient with dementia to the emergency department; the lengthy delays caused unnecessary stress and anxiety for these patients. They became confused and upset and staff said this sometimes added further complications to their treatment of care.
- The PRF form provided mental health assessments for ambulance crew to follow to determine the best pathway of care. However, as mentioned previously there was a severe lack of capacity and access to the appropriate centres, so for the majority of cases the pathways did not work. Staff said they did follow the pathways but very rarely gained access to the appropriate mental health facilities. Staff acknowledged that sending a patient with mental health concerns to emergency and care departments was not always in the best interest of the patient. However, there were no other options available due to the lack of mental health facilities to accommodate patients. This was a cause of huge frustration amongst staff. Staff told us they had seen an increase in attending call outs to patients with mental health concerns, but the systems in place in London were not sufficient to accommodate and help these patients. We were told of incidents where staff with patients would have to wait, for sometimes more than two hours at emergency departments to be seen.

Access and flow

- The trust served a population of eight million people and covered an area of around 620 square miles. This predominantly covered urban areas. There were 70 ambulance stations based around London. Most hub stations had Make Ready centres and the trust made use of the first responders to ensure they could attend patients quickly.
- Due to London being heavily populated, access to certain streets proved to be difficult for ambulance vehicles, mainly due to the width of the street with

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vehicles parked on both sides of the road. The service made use of motorbikes and cars to respond quickly to patients to attend their needs and assess the scene to see if necessary support was required.

- The trust was achieving the mandated 95% of 999 calls answered within five seconds, which meant the trust had a low rate of abandoned calls. Most callers were able to make contact with the London Ambulance service.
- Handover delays at accident and emergency departments proved to be the biggest problem the trust faced, affecting the smooth access and flow of patients.
- During our inspection, we observed ambulance vehicles queuing to gain access into hospitals and queuing in hospital corridors, waiting to handover patients safely to medical hospital staff. It was apparent that certain hospitals and regions experienced significantly more delays than others did.
- Ambulance crews gave us examples of worse case scenarios of having to wait over three hours at certain acute trusts. Staff told us they were often late finishing their shift because of delays in handing over patients at hospital.
- During April to November 2016, the trust experienced a 31.41% increase in emergency department (ED) handover delays over 15 minutes. In context, the productive hours lost while delayed at an ED beyond the target handover maximum of 15 minutes equated to 35740 hours, or 2978 lost, 12-hour ambulance shifts, as compared to the same period the previous year. 22 CCG's had been asked to reduce demand on both ambulance services and ED by 5%. Use of intelligent conveyance and promotion of alternative care pathways were important tactics for the trust to assist in managing ED demand.
- The trust was in consultation with external partners and we saw escalation plans for the management of ambulance delays at emergency departments. We were told NHS England (London) and NHS Improvement (NHSI) have agreed a draft policy for NHS England (London)'s Emergency Department Capacity, Management, Redirect and Closure Protocol (ED Policy). This was a new policy, which had set procedures for acute trusts to follow to ease the delay in handover times at emergency departments, to free LAS staff from delays to answer emergency calls.
- Such escalation plans included those people responsible for ensuring handovers were dealt with quickly and efficiently and the systems acute hospitals had in place to deal with those patients.
- This was a new procedure and therefore we had not seen any evidence to see if this had proved effective.
- Some hospitals had developed initiatives to help improve handover times. Some had a hospital ambulance liaison officer (HALO) in place to reduce the ambulance waiting time. These staff looked after patients while they waited for space within the hospital. This allowed ambulance crew to become available for emergency calls.
- IRO's were dispatched by the service and managed handovers at those hospitals, which experienced severe handover delays, allowing ambulance crew to become available to take emergency calls.
- Staff within the EOC were encouraged to 'hear and treat' patients, an initiative where staff's clinical experience was used to assess patients on the phone and provide effective treatment without the need for emergency crew. Using available alternative pathways of care was key to the success of treatment.
- Due to delays at emergency departments, those ambulance staff starting a shift were sometimes unable to become available to attend calls, as they had no vehicle. Ambulance crew were able to contact EOC to see if there was an alternative available vehicle but this caused delays in starting their shift. We observed this several times during our inspection.
- The trust employed advanced grades of paramedics, such as APPs, who were skilled to provide medicines that other paramedics could not. This enabled the APP to provide enhanced care and treatment to the patient, which meant they did not necessarily have to attend emergency departments.
- Staff told us, patients sometimes demanded to be taken to a certain emergency department, even though EOC had requested they convey them to a less busy one.

Learning from complaints and concerns

- We saw the trusts complaints and feedback policy. The patient experiences report for 2015/2016 indicated 1051 complaints were received (including 71 referrals by other health and social care professionals managed as being made on behalf of the patient). Each complaint was broken down into specific areas, stations, and departments, so trends could be identified. Common

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themes included, staff challenging the validity of the 999 call, sequential call management errors at times of significant demand, failure to re-triage repeat 999 calls about the same patient, an increased correlation between delay and poor staff attitude (altercations arising from the delay) and an increase in non-conveyance where the patient had been referred to an alternative care pathway.

- We reviewed the formal complaints process with a member of the complaints team. We reviewed the electronic system for recording and managing complaints through Datix. The current system came into use in May 2016, and was based on the patient experience model. This categorised complaints by six criteria and a separate category related to enquiries, which came through the Patient Advice and Liaison Service, (PALS). Complaints were risk rated, including having an impact score related to the consequences.
- The database was logical and provided opportunities to collect all relevant information throughout the process from receipt to closure. There was a facility, which enabled data to be reviewed by sector, and reports could be run off for formal review.
- We saw complaints were to be acknowledged within three working days and there were expected times to reach closure, subject to the type and seriousness of the matter. Complainants were also provided with information about the complaints process, including details of the Ombudsman.
- We reviewed five complaints of varying nature and saw in each case a detailed and thorough investigation had been undertaken. This included where relevant referral on to the serious incident investigation team. The investigation process had also included obtaining clinical opinion, review of statements, and call logs. Each complainant had been sent a detailed letter with a full explanation and apology. Where further action was required of staff, this was stated in the letter.
- We saw evidence of actions taken as a result of patient complaints. For example, the family of an elderly patient questioned the delay in an ambulance attending the patient after they had fallen. The trust advised they had a system so that automatic upgrades could be made to calls involving patients identified as people who are vulnerable as a result of their circumstances in keeping with the 60 minute schedule from the time of the initial 999 call.

- We saw there were leaflets on board ambulance vehicles staff were able to provide to patients if they wished to provide feedback or complain. The leaflets provided information on how to make a complaint. Most staff we spoke with said they would try to diffuse any concerns patients or relatives had, before a formal complaint was made.
- The LAS website provided information on how to make a complaint. The website also informed patients that when the service had anticipated capacity issues, patients might experience a delay in responding to complaints and enquiries.

Are emergency and urgent care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- Although the trust had a strategy and core values in place, most frontline staff did not know what these were and did not feel engaged with the trust's vision.
- There was still a disconnect between the executive team, middle tier management and frontline staff. Staff were unsettled with frequent changes made within the executive team, and wanted more stability.
- We found the visibility of the executive team had not improved. Staff told us they rarely saw managers above Band 8, with the exception of the medical director and director of operations.
- Staff morale was varied. Staff said the trust was very target driven and sometimes lacked the 'human' touch. Staff felt harassed with the constant monitoring and measuring of their operational performance. Staff did not feel the trust recognised talented staff.
- Although the trust had placed a great deal of emphasis on tackling bullying and harassment, at certain stations there was still a perception from staff of bullying harassment and discrimination. There were still high levels of work overload and high levels of stress. There were clear differences between the ways certain stations were managed locally.
- Group station managers needed more support locally. Due to their heavy workload, they were unable to develop their role, as they would have liked, such as becoming more involved in local community issues.

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However:

- The trust had a clear clinical strategy, which involved tackling their immediate problems of handover delays and managing increased activity
- The trust had a more streamlined system for managing risks and local stations now had their own risk registers. Staff were able to tell us what their stations risks were and what action plans were in place to mitigate such risks.
- The trust had seen an improvement in the embargoed staff survey results for 2016. There were improvements in areas such as the organisation being a recommended place of work, the standard of care provided and having enough staff to do their role properly.

Vision and strategy for this service

- The trust had a vision and strategy. The vision was “to make the London Ambulance service great.”
- The trusts values were: In everything we do we will provide care, clinical excellence, commitment.
- Some of the clinical team leaders and station managers were aware of the trusts vision and values; however, most frontline staff told us they did not know what these were. Staff said there had been more communication, with signs, posters, and information in newsletters. However, they did not fully understand the vision, as they were not fully engaged with the organisations strategy and core purpose.
- Through discussions and observations, we could see staff were committed to providing clinical excellence and care. The behaviour of staff when providing care and treatment for patients was aligned with the trusts vision and core values. Patient care was at the heart of the service.
- We saw visible signs, posters, and leaflets throughout stations on the trusts vision and purpose. During the inspection, staff feedback they were unhappy with the tall stands, which had been erected at each station we visited. These stands displayed the vision and core values, however staff said they had been purposely made and delivered for our inspection, and some had only been placed at stations the day before our inspection. We observed the stands were too big for some of the stations and had to be placed outside in the enclosed parking areas.
- The trust had a strategic plan for 2014 to 2019. Strategic priorities included reviewing and improving current practices of all functions. For example, improving the

direction of patients to urgent care centres, GP led health centres, minor injury units and community-based services to ensure out of hospital pathways were appropriately used.

- The trust had a clinical strategy as part of their overall strategic plan. The clinical strategy defined how they would deliver services in line with the integrated and emergency care plans for each of the five STP footprints pan London. The trust have recognised that there were differences in locally commissioned services and will endeavour to ensure there is an agreed set of minimum standards and appropriate care pathways across London.
- We were told the clinical strategy was discussed with 1000 staff who attended the roadshows in October and November 2016.

Governance, risk management and quality measurement

- The governance structure for service delivery was fulfilled by the Service Delivery Group, A&E Resources Group, and Operations Board. These groups were focussed around demand, capacity (staffing and vehicles), and efficiency in order to ensure optimum service delivery and performance. This meeting framework had been in operation since May 2016. The governance structure for quality related matters including clinical compliance, workplace reviews, medicines management, risk and incident investigation and learning was provided by area level quality governance meetings chaired by a deputy director of operations. These meetings reported to the board level Quality Committee (specifically to the Clinical Safety & Standards subgroup). Risk and risk registers were currently managed via these area quality governance meetings.
- In November 2016 the director of operations consulted managers on introducing a consistent quality governance framework across operations, which would expedite the risk escalation process by ensuring all quality governance meetings at all levels occur at a similar time of the month in an agreed sequence.
- The Service Delivery Group met weekly and was used to set the latest weekly forecast position and communicate this to senior operations and non-operational staff. The

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group highlighted any critical issues seen in the latest week's data and four week look ahead. Members of the operations board used this group to agree and review analysis requested of the strategic taskforce.

- The weekly A&E Resources Group provided oversight, scrutiny, and challenge for all the trust's processes that influenced the number of operational hours, which were available to deliver services for patients.
- The monthly Operations Board had representation from across the directorates in the organisation and carried out the medium term forecasting and planning for issues, which affected trust wide performance. It reported activities to the trust board and responded to challenges made by the board regarding operational issue.
- Area quality governance meetings were held monthly or quarterly dependant on the region. The primary focus of the area quality governance meetings were to assure the chair (Deputy Director of Operations) of clinical governance, risk and audit through monitoring the standards of care set by the Board, ensuring the three key facets of quality – effectiveness and outcomes, patient safety and patient experience – were being met. This helped the chair's oversight of quality performance and risk. The chair then fed back to the board, via the quality governance committee of these facets within the area. We viewed the minutes of meetings for each group meeting and saw discussions took place on service delivery improvements, planning and current risks.
- Following the outcome of our previous inspection in June 2015, the Quality Improvement Programme (QIP) was set up and led by the Director of Transformation, Strategy and Workforce and was accountable to the CEO and chair. The programme was categorised into five key themes, each with an executive director lead accountable for delivering progress. Additional support for the programme had been provided by an Improvement Director appointed by NHS Improvement and regular assurance reporting provided to key external stakeholders such as NHS England, NHS Improvement and CCG's. We saw from October 2016 board meeting, clinical and quality items were raised and discussed as items on the agenda.
- The trust's risks were escalated via an established governance framework of committees, from local level meetings to the trust board. Thresholds were set for

local, trust, and board assurance level risks. They were reviewed and monitored at the appropriate committee meeting as set out in the trust's risk assessment and reporting procedure

- Risks qualifying for inclusion for the trust risk register (risks with a net score of 10 and above) and risks qualifying for inclusion on the Board Assurance Framework (risks with a net rating of 15 and above) needed to be approved by the Risk Compliance and Assurance Group (RCAG).
- The RCAG also had responsibility for approving the de-escalation of risks currently included on the Board Assurance Framework and trust risk register. Compliance with management of risk at all levels was reviewed by the RCAG, which met monthly.
- Each area had a designated contact from the governance team to support them.
- Just over two thirds of the overall trusts risks sat within operations. There were three risks rated high.
- One of the high rated risks referred to the service performance adversely affected by the inability to match resources to demand. We saw examples of the controls in place to mitigate such risks. These included ongoing recruitment campaigns, use of voluntary, and private sector at the times of peak demand, overtime initiatives, and a surge plan in place.
- An internal audit on risk management within the organisation was undertaken during July to September 2016. The review included opportunities for improvement, which included changes to the key performance indicator (KPI) for risk management. The new KPI had four measures, which included having a risk register in place; risk meetings take place on a regular basis, the risk register being complete, and all risks being up to date.
- All risk registers were rated against the four measures and were only rated as green if they were all met. Risk registers were rated as amber if they required minor actions in order to comply with the four elements. Between April to June 2016, 86% of all local risk registers were fully updated. All risks were reviewed monthly and every six months, and rated according to accuracy and frequency of refresh.
- There were a small number of amber rated areas where updates were pending during our inspection. The governance and assurance were working with the owners of these registers to ensure they were regularly

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updated. All risk registers were held in the electronic incident reporting system, which meant they could be reviewed and managed centrally. 88% of managers had completed risk management training.

- We saw local risk registers were kept at stations and were updated and reviewed on a regular basis. Station managers told us there was a more robust system in place to manage risks and recognising local risks within their stations was just as important in the smooth running of the service. For example, the electronic access gate to one station was placed on their local risk register as the likelihood of the gate not opening electronically posed a problem in allowing vehicles to exit the station to answer emergency calls. We saw the plans in place to mitigate the risk and the regular reviews, which had been undertaken. Most stations we visited had a “top three risks” displayed for staff to see. Staff we spoke with were able to list the top three risks of their station.
- The quality governance and assurance managers (QGAM) were introduced during the operational re-structure in 2016 to assist in delivering sector based quality by having responsibility for group station and sector risk registers, providing meetings with staff following highlighted incidents and providing feedback on complaints and serious incidents.
- The QGAM’s were established paramedics with backgrounds in management within the trust. They also reviewed all clinical performance indicator (CPI) data. This data included a collection of data from the PRF records which provided information on aspects of care such as mental health, cardiac arrest, difficulty in breathing, severe sepsis, and general documentation. They had oversight of safeguarding activity within their sector. We reviewed the Northeast Area quality matters newsletter of February 2017. This provided staff information on quality performance updates. For example, information on care bundles, ways to improve compliance, learning from incidents and medicine management.
- We reviewed minutes of the Clinical Quality Review Group and saw these contained a quarterly IPC report. The author of which was the IPC lead and information was formally presented by the DIPC. We noted this report had also been presented at the Clinical Standards and Safety Committee, and contained an update as to progress against the IPC annual work plan for 2016/17. Detailed information was contained therein,

including where action was required, an update of risks. It was noted in the January 2017 minutes a lack of pace in completing outstanding actions in the IPC work plan, which required local ownership and timely actions if risks were to be mitigated.

- The trust had a medicines management oversight group (MMOG), which met monthly, and a medicine management group that met every three months, with the prime purpose of maintaining strategic oversight of all matters relating to medicines management to ensure effective use and management of medicines.

Leadership of service

- Nearly all frontline staff we spoke with said the executive team was target driven and this sometimes took away the ‘human factor’ side of leadership. Staff felt leadership was of a heavy ‘top down’ approach and there was little room for discussion. It was clear the executive team needed more engagement with staff to allay their fears and gain their support and participation in leading the service forward. Staff told us they still felt disconnected from the executive team and middle management tier. We did receive positive feedback from staff regarding the medical director and their visibility at stations.
- A group station manager (GSM) managed each station. GSM’s were responsible for the day-to-day management of stations, sub stations including all the staff and operations of each station. Clinical team leaders provided support to the GSM’s and supervised frontline staff.
- For each sector, there was an assistant director of operations, sector delivery manager (SDM), quality governance and assurance manager (QGAM) and a stakeholder engagement manager (SEM). The SDM was responsible for line managing group station managers and responsible for the staffing, service delivery and efficiency of the sector. The QGAM was responsible for managing quality governance in the sector, investigating incidents, medicines, management, safeguarding, and other quality related governance matters. The SEM worked with the sector’s local health community including acute trusts and community providers to advocate the priorities of LAS and to ensure collaborative working with stakeholders.

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- Staff were generally positive of local leadership. There were a few stations we visited where staff were not happy with the style of management, but overall staff were confident in their local manager's abilities.
- We received a mixture of positive and negative feedback from the clinical team leaders (CTL) regarding the scope of their role. CTL were meant to provide clinical support, supervision, and leadership to staff within a dedicated team in their geographical area of operation. Their role involved an equal split between clinical activity and management/supervisory non-clinical duties. It was apparent this was not happening or consistent across the organisation. Some CTL were unable to provide supervision to frontline staff as operational requirements meant they were placed on clinical duties for more than fifty percent of their time. Some CTL were responsible for a large number of staff where it was almost impossible to offer the necessary support and management on a one to one basis. Others felt extra duties had been placed on their role and they had not received the sufficient training for this. Some frontline staff feedback that not all CTL had the appropriate management or supervisory skills.
- Some CTL said they were well supported by their GSM and were able to provide the supervision to frontline staff. They said the role was ever growing, and changing. Most CTL expressed concern at the lack of sufficient time to fulfil the scope of their role to the full potential. This was source of frustration to CTL, however the director of operations was aware of this problem and ongoing discussions had taken place between management and staff. Discussions were still ongoing at the time of our inspection.
- Most GSM's we spoke with said they could do with extra support, due to their heavy workload as they were unable to explore avenues of the role they were keen to develop. For example, engaging with the local community.
- It was clear during our inspection there were different styles of management shown by GSM's and from the different feedback, we received from frontline staff. Good leadership at certain stations inspired staff. For example at Twickenham, station, staff highly praised their GSM and said they were fair, proportionate, and supportive of their needs. The GSM was proud of the staff who attended the 'safe drive, stay alive' campaign at local schools the two acting GSMs at Greenwich station were praised highly by the crew we spoke with.
- Staff provided positive feedback on their GSM at Croydon station, especially of their leadership skills during the Croydon tram derailment incident in 2016. They said the GSM showed support and kindness and staff welfare was at the forefront of their priorities.
- We spoke with a fleet manager for one of the workshops. They told us they did not receive any visits from the head of fleet services, even though they were the nearest workshop to where they were based. They did not receive any feedback for concerns raised and felt they were not a part of the trust.
- Mechanics felt the regular changing of vehicle brake discs and brake pads was unnecessary and costly, however they have been told to do so for every three-month vehicle service. Staff said this took away their autonomy as trained mechanics and felt their experience and skilled advice was ignored.
- Staff reported rarely receiving a rest break, and therefore worked up to 12 hour shifts with no sufficient rest. This posed a health and safety risk to staff members' welfare. However, at the time of our inspection the trust was in discussion with staff groups on new rest break policy.
- Staff reported the beneficial aspects of the physiotherapy service offered by the organisation, for those staff that had been injured at work or returning from sickness due to injury.
- After two instances of sickness within the rolling year, staff were required to attend management attendance policy (MAP) meetings with their line manager, to discuss the reasons of their sickness records.
- Staff were not happy with the current process of MAP monitoring of sickness. Staff said the trust were not flexible and felt they were penalised for being sick. Therefore, many staff attended work when they were unwell for fear of being reprimanded. They were particularly critical of the way work related sickness was not monitored separately. Staff told us managers at each station managed MAP differently and there was no consistency.
- Staff reported when they were sick a welfare call was made. Staff reported they did not like this and felt it was not for their welfare but more of a check from the organisation as to when they would return to work.
- There was a lone workers policy for staff to follow to help with their safety. The policy included flowcharts of when to wait for back up before attending an incident and, when a call had been high risk. This policy applied to first response FFR vehicles and motorbikes. All staff

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we spoke with did not express concern and knew what actions to follow if they felt in need of assistance. One staff member was able to provide an example of when they had to request assistance and how quickly and well managed the incident be.

- Staff were able to 'stand down' after difficult incidents and an IRO would speak and offer support. We observed the support of an IRO following a particularly difficult call. The IRO spoke to the crew regarding the call and answered questions the crew had and left when he was assured that the welfare of the crew was good.
- Staff at Croydon station who attended the Croydon tram incident in 2016, staff were offered counselling and were assessed for a week, to ensure they had the necessary support. Staff told us they had felt well supported and were given opportunities to discuss the incident.
- Welfare checks were made to ambulance crew if they had been on a call for over an hour. The checks were meant to ensure staff had the necessary support for difficult incidents; however, staff told us the calls were made to hurry them along to the next call. Staff told us the calls often made them feel under pressure. During our observations, we noted no welfare check calls were made for a difficult incident involving a patient with mental health issues. The ambulance crew told us this was because the incident was the last of their shift so they could not be used for calls anymore that day.
- Staff we spoke with said they rarely reported verbal abuse they had received from patients as an incident of this kind happened frequently. During 2015/16 there were 452 staff related assaults, which meant on average one staff member was assaulted each day in London. All staff were offered counselling and support following an assault. The trust recognised that each individual was different and the level of support required varied according to individual need. Everyone was able access the same level of support. Staff we spoke with were able to describe the support the trust would offer if they required.
- The trust had a zero tolerance policy for abuse to their staff. Spit kits had been rolled out across the service to help support staff.

Culture within the service

- Although the trust had made significant strides in tackling bullying and harassment since our last inspection, there were still pockets of areas that needed to be vigilantly managed. We observed a varied but

mainly positive response from frontline crew regarding bullying and harassment. Most staff said they had not experienced any concerns, but others said it still existed at local level dependant on different stations. It was evident that each station was managed differently. We observed both well managed stations where staff were inspired, the culture was one of respect and staff were valued, while at other stations staff told us they felt intimidated by their local leaders and there was a culture of harassment and fear. However, the majority of stations we visited we received positive feedback from the staff.

- The majority of staff felt harassed with the operational targets set, and requirements placed on them, those being the 14-minute turnaround times at emergency departments and the 10-minute pre-checks before the start of shifts. Staff understood the operational demands placed on the service, but were unhappy with the approach from the leadership team. Some staff said they felt pressurised as they were constantly being checked upon and having to justify their actions. It was apparent there was a disconnect between frontline staff and management as to how operational monitoring was managed and communicated.
- One FRU told us they had been contacted by their management team as they had taken 50 bathroom breaks within 57, twelve-hour shifts. FRU's mainly attend patients at the scene and do not visit emergency departments where they can use bathroom facilities. Therefore, they have to stand down to take a bathroom break. Most staff told us having to explain bathroom breaks to the call operations centre was undignified and humiliating. They understood the pressures placed on the operations centre, but said this could be better managed in terms of the pressure placed on staff.
- Other staff told us bathroom break times were discussed in their PDR. This made staff feel humiliated and embarrassed. It was clear the style of managing these discussions was not effective and alienated staff from the service.
- We were given examples of perceived bullying from team leaders and managers to frontline staff. During the inspection, we were shown an example of a message, which had been sent via a local, closed Facebook page. The message was terse and staff at the station told us they were upset at the tone of communication. This then led to the staff feeling dissatisfied and unable to

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challenge the management for fear of being harassed. When asked for an example, they explained their rosters would be altered if they did not agree with the station manager.

- One GSM told us how they were asked to produce a report one hour before they were due to finish work. There was no consideration for their welfare and they felt pressurised to stay extra hours to complete the work.
- However, the trust had worked hard to improve the bullying and harassment culture at the service in the past year. The trust recognised they had to do more work to complete in this area. To this end they had recruited a bullying and harassment specialist, who was given the task to deliver a programme to improve culture within the service. So far the service had delivered bullying and awareness training sessions to 716 staff and held 'courageous conversations' workshops attended by 19 staff and mediation workshop attended by 44 staff.
- Bullying and harassment investigation training had been delivered to 69 staff, which had exceeded the QIP target.
- A new 'Dignity at work' policy had been introduced which placed emphasis on mediation and facilitated conversations to encourage early resolution of concerns. Staff we spoke with were aware of the new policy and of the bullying and harassment contact numbers.
- Local managers told us of the extra training and guidance they had received to tackle bullying and harassment in the workplace. They said they found the training and information valuable.
- Late finishes, lack of breaks and poor vehicle preparation was a cause of frustration for staff. We understood there were working groups in progress to address these issues, which included participation from frontline staff.
- Some staff said although they appreciated the increase in frontline staff within the last year, they had not felt the full impact of the additional capacity as increased demand had overshadowed this.
- Staff reported they felt the culture was one of a constant cycle of change that was not working well. Many staff told us the executive team made quick fix decisions rather than thinking of long-term solutions. The recent

re-structure of the roles was given as one example. We were told the old structure just needed tweaking rather than a new system, which they did not feel was working well.

- A new action plan to address race equality issues in the service had been agreed by the trust board in July 2016.
- It was widely accepted within the trust, in terms of their workforce, LAS did not represent the local communities within London.
- We reviewed a proposal document provided by the interim equality and diversity lead, in which it set out its aims to widen the opportunities for black and minority ethnic (BME) people in LAS.
- Current data indicated the LAS employed 5155 staff, of whom only 13% were from BME groups. This was significantly low when the demographics of London were taken into account. BME individuals make up 40% of the London demographics.
- Within the current workforce 101 (11%) BME staff worked in a band 4 role, such as TEACS, EACs and NETs. 171 (7.14%) of paramedics and EMTs were BME working at band 5. Non-operational band 5 had 41 (36.6%) BME staff.
- Of the 297 non-operational managers and specialists band 6 & 7, 58 (19.5%) were BME.
- There were 487 Operational teams leaders, senior paramedics and resource staff band 6 & 7, of which 49 (10%) were BME.
- 123 managers band 8a and above, 13 (7.1%) BME. In addition, there were 42 senior managers above band 8c, of whom one (2.3%) were BME.
- No BME staff were employed in the executive team or non-executive director team.
- The majority of BME staff 183 (3%) were employed in operational band 3 roles, followed by 57 (30.5%) in non-operational band 4 roles. Two BME staff (15%) were in operational band 2 roles, and 10 (50%) in non-operational band 2 posts.
- The proposal sets out areas of focus, which include increasing the visibility of leadership, getting ready for future workforce. This would be done by focusing on schools, colleges and universities, as well as working with voluntary services. Other areas to be addressed include accessibility to recruitment and training opportunities, developing learning opportunities and the re-launch of the leadership programme.
- We reviewed the report presented to the trust board on 4 October 2016, which provided an update on the

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progress of the workforce race equality scheme, (WRES). This outlined the significant actions taken since the board had signed off the WRES action plan on the 26 July 2016. For example, a board seminar had been held on 8 September for executives and NEDs. This had been led by NHSE joint programme directors. Various meetings had been held with internal and external stakeholders, and external conferences and workshops had been attended. The staff survey undertaken for 2016/17 had also included a number of additional equality and diversity questions.

Public and staff engagement

- In June 2017, the trust launched “Making the LAS great”. This was started to create conversations and engagement locally about personal contributions to the QIP plan. Managers were encouraged to engage with staff on the vision and values of the organisation. 180 conversation packs were issued to all teams, conversation toolkit for managers was provided to support them in engaging with staff, and local videos, social media activity and internal communication channels.
- The corporate communications campaign was a call-to-action for every member of staff around improving the service. The campaign centred on eight must do’s, with each having its own communication plan with objectives, deliverables and key messages. Such must-do’s included booking an appraisal, medicines management, looking after equipment and keeping information safe.
- We observed posters at stations displayed near medicines with the key message “shut it, local it, prove it, return it”. Staff told us medicine management was the biggest improvement they had seen since our last inspection.
- Although the trust had significantly improved their channels, of communication, there was still a sense of disengagement from the staff and this would be an area the trust needs to focus more attention on. For example, although the trust had focused on communicating the vision and core values of the service, staff could not tell us what they were. More focus needed to be spent on why their staff were not fully engaged with the corporate vision and strategy.
- Each week the trust produced a content grid of news stories published across all their internal communications channels on delivery of improvements. This was to ensure received positive stories of the organisation.
- Before our inspection, we held focus groups whereby staff of all levels attended to provide feedback on the service. Staff told us they liked the Facebook closed LAS group. Staff said they were able to ask clinical questions and get answers from senior management. They found it a useful tool for discussing clinical issues. However, local stations had their own closed Facebook and WhatsApp groups and we were not assured of how senior management monitored these.
- In April 2016, the executive leadership team approved the LAS using the University of Warwick’s healthcare engagement scale (HES) to measure the engagement of patient facing staff in the different areas of the service. The aim in using HES was to, measure the engagement levels of patient facing staff in specific areas so they could identify different gaps in each area, and then support local managers to take the right local action. This also gave managers the intelligence to engage with their workforce to improve delivery of the QIP programme.
- 653 members of staff completed the HES survey. The results of the correct survey indicated staff engagement was generally low and the report provided details of staff groups, which were more engaged than others were.
- The results showed staff engagement was more dependent on staff role than staff location. The trust recognised there were current shortfalls in staff engagement, partly due to operational manager’s ability to have protected time to have conversations with their staff and the skills and training to enable them to be effective. The director of communications was working with the operations directorate to produce an action plan, which would become part of the director of operations review of the management structure.
- Road shows attended by the chief executive, medical director, and senior leaders in operations were attended by 1000 staff. Some staff told us they had attended the roadshows and found them useful; others said they had not attended due to time constraints.
- The trust undertook a staff friends and family test (FFT) which gave staff the opportunity to feedback on the services provided and whether they would recommend

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the service to friends and family who may require similar care. There was an increase from 15% in 2015 to 23% in 2016 for the question, “enough staff at my organisation to do my job properly”. For recommending the organisation as a place to work, 42% of staff agreed compared to 29% in 2015. For the question “if a friend/relative needed treatment, would you be happy with the standard of care provided” 70% of staff said yes compared to 56% in 2015. This showed the trust was improving in certain areas; however, it was recognised there was still some way to go in increasing staff morale and engagement. The trust will be measured again when the service takes part in the HES survey for 2017.

- Staff were able to nominate staff regardless of role for the services VIP awards, which recognised staff’s contribution across the organisation. For 2015/16, 329 nominations were received for staff and 13 finalists were put forward for the award. Over 300 staff attended the event for employee of the year.
- The embargoed staff survey results for 2016 showed out of a total of 88 questions asked the trust were significantly better on 67 of the questions and significantly worse for 0 questions.
- 42% of staff recommended the organisation as a place to work compared to 29% in 2015. 61% of staff said their immediate manager valued their work, compared to 47% in 2015. 95% of staff said they had not experienced discrimination from a manager or team leader compared to 85% in 2015. 63% of staff often/always felt enthusiastic about their job compared to 55% in 2015. However, for the question “not put myself under pressure to come to work when not feeling well enough” had risen from 9% in 2015 to 11%.
- Staff engagement also took the form of newsletters and magazine, for example “Routine Information Bulletin” and, “Insight”, a new magazine aimed at providing patient real case scenarios and the sharing of clinical advice and information. Staff were able to get company e-mails through their mobile phones. However, staff still felt disengaged from the management of the service.
- The trust’s website provided information on the service and how the public could get in touch and become involved. The website provided information on how they were able to arrange visits for schools, local community events, and colleges. Staff at Isleworth and Croydon station told us of how they attended schools to promote the “Safe drive, stay alive” campaign to promote safe driving for young people. The community involvement

officer at Croydon had actively liaised with local CCG’s and community services to create local pathways of care and help prevent unnecessary ambulance callouts through training. A few station managers who did not have community officers commented how they would benefit if they did.

- There was an independent Patient’s Forum, which met with the trust on a monthly basis. The forum was made up of members of the public. The monitoring of their information was made public on their website and we were told there had been increased engagement with the trust since our last inspection. The Patient’s Forum was a diligent well-managed forum that served to improve the patient experience within LAS and provided the voice for the public on services provided by the trust. We would recommend continued strong engagement with the Patient Forum, to enable quality patient insight and empower patients’ opinions to be heard within the trust. Some members of the public provided a voluntary service and operated as community first responders. They were given the training to provide care and treatment to patients.
- In 2016, London Ambulance Service opened its doors to the BBC, for a new prime time television series. As a result: over 88% of staff felt proud to work for the service following the documentary, up from 54%. Job applications for control room and paramedic vacancies more than doubled during the broadcast period. YouGov research found that the programme had changed public perception and two fifths would think twice about calling for an ambulance if the situation was not an emergency. A third of people said will now use other healthcare options, rather than using London Ambulance Service in a non-emergency.
- After the ‘What Tops’ alcohol awareness campaign, from 1-31 December 2016, LAS attended 5% (307) less alcohol related incidents than 2015, despite a 7% rise in the overall demand. The campaign received 1.9 million impressions across social media channels and the communications team ran two live social media events, which profiled the work of control room and front line staff during a particular busy period.

Innovation, improvement and sustainability

- Several quality improvement projects were underway to ensure cost effective systems were in place. The new vehicle Make Ready hubs had been trialled and were in

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the process of being implemented across London. Since the introduction of the Make Ready hubs, the trust had seen a reduction in out of service related issues to vehicles and equipment.

- The clinical strategy set out an overarching clinical leadership, responsibilities, and behaviours needed with clear emphasis on assessment and treatment at the scene and in community settings, with transportation to hospital no longer the default option. The strategy included developments and progression focused around the need for strong clinical audits, education, and development requirements and enhanced care provision to specific patient groups.
- The provision of non-emergency transport (NET) base had been approved by the trust board in September. This was to support the roll out of NETS, especially to areas where current stations did not provide adequate operational coverage.
- NHSI gave formal approval in November 2016 for 140 double-crewed ambulance vehicle replacements for 2017.
- There had been the introduction of a Band 6 paramedic role. Funding was provided as part of the QIP investment programme to support this.
- The LAS worked together with NHS England to produce the emergency department capacity management,

redirect, and closure protocol. These are a set of procedures and protocols emergency department must follow to ease handover delays for LAS staff. This was currently being implemented.

- There was provision of a maternity Pre-Hospital Screening and Action Tool, had helped to give clinician's additional support when attending obstetric related calls.
- The new electronic portal 'MedMan' had enabled the trust to reconcile drug usage forms with completed patient report forms. This also had helped the trust to search and match drugs taken from drug bags and track their administration to patients
- The trust had won "Best social media account of the year" in December 2016 for the most engaging organisation online.
- The trust won a Stonewall award for being one of the top five health and social care organisations. 2016.
- At the 2016 Pride of Britain Awards, the trust were winners in the emergency services category for a pioneering balloon procedure, which prevented a cyclist from bleeding to death at the roadside.
- The trust was part of the new model of care vanguard scheme, which aimed to provide care in the community setting and reduce the number of patients going to hospital.

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

Information about the service

London Ambulance Service NHS Trust (LAS) became an NHS Trust on 1 April 1996 and covers the Greater London area, which has a population of around 8.6 million people. The trust employs around 5000 whole time equivalent (WTE) staff.

LAS currently operates its control services function from the Emergency Operations Centre's (EOC) in a dual operating configuration. The primary focus is the management of all 999 call-taking and dispatch functions, which are split across the trust headquarters (HQ) at Waterloo and Bow EOCs.

To do this the trust uses a command and control Computer Aided Dispatch (CAD) system. In the year 2015-2016 the LAS received 1.86 million 999 calls into its two operations centres.

The main objectives for Control Services are currently as follows:

- Provide a command and control function delivering call answering to all patients.
- Provide safe, effective triage to determine the most appropriate care package, thus adhering to effective clinical governance.
- Provide regular structured welfare calls to patients who are awaiting an ambulance response.
- Distribute and dispatch the most appropriate operational patient facing resources produced by the trust on a daily basis, for example, ambulances.
- Ensure appropriate actions are taken to optimise patient care by referral and/or deployment.

- Maintain capacity and capability to co-ordinate and manage any significant/major incidents.
- Provide enhanced clinical assessments for lower acuity incidents via the LAS Clinical Hub (CHUB) or NHS 111.

During the inspection we spoke with over 40 staff members at Waterloo and Bow EOCs. We made observations and listened to EOC staff responding to calls during the inspection. We reviewed a range of documents during and following the inspection.

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Summary of findings

We rated this service as requires improvement because:

- Staff did not recognise concerns, incidents or near misses and there was little evidence of staff learning from incidents.
- There was insufficient attention given to safeguarding training, meaning staff may not have had the skills necessary to respond to abusive situations.
- Mandatory training figures were below trust targets of 95%. This meant there was a risk that staff may not have the most up to date skills and knowledge to perform their roles.
- Response times for patients were below expectations compared with similar services.
- There was limited evidence of learning from complaints and concerns.
- Staff did not feel fully consulted and engaged in the trust change agenda and the trust leadership had a top down managerial approach. Some staff who worked on New Year's Eve 2016/17 during the CAD system outage, told us staff including senior managers did not appear to know how to respond initially to the outage of the system, even though staff had received training on the system. The benefits of an electronic back-up system had been discussed informally, but there was no formal plan in place in regards to a back-up system.
- The EOC clinical strategy was complete and work was in progress on a new organisational strategy. However, this was not embedded. Managers we spoke with highlighted that LAS could be bureaucratic and implementing change could be a slow process.
- The number of BME staff employed did not reflect the demographics of the population the service served.
- However, we also found staff used evidence-based systems to provide care, advice and treatment to patients. Clinicians worked to national guidance and standards when providing advice over the phone.
- There was effective working between Waterloo and Bow EOCs and with other emergency services. The

service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.

- Staff were compassionate and caring towards patients. We observed examples of staff treating patients and callers with dignity, respect, and supported by staff over the phone.
- Between October 2016 and February 2017, the proportion of patients who re-contacted the service within 24 hours following discharge by telephone, was better than the England average throughout this time period.
- The service had processes and systems to cope with different levels of demand. There were different ways for patients to access the service and interpreting services were available for patients whose first language was not English. The service had systems and processes to manage and work with patients with complex needs.
- The service managed risk appropriately and quality measured through monthly staff key performance indicators (KPI), management meetings, and reports to the board. Work was also in progress on a comprehensive review the trust's major incident processes and IT systems.
- We found that staff morale in both Waterloo and Bow EOCs had significantly improved since the trust's previous inspection in June 2015.

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Is emergency operations centre safe?

Requires improvement



We rated this service as requires improvement because:

- There was limited evidence of staff acquiring measurable learning from incidents both within the EOC service and across the trust.
- Some staff reported confusion over the definition of an incident and what to report as an incident.
- All staff were not trained to an appropriate level in both adults and children's safeguarding. This meant staff may not have had the knowledge and skills to recognise and act on safeguarding risks to callers and patients.
- We found 86% of staff had elements of mandatory and statutory training which was not up to date. This meant there was a risk that staff may not have the most up to date skills and knowledge to perform their roles.

However, we also found:

- Staff followed guidance on providing medicines advice to patients.
- The trust had made environmental improvements to both Waterloo and Bow EOCs and staff could identify potential infection control risks to crews.
- Records were appropriately stored on an electronic system and special notes were available for patients who had specific individual requirements.
- The trust were in the process of comprehensively reviewing their systems and processes in response to major incidents following a New Year's Eve outage of the computer aided dispatch (CAD) system.

Incidents

- In accordance with the Serious Incident Framework 2015, the Emergency Operations Centre (EOC) reported 12 serious incidents (SIs) which met the reporting criteria set by NHS England between January 2016 and December 2016. Of these the most common type of incidents reported, 53.85%, were diagnostic related, including delays in meeting SI criteria, (ambulance delays).
- The chief executive officer (CEO) told us there was one SI review in progress as a result of a patient's death. The root cause analysis investigation report was not

available for review at the time of our inspection as it had not been concluded. However, the trust had assigned family liaison support to support the patient's family through the process.

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between January 2016 and December 2016 the trust reported no incidents classified as Never Events for the EOC.
- Managers told us staff would get feedback from incidents individually. However, one manager told us, "Shared learning from incidents is limited. It's a bit hit and miss." Staff told us there was a governance and action magazine monthly, which captured learning from incidents. However, there was a reliance on staff reading this information and taking on board the detail, including any necessary actions. This was confirmed by our discussion with staff, who were unable to tell us about any recent incidents the magazine had covered. This meant the EOC could not be sure the staff had learned from incidents across the wider trust.
- The trust had rolled out a patient electronic incident reporting system in 2016. Staff were aware of the system. However, staff reported confusion about how to use the system. Managers told us the trust were rolling out training on the electronic system. But some staff were still reporting incidents on the trust's paper based system, where the local manager would review the incident and send the information to the safety and risk team. Some staff told us they were uncertain about how to categorise incidents or what they should report as an incident.
- Quality assurance managers told us staff would receive individual feedback if an incident involved them or they had reported an incident. However, some staff told us there was generally a lack of feedback and learning from incidents.
- The 'learning from experience group' provided a co-ordinated and focused approach to the review of incidents, and monitored how teams implemented improvements for patients, carers and staff. Learning from incidents was captured and disseminated monthly via the trust's governance and action magazine. But,

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learning was dependent upon staff reading the magazines that were sent via email. Some staff told us they didn't have time to read all the bulletins the trust sent.

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw from incident investigations patients and their families had been involved in the investigation process.

Mandatory training

- EOC training included statutory and mandatory training. Statutory training included display screen equipment, equality, diversity and human rights and fire safety. The trust set a mandatory training target of 100% of its 2270 staff for Emergency Operations Centre to be completed by October 2016. In October 2016 the trust reported 322 (14%) of EOC staff had completed mandatory training. As a result 86% of staff did not have up to date training in some essential areas of their practice.
- Staff told us they accessed some training through e-learning and some training was delivered face to face.
- The training strategy group was responsible for determining which training was mandatory for LAS staff and the frequency for delivery of core training. For example, 22% of staff had completed training in the 'duty of candour'. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Safeguarding

- We reviewed the safeguarding annual report 2015/16. This detailed the level of partnership engagement across the boroughs.
- The chief quality officer was the accountable executive director lead for safeguarding. Following our inspection the trust informed us the director of nursing and quality post was incorporated into the chief quality officer post.
- The head of safeguarding provided a safeguarding report to the Clinical Safety and Standards Committee. This included progress with regard to serious case reviews, action plan progress, as well as legislation and safeguarding activity within the trust.
- A safeguarding action plan formed part of the trust's annual report. This detailed completion rates and progress.

- We saw copies of an easy read version of a safeguarding information document. This helped individuals to understand abuse and how to report it, with clear contact details for additional help.
- Clinicians at the clinical hub (CHUB) had access to 'The Spine' (NHS National patient database), which contained information relating to child protection.
- LAS were signed up to implement the Child Protection Implementation System. This provided access to information about Child Protection Plans (CPP) and children's Looked-After Status (LAC) in all cases where a child accessed emergency or unscheduled care. The process had not yet been fully implemented as it had not received full trust board sign off, but an operational group had been set up.
- In addition, the trust received unborn child protection alerts which were flagged on the CAD system in EOC, when the address was known and the details were held on the clinical support desk.
- Staff told us the safeguarding team had held drop-in sessions for staff at both Bow and Waterloo EOC. Staff told us the safeguarding team were sending EOC teams a report as a result of the sessions which captured the main themes. However, we did not see the report as staff said it was a work in progress.
- Staff raised safeguarding concerns with the watch manager and general manager.
- The emergency bed service (EBS) was responsible for referring safeguarding concerns to the local authority.
- The trust were in the process of introducing safeguarding supervision for EOC staff.
- There were procedures for staff to follow, which included contacting the DBS where there was an event which involved rape or domestic abuse.
- Staff told us call handlers, dispatchers and allocators were provided with level 1 online safeguarding training annually. There was also a two hour session on safeguarding allocated during staffs annual core skills refresher training.
- Records indicated that 51% of control services staff had received level 1 safeguarding adults training, with 40% having completed level 2 training. 51% of staff had received level 2 safeguarding children training and 40% had received level 2.
- In addition to assessing clinical care, staff in CARU also ensured the safety and wellbeing of patients by making

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safeguarding referrals for patients whose clinical record suggested they may be vulnerable, when there was no documentation by the attending clinician that a referral had been made.

- The service's risk register recorded a risk of EOC staff not making appropriate safeguarding referrals to the local authority, in response the register recorded that the service had trained dispatch supervisors to level 3 in safeguarding and had appointed operational leads for safeguarding. The EOC were also monitoring the quality of telephone referrals as part of staff key performance indicators (KPI).

Cleanliness, infection control and hygiene

- Call handlers relayed information related to health associated infections to ambulance crews. Risks were noted in the 'special notes' on the patient record where required.
- There were up to date protocols which advised staff on special measures and how to respond to diseases such as: rabies, plague, viral haemorrhagic diseases, (these are a group of diseases caused by viral infection), and Ebola virus.
- The service worked closely with the hazardous area response team (HART) for the transfer of patients with a high infection risk to the high security infectious diseases unit (HSIDU) at the Royal Free Hospital.
- There were appropriate hand washing and drying facilities available in toilets for staff and visitors. Hand sanitizing gel dispensers were also available to staff and visitors at the entrances to both Bow and Waterloo EOC.
- There was a designated infection prevention and control (IPC) lead, who reported to the director of infection prevention and control (DIPC). The DIPC was newly appointed in January this year.
- The trust had an IPC committee, which met four times per year. This committee provided scrutiny of the delivery of IPC and assurances to the board through key performance indicators. This included assurance that services were provided in a clean and safe environment.
- The IPC lead told us their day to day responsibilities included ensuring the practical application of IPC standards, as well as having an administrative, strategic and operational role. We were told 19 staff had recently been trained as IPC champions by the IPC lead.
- We were provided with information which indicated that all new staff attended induction training where they were signposted to the contact details of the infection

prevention control team and the main sources of information. The latter was mainly held on the IPC page on the Pulse (Intranet). All new non-patient facing staff were directed to an e-learning IPC module on LAS Live, and the content of the course was equivalent to Core Skills Level 1 (with a requirement for 3 yearly refreshers).

- In addition to a one and a quarter hour IPC session on the induction, we were told by the IPC lead IPC was part of mandatory safety training, and was based on key skills levels one and two. The target for IPC training was 90%, although we were told the capture of training data was not accurate, which made it difficult to know if this was achieved.
- All new staff received an induction which signposted them to the contact details of the infection prevention control (IPC) team and the main sources of information which were held on the IPC page on the Pulse (Intranet).
- The Pulse (intranet) IPC page carried information and guidance on Clostridium difficile (C diff), meticillin-resistant Staphylococcus Aureus (MRSA), Norovirus, Tuberculosis and Carbapenemase producing enterobacteriaceae (CPE). The Pulse had a weblink to the Public Health England website for a comprehensive list of Infectious Diseases to provide further support. The HART used the National Ambulance Resilience Unit (NARU) guidance on IPC. In addition, patients were provided with information on Norovirus on the trust website, which also carried a weblink to the NHS Choices website.
- The Pulse intranet provided staff with information on hand hygiene and bare-below-the-elbow policies to guide staff to alcohol hand gel use, hand hygiene technique, glove usage, , including a poster and the link to the trust's 'uniform and workwear' policy.

Environment and equipment

- The primary computer system used in EOC was the Computer Aided Dispatch (CAD) system. The software was a commercial off the shelf product and had a road map of development which resulted in at least one release of software per year. Due to changes of operational requirements, the trust commissioned the supplier to develop or enhance features of the software and receive more than one release per year. The CAD hardware contract mandated replacement. The trust informed us that this would be implemented sometime in 2017/18.

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- Working with the CAD was an off the shelf mapping and gazetteer geographical information system (GIS), this was a system that allowed the EOC to track all operational vehicles across London. The data used by the GIS was provided by Ordnance Survey and was constantly updated. The GIS was supplied to the trust under a public sector mapping agreement at six weekly intervals.
- Also interfaced to the CAD was an electronic medical triaging and prioritisation tool. This enable staff in making appropriate assessments of patients clinical needs and prioritising calls. Data content was refreshed annually or more frequently if there was a clinical necessity, for example, a new or updated protocol. Changes to the system were tested by EOC quality assurance staff prior to its deployment.
- Server hardware, other than the CAD, was procured and managed by a private provider. Servers were purchased with three to five year warranties which set a realistic expectation of service life. A rolling capital program scheduled replacement as warranties expired.
- The desktop equipment in the EOC was comprised of computers and multiple monitors. The version of software was CAD compatible and had recently been upgraded. to Windows 7. Staff had access to sufficient numbers of computers, headsets, visual display screens, telephones and radios.
- The primary telephone system was supplied by a private provider. However, a replacement project was underway and was scheduled for implementation during 2017 to 2018. In the meantime maintenance arrangements were extended for the system that was in use.
- All primary communications systems were subject to voice recording. A project was underway to replace the equipment that was in current use. A contract was in place with a private provider to expand and enhance the product, which was already being used for 111 recording, and this was due to be implemented in April 2017.
- On a day to day basis a duty engineer was contracted to be present on the Waterloo EOC site. Daily duties included proactive equipment, datacentre, telephony and radio checks. In addition the duty engineer was the first responder to any technical issues in EOC and would mobilise IT specialists, as well as third party suppliers of maintenance.
- The EOC premises were secure and all areas were accessed via card entry systems.
- The EOCs had access to large visual display screens. The screens in Waterloo displayed service updates and service information such as GIS. However, the screens in Bow were not switched on with the exception of one screen, and this was displaying BBC television programmes. The screen was not in an area where the dispatchers and call handlers were stationed and did not pose a risk to callers to the service. However, screens displaying television programmes could be distracting for staff.
- Staff were trained in health and safety around their work stations and how to adjust equipment, including chairs, to suit their individual needs. Both Waterloo and Bow EOC control rooms had dedicated work based assessors available on every team to ensure staff workspaces complied with health and safety at work requirements.
- The majority of EOC IT equipment and systems had associated maintenance contracts or warranties. Although we did not view these, we were informed that a schedule of all maintenance contracts and warranties were held by the equipment providers in partnership with the LAS Procurement Department.
- The trust had undertaken improvements to the environment at both Waterloo and Bow EOC. Both Waterloo and Bow EOC centres had recently been redecorated and refurbished. Staff told us the improvements had improved working conditions. However, staff highlighted that due to the design of the Waterloo building and position of windows, there was a limited amount of natural light in the EOC.
- Staff at both Waterloo and Bow had access to a staff room and a kitchen. We saw staff in Waterloo preparing snacks and drinks in the staff room. We also saw a member of staff using the Waterloo staff room and reading a magazine during a scheduled work break. Staff told us this gave them a more appropriate environment to take breaks.

Medicines

- Call handlers asked patients or callers whether they were taking any medicines or pain control medication and provided advice. Call handler told us they could obtain advice from the CHUB desk if they required further advice on the medicines patients had taken or were prescribed to ensure any advice they gave callers was safe.
- Call handlers only provided advice on medicines which were identified in the medical priority dispatch system

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(MPDS). For example, in the MPDS 'protocol 6; breathing problems', in instances where the breathing problem was an asthma attack, call handlers would advise patients to use their inhaler, as directed by their GP. Similarly in 'protocol 2; allergic reaction', call handlers would advise patients or callers to use an 'EpiPen' where the patient was having an allergic reaction with a history of anaphylaxis. The call handlers' instruction to the caller was to follow the instructions on the side of the device. Call handlers would not otherwise give advice about medicines or prescribe medicines. If a patient needed advice about prescribed medicines they would either be transferred to a clinician on the CHUB or where appropriate advised to contact their pharmacist or NHS111.

- Staff told us there had been improvements in the security of medicines, as the trust had implemented new policies and procedures on the safe storage and administration of medicines. For example, staff told us controlled drugs (CD) procedures had changed and CD were stored in a controlled drug safe in specific ambulance stations.

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 MPDS. All answers we observed were recorded appropriately, and staff were able to update records as more information became available.
- The trust used 'special notes' about patients to share with ambulance crews. These were notes that could be added to the system to provide further detail on patients' clinical needs. For example, information about patients with complex needs, possible risks or if there was a safety concern. We observed these notes were easily accessible through the Command Point system used. We spoke with three operational ambulance crews who told us they could access special notes directly from their mobile data terminals.

Assessing and responding to patient risk

- The IPC team had developed specific guidance related to patient and staff safety with regard to Viral Haemorrhagic Fever, a copy of which we were provided with. This was based on national guidance and

contained a risk assessment, with a red, amber, green (RAG) rating and associated flow chart for staff to follow in such circumstances. On scene assessment included specific guidance for minimising risk of infection transmission.

- The procedure for the dispatch of resources by the EOC was up to date. This provided guidance on the roles, responsibilities and actions that were required to provide appropriate responses and the timescales to meet patients' needs.
- The MPDS was used by call handlers to make decisions related to dispatch appropriate aid to medical emergencies. The system allowed for systematised caller interviews and for providing callers with pre-arrival instructions. The Manchester Triage System (MTS) was used by staff. This was a system that provided rapid assessment of patients' clinical needs. The MTS supported decisions made by clinicians working in the CHUB.
- Every call received in the dispatch area of EOC was categorised with a priority level linked. Call priority changed at varying points during the call process and risks were assessed as more information was obtained from the caller.
- 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 crews, log the time crews were mobile to attend patients, arrival times, and times crews left the scenes. This enabled staff to locate crews in real time and provided information on their readiness to respond to emergencies.
- 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. This ensured callers remained informed of delays and allowed staff to update calls with any additional information or changes to the patient's condition.
- Where appropriate calls were re-prioritised. The team responsible for call backs was guided by set time frames for call backs. Records indicated they were not always able to meet these targets. 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

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delays at any particular time. However, the information was 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 alongside ambulance crews and were able to provide immediate lifesaving support. CFR volunteers were home based and were dispatched alongside the regular vehicle crews in situations where additional resources were needed or if their estimated arrival time was faster than LAS. CFR were instructed over the telephone as they were not equipped with mobile data terminals used to pass details of jobs to the crew.
 - The core functions of the CHUB were the provision of the 'hear and treat' service and to provide clinical oversight of all calls awaiting a response. It was expected that any action taken by a clinician working within the CHUB had the primary intention of ensuring responses were safe and appropriate to the needs of the patient, whilst considering the appropriate utilization of the trust's vehicles and resources. Clinical team leaders working within the CHUB provided clinical advice and support to both EOC and operational staff in the field.
 - The CAD system listed calls chronologically, as well as colour coding calls to prioritise which calls needed an immediate response. The system could change the colour coding of calls each time information from an incident was updated and could re-prioritise calls based on clinical priority as well as changing the colour coding in response to updates.
 - To reduce the risk of information not being passed on at the completion of shifts a formal handover took place between the off-going and on-coming dispatcher. The handover discussed the number of calls being held, on-going incidents, staffing issues, and any technical issues the EOC were experiencing.
- Staffing**
- In December 2016, the trust reported a vacancy rate of 3.4% in the Emergency Operations Centre, with a whole time equivalent (WTE) number of 19.3. Administrative and clerical staff in control services management reported a 100% vacancy rate, and nurses in the CHUB reported 61.7%. However, both of these staff groups were very small, with an expected staff of 2.8 and 8 whole WTE respectively. .
 - Administrative and clerical staff in the CHUB, D and E Watch, quality improvement unit and training and development all reported surplus staffing.
 - The LAS call handling function was resourced using data which set out by day and by hour how many call handlers were required. The resourcing levels were produced by the LAS resourcing team, utilising a sub set of staff skilled in control services issues. These resource levels were provided to the 'Watch' management teams, who then deployed staff on a day to day basis to the roles required within the EOC's. Calls handling resourcing levels were reported against the required levels daily and hourly. At times of spikes in demand staff were redeployed to support call handling. To manage the incoming calls staff used a triage and assessment tool called Advanced Medical Priority Dispatch System (AMPDS).
 - Between November 2015 and October 2016, the trust reported a turnover rate of 16.9% in the emergency operations centre with a whole number of 157.5 FTE. The highest turnover rates were reported in the EOC control office and training and development, which both reported rates of 56.6%, or 24.7 FTE. Below these two groups, the next highest turnover rate was 15.2% (12.7 FTE), reported in both the CHUB and A Watch team. Managers and staff we spoke with told us the EOC was reliant on staff being prepared to work overtime to ensure shifts were filled, and staff were very good at offering to work overtime.
 - Managers told us the EOC tended to lose staff within 12 months of employment. Managers said work was in progress on a plan to offer enhanced support to staff in the first 12 months. They also told us they were advertising jobs on the NHS jobs website, and had held 'open days. Staff were also being offered 'disruption payments' to encourage them to cover extra shifts.
 - Due to the format used by the trust to report sickness figures, it was not possible to calculate an overall sickness figure for all of the EOC. However, between October 2015 and September 2016, the trust reported relatively low sickness rates for all teams. The highest long-term sickness rate was reported by D Watch, at 4.5%. E Watch reported the highest short-term rate, of 2.7%. The trust had introduced a new sickness policy

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and procedure. Some staff we spoke with told us this had caused some dissatisfaction with staff, due to staff only being allowed three periods of absence in a 12 month period, commencing on the first period of absence, after which they would be subject to management review.

- Managers at the EOC told us they were aware the service needed to increase permanent staffing numbers. Managers told us EOC had a recruitment drive for emergency dispatch staff (EMD) grades two and three. The EOC had also had a number of staff on internal secondment to EOC. The service had also held a recruitment evening at Waterloo LAS Headquarters. The service was also advertising on the NHS Jobs website. Managers at the Bow EOC told us they had worked with some local black and minority ethnic (BME) groups to try and increase the numbers of BME staff working at the EOC.
- As of the week commencing 6 February 2017, the EOC were fully staffed in regards to managers, with the exception of watch manager, where the whole time equivalent (WTE) rate was 16 watch manager posts, the actual number of watch managers in post was 15.84. There were also six WTE posts for training managers, with the actual figure being 2.33. There were 17 funded quality assurance manager positions, with 11.56 of these positions filled, meaning that 5.44 were vacant. There were also three area controller vacancies. There were 24 EMD 3 vacancies, but these had been mitigated to some extent by the EOC recruiting 12 extra EMD 2 and eight extra EMD 1 staff.
- The CHUB had 27 vacancies out of 84 WTE funded posts. The posts with the largest vacancy rates were team leader where there were 13 vacancies out of 40 WTE posts; and clinical assessors where there were 10 vacancies out of 30 WTE posts.
- We viewed the rotas for the planned number of hours for call takers for the week commencing 23 January 2017. The rotas indicated the EOC were 12% above planned staffing levels every day of the week, and actual staffing levels were 12% above the WTE planned staffing level.

Anticipated resource and capacity risks

- The trust had a business continuity policy in the form of the 'Operational Procedure for Control Services Business Continuity and Disaster Recovery' dated 29 November 2016. The procedure detailed actions the

service should take in the event of an incident which had an impact on the ability of the service to effectively carry out control services core functions at the HQ or Bow sites. The policy explained how consideration must be given to transfer some or all of the control functions to the unaffected site. This transfer would normally be done under pre-planned conditions. The policy also detailed the procedure OP66. This was the operational procedure for the use of paper operations within control services. This procedure was implemented during the New Year's Eve CAD outage.

- Managers explained that the business portal and command point electronic systems were used to monitor calls that were being held in the system. The system would change colour to alert staff of a call that had reached the limit of its call back time.
- Minutes from a CAD Project Executive team meeting, 20 January 2017, recorded that at 3am on 1 January 2017 there was an outage of the LAS computer aided dispatch (CAD) system which lasted until 5.10am. LAS implemented business continuity plans in both Waterloo and Bow EOC. A paper based system was used to recall call details and radios were used to transfer information to ambulance crews. Paper systems resulted in longer recording and processing times for EOC call handlers. Call centre staff at Waterloo we spoke with told us they had to fax any calls that came through Waterloo, which should have gone to the Bow EOC to staff at Bow. This resulted in two of the fax machines breaking down during the night.
- The minutes of the CAD Project Executive team meeting on 20 January 2017 reviewed the CAD outage on New Year's Eve 2016/17. The minutes recorded that additional resources were in place in excess of the services winter plan, with both Fast Response Units (FRU) and Motorcycle Response Units (MRU). This included top-loading staff from 7pm on 31 December 2016 and front loading call handling staff to reduce call holding during the busiest hours.
- Between 9 to 15 December 2016, LAS updated their New Year's Eve event plan, for example, between midnight and 6am on 1 January 2017 there was a planned 25% increase in control services staffing for New Year's Eve 2016-2017
- LAS managed the central London New Year's Eve firework event through the event plan; this was managed through a dedicated team based at Bow. The event plan was provided to NHS England and other

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stakeholders. The minutes of the meeting CAD Project Executive meeting recorded that the CAD system acted as an electronic logging facility, whereby 999 calls would be received in the EOC and triaged, with resources being dispatched where required. The meeting minutes recorded that the management of a major incident was not dependent on the CAD system, and the main value of the CAD system was as an electronic logging facility.

- Some EOC staff told us they thought increased demand and delays at hospital accident and emergency departments (ED) had led to delays in ambulances availability. A staff member said, "Some crews can be sitting outside an A&E for two to three hours."
- 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 (this included 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. 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, and communicating with hospitals, performance of 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 co-ordination 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. The structure outlined the decisions that needed to be taken on and operational level as well as tactical and strategic decision making. 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.

- The EOCs were reliant on specialist complex IT systems and needed uninterrupted power supplies. Any failures of these systems could have an immediate impact on the CAD system which could compromise the receipt, triage and dispatch of emergency 999 calls and other requests for ambulance service assistance. In the case of a power failure both Waterloo and Bow EOCs had battery back up which would be operated immediately following a loss of power. The battery back up would cover an interim period between generators becoming operative. Generators would then provide power to the EOCs, until the mains power supply was restored.
- The Waterloo and Bow EOC's had IT systems that mirrored one another. Some key functions of the system were constantly being updated and maintained with real time data being copied from one site to the other. This allowed for calls to be received at either EOC, for example, vehicle positioning and calls awaiting dispatch information to be available to both.
- LAS operated its control services function from the EOC at Trust headquarters (HQ) in Waterloo and the EOC in Bow. Both sites acted as one virtual control room using computer-aided call taking and dispatch. Each control room had call taking and dispatching functions which allowed the transfer of any sections of the operation to either site depending on the needs of the service.

Response to major incidents

- There had been an outage of the LAS CAD system on New Year's Eve 2016/17. The trust's back up system was paper based. However, this was not unusual for UK ambulance services. Additional resources were in place over and above the New Year's Eve plan for 2015/16, including 25% increase in control service staffing. A dedicated separate New Year's Eve plan was also in place, including an event plan for the central London New Year's Eve firework event.
- LAS were managed through a command team in the special operations centre (SOC) at Bow. This event plan was provided in advance to NHS England and other

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stakeholders prior to the event. Added capacity was provided in terms of both ambulances and crews and the EOC to manage additional forecasted demand. The trust highlighted that the management of a major incident was not dependent upon the CAD system; even though the trust acknowledged that using a paper based system resulted in longer recording and processing times for the EOC.

- At 0.30am on 1 January 2017 the computer screens froze and there was CAD outage at both Waterloo and Bow EOC. The business continuity plan 'OP66' was invoked. At 0.44am the surge level was escalated to 'purple'. At 1.30am the primary service was recovered to allow health checks and testing before transitioning back from paper based systems. At 4.39am the 'Command Point' system was brought back into operation and a backlog of calls needed to be entered onto the system. At 4.49am dispatchers began to log back onto the system and at 5.10am the CAD system was fully operational.
- At 1.33am LAS approached 'Buddy' sites for support if required. There was an existing service level agreement in place to manage delays in answering calls, whereby BT diverted calls that were not answered within three minutes to a Buddy site. Buddy site arrangements were part of the normal resilience and escalation arrangements should BT be unable to deliver a 999 call to LAS. However, the Buddy sites were unable to support LAS calls due to pressure on their own services on New Year's Eve. Due to high demand BT were unable to connect all calls to the agreed sites and distributed calls to ambulance services that were not part of the normal LAS resilience arrangements. Calls from other ambulance services were prioritised, but due to EOC operators being busy other ambulance services were also waiting in a queue of 200 calls, as were calls from the 999 service. At 3.30am an internal major incident was declared and contact was made with another ambulance service. At 3.50am staff working in the SOC New Year's Eve event were released due to the event concluding and extra capacity was available. This was used to cover permanently connected lines to other services to facilitate a quick handover of any call they had taken on behalf of LAS. At 04.49 the 'Command Point' system was reinstated, but there was a backlog of calls that needed to be entered onto the system. However, auto-dispatch and CAD links remained off. At

5.42am feedback from NARU hosted teleconference (NACC) where concerns were expressed about 300 calls being held, but it was highlighted that this was not unusual for New Year's Eve.

- The outcome of the subsequent discussion and analysis undertaken with both LAS and NHS England EPRR colleagues made these observations: LAS Gold provided comprehensive decision logging and justification for the decisions and actions taken: LAS followed the appropriate course of action given the set of circumstances and information available to them at the time; Declaration of an internal major incident was not required to activate command and control, as a full Gold command and control structure was in place during the night; The decision to declare a major incident at 3.21am was to constitute a relief Gold group to ensure continuity in the management of the incident and to prepare for the ongoing recovery process: NHS01 provided logging of the discussions held with Gold, and escalated within NHS England.
- LAS Business continuity plans were in place. Each procedure was accompanied with a series of action cards and staff received training in the use of these, and we saw training being rolled out to staff at Bow in the use of action cards and paper-based systems). However, a few staff told us it was different in a live situation on New Year's Eve, and they didn't feel confident in using the system. LAS highlighted that exercises in using the system took place during planned CAD system outages, and there was a CAD outage planned for 22 February 2017.
- Work on an RCA investigation was still in progress, an external investigation was also in progress into the cause of the technical issue by an independent IT consultancy. The CAD system provider was also conducting a review in collaboration with LAS, and was still in progress.
- A clinical safety review was being undertaken by the executive leader team, trust board and stakeholders on the safety of care provided during the CAD outage. The methodology was the same as previous reviews LAS had undertaken, with the addition of data provided by BT and other ambulance services who answered calls on behalf of LAS during the outage. An interim report was in preparation and a full report was due to be submitted to the CEO within 10 weeks, approximately mid-March 2017, dependent upon the availability of information.

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- During the outage the call volume reconciliation was: 1670 total calls to BT and 685 to other lines. The numbers of unique callers identified were: 1212 answered by BT; 147 answered by others; and 80 calls, (5.5%) went unanswered. The trust said these calls involved actually involved 800 reported incidents, as some incidents had multiple callers. Unanswered calls from public places were traced from paper records. The CEO told us the trust had taken action to trace the callers and had received no complaints from unanswered callers relating to the incident on New Year's Eve.
- The CEO told us LAS had 11 CAD system outages since 2011, and the trust did not consider themselves to be an outlier in regards to CAD outages. However, the trust had commissioned an independent report to review whether the CAD system was "fit for purpose." The trust also produced a 'Recommendations Paper' dated 25 January 2017. The paper identified potential risks to the system, and potential sources of the outage. As a result the trust had taken remedial actions which were on-going. These included actions identified by the CAD system provider company, which were due be implemented on 22 February 2017, during an authorized scheduled downtime of the CAD system. A further outage was planned for March/April 2017 to apply software upgrades, bug fixes and configuration changes recommended by the CAD service provider.
- The CEO and director of operations both told us the trust had undertaken informal talks about the possibility of an electronic back up CAD system. The CEO highlighted that the cost of this could potentially be prohibitive. However, the director of operations said discussions about a potential electronic back up system were still in progress. LAS backup arrangements meant that EOC staff were reliant upon a "pen and paper" operation during periods of sustained system compromise. Further, the volume of calls handled by LAS created a risk that a manual system would struggle to cope, with a risk to patients that they may not receive a seamless service, which ensured immediate transfer between the primary EOC and the backup EOC.
- Staff we spoke with told us the CAD outage had been stressful for staff. Staff told us some staff on duty on New Year's Eve were unfamiliar with OP-66, the CAD back up system. However, the trust was rolling out training in OP-66 to all staff.

- 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 needed 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 also a chart available to staff with allocated responsibilities for other command levels.

Is emergency operations centre effective?

Good



We rated effective as good because:

- Staff used evidence-based systems to provide care, advice and treatment to patients.
- The clinical hub team (CHUB) could assess and discuss care and treatment with patients.
- Clinicians worked to national guidance and standards such as National Institute for Health and Care Excellence (NICE) when providing advice over the phone.
- The trust took part in national audits and we saw actions and learning from these. Managers shared actions and learning with staff.
- The proportion of abandoned calls made to the EOC was lower than the England average.
- Between October 2016 and February 2017, the proportion of patients who re-contacted the service within 24 hours following discharge by telephone, was better than the England average throughout this time period.
- Both Waterloo and Bow EOC's worked effectively with other emergency services.

However, we also found:

- The triage system did not include all possible questions, which meant staff sometimes had to seek additional information in order to categorise the level of urgency of the call.

Evidence-based care and treatment

- The procedure for the dispatch of resources by EOC was up to date and informed by relevant guidance. For

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example, the Office of Clinical Commissioning Groups 'Emergency Services Review: Good practice guide for ambulance services and their commissioners.' The dispatch team managed the allocation and prioritisation of vehicles based upon patients clinical needs, and gave instructions to vehicles to attend the scene. The dispatch operators had an overview of where ambulances were, and which call each crew was responding to. Dispatchers were able to allocate and re-allocate calls as required, based upon a priority of clinical need.

- The EOC used the GIS system to monitor how many vehicles were attending a call. The system could also be used to monitor the status of ambulances. The intelligence conveyance desk (ICD) could contact vehicles and redirect based on the priority of clinical need. Staff told us redirects were based upon NICE guidance for redirects.
- EOC staff used the Advanced Medical Priority Dispatch System (AMPDS) to assess and prioritise emergency calls. The International Academy of Emergency Dispatch (IAED), a standard setting research based non-profit organisation, oversaw the creation, development and updates of the emergency protocols.
- The EOC had recently changed the procedure for the opening question callers were asked to, "is the patient breathing." Staff said there had been numerous changes to procedures in the previous 12 months and this could be, "challenging."
- A staff member told us the trust had an incident where a patient's fistula, this is an abnormal connection between two hollow spaces, such as blood vessels, had bled out. In response the trust had produced a fact sheet, and this had been sent to all members of staff to act as an aide memoire.
- Work was in progress for a standard operating procedure (SOP) for abusive callers to enable staff to deal with callers who became abusive in an appropriate manner. Staff confirmed the abusive callers policy was waiting to be validated.
- The IPC lead had a responsibility for ensuring the respective audits were up to the required national standards. Most IPC audits were undertaken by station staff. However, the IPC lead told us there were inconsistencies across the units as to what was expected and accepted.
- The trust had a flowchart which gave staff guidance on critical and immediate transfers of patients, including

between hospital sites. LAS was unable to undertake routine transfer of patients between hospitals for booked admission, clinic appointments or routine treatments, for example, radiotherapy, pre-booked angioplasty, routine renal dialysis so as to eliminate unnecessary inter-hospital transfer requests, that were outside of the contract. Where LAS held the Acute NHS Trust's PTS contract, requests were booked via the patients hospital transport office. The PTS contracts were unaffected by the critical or immediate transfers policy. Routine transfers between different hospital sites (intra-trust) were not the responsibility of LAS unless the patient fell into the critical and immediate transfer group or if LAS held the PTS contract with the Acute Trust.

- Principles of professional guidance on the structure and content of ambulance records issued by Health and Social Care Information Centre (HSCIC), NHS England, and the Royal College of Physicians were followed. This 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 that was recorded and communicated by the dispatcher following allocation of the incident.
- 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.
- 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.

Assessment and planning of care

- All calls were categorised in line with national guidance, for example Red1 calls, these were calls assessed as

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immediately life threatening, required a response within eight minutes. EOC staff aimed to dispatch any resource available including hospital emergency department (ED) support, these were responses to lower category calls that would take patients who were in a stable condition to hospital emergency departments, or any other nearest or additional vehicles allocated through the computer-aided dispatch (CAD) system. There were measures in place to ensure the second vehicle was not cancelled if the ED support crew arrived on scene before the back-up had been dispatched. ED support crews formed one of two or three responders sent to these calls.

- Call handlers were supported by clinical staff and were able to transfer calls to the CHUB if they felt additional assessment was required.
- Staff on the CHUB 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

- Data was collected by the trust for Unify 2. This is the England national dataset for Ambulance System Indicators and Clinical Outcomes for all ambulance services in England. For example, in January 2017 the proportion of LAS EOC calls abandoned before being answered was 1%, which was lower than the England average of 1.3%. This indicator measures the percentage of 999 callers who have hung up before their call was answered in an emergency control room. We saw that most calls to the EOC had been answered immediately during our inspection.
- Staff at the CHUB told us the services biggest concerns were the number of held calls. Staff at CHUB said they were responsible for vulnerable patients, and this could lead to delays for these patients. However, the CHUB manager told us they monitored and prioritised all calls to the CHUB, 24 hours a day, 365 days of the year and vulnerable patients were prioritised appropriately.
- The intelligence conveyance desk (ICD) managed delays at hospitals, to ensure vehicles at hospitals were released as soon as possible.
- Frequent callers were identified by the call handler and allocator. The call manager would review frequent callers care plans. Staff told us the frequent caller system was generally effective.

- Real time monitoring of Multiple Attendance Ratios (MAR) occurred via the EOC business intelligence dashboard. The numbers in the dashboard provided the MAR on a rolling 60 minute basis. MAR was defined as the number of agreed vehicle responses divided by the number of incidents. Green on the dashboard indicated that vehicles were within target and red indicated the MAR was below target. Control Room managers were also able to view a break down every hour.
- One of the functions of the Incident Management Desk (IMD) was to monitor calls that received multiple responses and quality review what vehicles had been sent to incidents. In order to ensure the trust had a robust quality assurance process for the IMD, the monitoring of multiple responses was being specifically written into the objectives of the EOC Head of Quality Assurance.
- A review was undertaken to identify how MAR could be reduced further and the paper detailing the recommendations was produced in December 2016. The director of operations and the medical director agreed all of the recommendations in the paper except recommendation three, amendments to paramedics practice. The remaining recommendations were being incorporated into the EOC Operational Plan for 2017/18.
- The CHUB call back triage was done by registered healthcare professionals, a mix of experienced paramedics and nurses, using the Manchester Triage System Telephone Triage. This enabled clinicians to determine an appropriate timeframe for the first required clinical intervention. Clinicians also had access to the NHS Directory of Services (DoS) to identify appropriate NHS services for patients.
- Calls could only be assigned a response profile following assessment by a clinician. Some profiles allowed for automatic upgrades if these timeframes were not met without further assessment, but for most calls if the stated timeframe was not met, a further clinical assessment was undertaken.
- The classification of calls that were rung back and the timeframes of these were defined by the surge plan as a pan-London position, but this did not prevent the clinical assessment of any call which was held and which was a concern to either a call-handler or clinician.
- Red classified calls could not be downgraded, but clinicians could alter the type of resource allocated to the call where it was clinically appropriate to do so, such as adding an Advanced Paramedic Practitioner.

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Patient outcomes

- Between October 2016 and February 2017, the proportion of patients who re-contacted the service within 24 hours following discharge by telephone, was better than the England average throughout this time period.
- The 'hear and treat' service was provided by paramedics working in the CHUB and METDG desk. The paramedics were responsible for triaging serious but not immediately life threatening calls (C1 and C2) and non-life-threatening emergencies (C3 and C4). Of calls that received a telephone or face-to-face response, the proportion resolved by telephone advice, 'hear and treat', was 10.3% according to the September 2016 National Quality Systems Indicators (NQSI). This was worse than the national average of 9.4%.
- According to NQSI information, where patients required transport from LAS, there were 64217 emergency patients' journeys to hospital emergency departments in the year up to September 2016. This was much higher than other trusts in England.
- Calls that received a face-to-face response from the ambulance service, 37.8% were managed without need for transport to hospital emergency departments. This was better than the national average of 38.3%.
- Between July 2015 and October 2016 the time of arrival of an ambulance-dispatched health professional for Category A calls within 16 minutes was 95%.
- A number of ambulance emergency calls presented to the switchboard were from frequent callers. There had been 235 (0.2%) of these frequent callers in the twelve months up to September 2016, and there was a locally agreed frequent caller procedure in place.
- There were 3.4% emergency calls closed with telephone advice, and re-contacted via 999 within 24 hours. This was better than the England average of 6.3% and the second lowest re-contact rate in England.
- 0.4% of calls presented to the LAS switchboard were abandoned before being answered. This was better than the England average of 1.2%.
- Surge Red (limited capacity to dispatch ambulance crews), calls categorised as C4 for patients aged two to 69 years were given self-referral advice. The call was then closed at call-taking. The service had been on 'red surge' level (or above) since October 2014 and this had the potential to increase the percentage of patients recorded as 'treated'.

Competent staff

- In December 2016, 73.3 % of staff within the Emergency Operations Centre had received an appraisal. The lowest rate of appraisal completion was in A Watch (63%), whilst training and development reported a rate of 100%; B, C, D and E Watch reported appraisal rates between 72 and 76%.
- Staff told us there were clearly defined career development opportunities for call handling staff and dispatch staff. Staff said there were opportunities for staff to train as operational staff and paramedics, but training would not be funded by the trust and staff would apply for bursaries.
- All new non-patient facing staff were provided with an induction which included face to face training and e-learning, with the contents conforming to Core Skills Level 1. All new clinical patient-facing staff undertook a clinical Induction relevant to their role with the contents conforming to Core Skills Level 2.
- New emergency dispatchers (EMD) staff completed a three day course which covered a range of potential callers, including children and people experiencing mental health issues. The trust informed us safeguarding refresher training also included elements of children's responses. Dispatch staff we spoke with told us they found dealing with callers with mental health issues challenging, with three dispatchers telling us they had not received training in mental health.
- Managers told us the trust had identified that a number of EOC staff tended to leave within 12 months of being employed. As a result the service were looking at ways of supporting staff in their first 12 months of employment with the trust. For example, the introduction of mentoring for new staff.
- The trust used the clinical hub desk (CHUB) to train senior paramedics. The CHUB team were led by a clinical manager. Paramedics in training worked at the desk for approximately seven weeks. This facilitated paramedic staff in gaining experience on the desk whilst training, but also mentoring the next group of senior paramedic trainees. Paramedics told us they were expected to work 10% of their shifts providing clinical advice to patients by telephone on the clinical desk to maintain their clinical skills. The CHUB team also used agency registered clinical nurse specialists in emergency medicine and critical care.
- Staff performance was monitored via regular three monthly personal development reviews (PDR). Staff had

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their performance monitored by monthly key performance indicators (KPI) reviews. Call handling staff received monthly feedback on their KPI from the quality assurance manager. For example, this included how staff performed in relation to triaging emergency calls and the average time staff spent to conclude a call. Staff that did not achieve their KPI targets would be placed on an 'individualised compliance improvement plan.' The quality assurance manager told us the plans were intended to support staff retention by highlighting areas that staff may have needed to develop, and supporting staff to develop these skills.

- Managers received 'accreditation performance' dashboards monthly from the quality assurance manager. This was based on an aggregated score based on individual team members performance. This enabled EOC managers to assess the performance of individual team members as well as their team's performance overall, and compare these to other teams. The quality assurance manager told us the EOC were generally compliant with trust KPIs. The trust aimed to routinely monitor 1% of calls received by the EOC to monitor whether staff were using correct protocols and providing appropriate advice to the caller. Members of staff told us they had received feedback after their calls were listened in to by managers and this enabled them to enhance their performance. The quality assurance compliance rate formed part of staff KPIs.
- Call handlers told us they received their individual monthly compliance figures to monitor their own performance. Managers told us they received monthly individual and team compliance reports, as these were distributed to all EOC ambulance operations managers and operational control managers by the quality assurance team.
- Staff were allocated 36 hours protected training time every year to complete both mandatory and non-mandatory training. Call handlers told us they had received training in dealing with abusive callers and dementia awareness.
- Manager's told us the trust had introduced 20 minutes a day breaks for staff to complete training. However, staff told us the 20 minutes were also supposed to be used as stress breaks if staff felt overwhelmed during a shift. Staff we asked told us they did not take the 20 minute breaks, unless they had dealt with a particularly stressful situation.
- We found across the EOC teams there were limited opportunities for cross-team and cross-site communications and learning, as there was no formal programme of team meetings that all staff attended.
- The Joint Emergency Services Interoperability Programme (JESIP) was established in 2012 to address the recommendations and findings from a number of major incident reports and was supported in 2013 with the release of the 'Joint Doctrine Interoperability Framework'. JESIP training was implemented by London Ambulance Service and in line with the guidance approximately 278 Operational and Tactical Commanders received the JESIP training programme appropriate to their role. Joint evaluation of senior incident posts JESIP training was only undertaken by commanders, whereas all operational staff had joint evaluation of senior incident posts JESIP awareness training.
- JESIP principles were part of the LAS incident response plans and methodology. All incident response officers (IRO) had completed an operational commanders course and attended JESIP training prior to being allowed to operate as an IRO. 88% of IROs had attended the trust's 'new' three day course, which was based on the Skills for Justice National Occupational Standards for Incident Commanders. IROs were required to retake this course every three years. 81% had also completed the Operational Commanders programme within the previous 12 months.
- 100% of eligible staff had completed incident response officer (IRO) joint emergency services interoperability programme (JESIP) training, this is training which enables emergency services staff to gain skills in joint working with other emergency services when dealing with major incidents.
- As part of the CPI programme, clinicians received personalised individual feedback on their clinical performance from a Clinical Team Leader. Figures on the number of feedback sessions provided to clinicians were reported in the monthly CPI reports and incorporated in the Quality Report which was shared internally with the trust board and externally through the Commissioner Clinical Quality Review Group (CQRG). An additional mechanism for individual clinician feedback was provided by staff in CARU, through their audit activities, which identified cases where

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improvement may be required. These cases were forwarded to the Quality Governance and Assurance Managers or clinical leads for review and feedback was delivered to the clinician where required.

Co-ordination with other providers

- LAS worked closely with the Metropolitan Police Service (MPS) to respond to emergencies which required the attendance of both services. There was a statement of purpose (SOP) in place for the METDG desk. Both organisations used an interface between each other's CAD systems to allow for rapid requests for attendance and updating of information. This prevented delays in calls being answered within the 999 system, bypassing the call handling stage, routing calls directly to the dispatch functions of both organisations. Over 2500 ambulance requests were sent from the MPS per week, with a total of 32100 calls made in the period April to August 2016. More than 50% of MPS calls resulted in no LAS resource being dispatched when assessed by METDG.
- When a request from the MPS was made using the CAD link, the Police operators answered limited basic triage questions known as the SEND protocol (Secondary Emergency Notification of Dispatch). This was primarily aimed at identifying any immediately life-threatening conditions, it did not triage the patient in detail as no direct contact was made and therefore predominantly resulted in a C3 category. With increasing 999 call demand this low priority could result in police officers waiting for protracted periods of time for a LAS response as priority is given to sending a response to the sickest and most seriously injured. It was recognised there could be a clinical risk due to the limitations of the SEND protocol but, given the large number of calls which would need to be processed through the 999 system, the benefit of receiving the information by this route outweighed the risk.
- The METDG was established to provide a co-ordinated response to on-site calls from the London Metropolitan Police. There was a specific code that calls from the police to ensure police calls were triaged directly to the service. The service could speak to the police on-site at an event. This meant the 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 an event. Staff told us the relationship with the police had deteriorated over the previous 12 months due to the service not being staffed for 24 hours a day as a result of demand on the EOC. However, managers highlighted that the service had been staffed for 24 hours a day in December 2016 and January 2017.

- Call handlers were provided with guidance on when to redirect callers to the 111 service, the 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. This included shared learning 'open days' with 111 service staff as well as staff from the 111 service visiting the EOC to develop their understanding of the EOC service.
- Staff gave examples of how they worked with other providers of health and social care such as; pre-alerting hospital emergency 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. This included patients with mental health conditions or those being detained under the Mental Health Act. Staff told us they had effective working relationships with providers of emergency alarm monitoring services including 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 informed the appropriate receiving hospital of the patients expected time of arrival.
- The trust was signed to a memorandum of understanding (MOU) for 'Managing incidents cross ambulance trust borders and passing incidents between ambulance trusts.' This was to ensure the nearest and fastest response would be dispatched to an incident.

Multidisciplinary working

- EOC allocators and dispatchers had a small geographical area were allocated geographical patches working with a limited number of ambulance crews

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which were allocated to a similar geographical patch. Staff told us this maintained effective communication between the EOC and operational staff in specific patches.

- EOC staff knew what type of calls should be allocated to the hazardous area response team (HART). This was a specialist team of staff who were trained to administer lifesaving medical care in hostile environments such as industrial accidents, natural disasters, and terrorist incidents.
- The EOC was a multidisciplinary team (MDT). We observed MDT working between the EMDs, clinical advisors and dispatch staff, and staff on the CHUB.
- The trust had a joint response unit (JRU) working with the police on Thursday, Friday and Saturday nights. The Tactical Response Unit team did this on these nights if not needed for firearms incidents.
- Staff told us they had shared training with staff from Thames Tidal Ways to deal with potential incidents of flood.
- LAS complied with the National Ambulance Resilience Unit (NARU) Memorandum of Understanding on the deployment of 'Mutual Aid'. The last deployment of Mutual Aid from the London Ambulance Service was to another ambulance trust in January 2014 due to flooding in the other trust's area. The process for requesting or providing mutual aid was an aspect of the NARU National Mutual Aid Memorandum of Understanding.
- The process for requesting a response to normal emergency calls for cross border support, as opposed to national mutual aid, was part of the 'National Directors of Operations Group National Procedure For NHS Ambulance Trusts - Managing Incidents Cross Ambulance Trust Borders and Passing Incidents Between Ambulance Trusts'.
- LAS also had an agreement with a trust for the provision of Mutual Aid to Heathrow Airport and for significant and major incidents in the west area of London.
- The service collaborated with a number of private and voluntary ambulance services, patient transport services and taxi providers to provide appropriate transportation for patients.
- LAS also had a range of community first responders, these are members of the public who are trained to the

level of First Person on Scheme (FPOS) qualification or equivalent. Volunteers decided when they would be available. Community First Responders were not provided by any particular organisation.

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.
- The medical priority dispatch system (MPDS) used by call handlers to make decisions on dispatching appropriate aid to medical emergencies, and provided staff with patient specific information. It allowed for systematised caller questioning and provided pre-arrival instructions to aid staff in advising callers.
- The Manchester Triage System (MTS) provided staff with information and supported decisions made by clinicians working in the 'clinical hub'. This allowed them to select from a range of signs and symptoms and clinically prioritise patient care.
- Community first responders (CFR) were provided with 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 an electronic computer-aided dispatch (CAD) system which helped resources to get to the scene of emergencies more rapidly and efficiently.
- Staff told us the CAD system had a few 'glitches', whereby when some information was entered into the system, calls that needed an immediate response would be downgraded. For example, male groin and testicular pain, sickle cell anaemia, and suspected meningitis. As a result the trust had implemented 'protocol 10'. This meant staff could work around these, by adapting information callers gave them to ensure an appropriate vehicle would be dispatched in a timely way. Staff told us, "It's a safety net." Staff said the AMPDS system was

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not aligned to the Department of Health (DoH) priorities and this was the cause of the “glitches.” Staff said there had not been any incidents as a result of the “glitches” and they identified potential problems early.

- Staff were able to monitor all calls across London via ‘Geo-tracker’. Staff could identify caller location, the length of a call, as well as multiple calls from a single event.
- LAS responded to the safety notice NHS England’s 2015 Patient Safety Alert: ‘Harm from delayed updates to ambulance dispatch and satellite navigation systems’ as part of the national response by Ambulance Services, the action plan included a project to re-engineer the LAS navigation systems to allow for more frequent updates to be implemented as part of the introduction of new sat-navs, and the sharing of learning from local investigations or locally developed good practice resources by email these to NHS net.
- There were 2,547 patients in the LAS frequent callers database that had been flagged as frequent callers. Specific patients were flagged with a patient specific protocol. This could be for a number of reasons, primarily patients on a high risk register due to complex needs. A message was relayed to crews via the MDT when a call from a flagged patient was received.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The EOC had access to registered mental health nurses (RMN) at Waterloo. The RMNs provided advice to EOC staff on mental health issues. However, mental health support was not routinely provided 24 hours a day with a few shifts being left uncovered.
- Staff in the mental health team told us the trust were running a recruitment campaign to increase the number of RMN qualified nurses on the team. However, RMN staff told us there was a lack of clinical pathways for patients with mental health needs.
- Staff allocating and dispatching vehicles were aware of specific response times and types of vehicles needed for patients being detained or transported under the Mental Health Act.
- Staff received ‘Capacity and Consent’ training, which included the Mental Capacity Act 2006 (MCA) and dementia awareness training. In addition, further dementia awareness training had been provided for EOC staff via drop in sessions. 73 EOC staff had attended this training with a further 112 staff who were engaged in

conversation with ‘Dementia Friends’ on 10th October 2016 as part of the EOC staff support day. The total number of staff who had attended additional dementia training was 185.

Is emergency operations centre caring?

Good



We rated caring as good because:

- Staff were compassionate and caring towards patients and callers. Staff treated patients with dignity and respect including those in mental health crisis.
- We observed some examples of patients in distressing situations being supported by staff over the telephone. Staff were compassionate and demonstrated concern for providing the best response possible.
- Staff recognised when patients and callers needed further support to understand their treatment and care and this was provided.
- The service had systems and processes for clinicians to advise patients how to manage their own health as well as to provide information about alternative patient pathways.

Compassionate care

- We listened to staff taking telephone calls from the public. Staff spoke to people in a compassionate manner and treated them with dignity and respect. Staff listened to what callers were saying and clarified information when necessary. Staff were sensitive and supportive whilst on the phone. For example, we observed staff speaking with distressed callers on the phone on several occasions.
- We heard staff talking to vulnerable patients with empathy and kindness.
- We listened to 45 calls. Without exception, staff were calm, reassuring, empathetic and kind. Staff were patient with callers when they became anxious. This enabled the caller to relax and answer the questions required to obtain information about the patient.
- Staff induction training included how to be caring and compassionate. The training lead told us there was an emphasis in induction training for EOC staff on customer service and treating callers with dignity and respect.

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- During busy periods, staff did not take patients through the full triage process. Staff asked patients a limited number of questions and then told them the service was very busy. We listened to calls and heard several examples of patients told to call their GP or find alternative responses to their condition. EMDs read from a script, which required them to end calls as quickly as possible. Staff acknowledged that the need for the use of scripts could make calls sound less compassionate, even though staff did feel compassion towards the caller.
- The service was developing a new standard operating procedure for staff to use when they received an abusive call. Staff described how they would handle and escalate abusive callers. Staff told us they would escalate the call appropriately to managers. Staff remained calm and respectful to abusive callers and felt supported by managers.

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 the ambulance would arrive sooner.
- Staff recognised when patients and callers needed additional support. Staff had access to interpreter services and chaperones if a vulnerable patients required transport to another health service.
- Staff communicated with patients and callers appropriately. We heard staff making sure callers understood information staff provided them with. We heard them explaining actions LAS were taking and what would happen next. Callers could ask questions to ensure they fully understood what was happening.
- The Advanced Medical Priority Dispatch System (AMPDS) had standard evidence based advice for callers on what they could do whilst waiting for an ambulance, which ranged from keeping someone warm and comfortable to full cardio pulmonary resuscitation advice. Staff clearly communicated advice to patients when required.

- Staff involved callers in conversation and provided clear, step-by-step instructions. Staff supported the callers while they were providing care. We heard staff encouraging and offering callers affirmations on how well they were doing.

Emotional support

- We heard staff providing emotional support to patients awaiting the arrival of emergency responders by staying on the call until the ambulance crews arrived.
- We observed staff supporting callers and patients who were distressed and anxious. Staff spoke to people in a calm manner. Staff communicated clearly about when help was on the way and what patients needed to do whilst waiting for LAS staff to arrive. Staff reassured callers before ending calls and ensured callers were calm and understood what was happening before ending calls.
- CHUB staff demonstrated understanding of the impact of patients care, treatment and condition on their well-being. Clinicians gave appropriate advice and used the Manchester Triage System as a support tool for their advice and decision-making.
- Staff showed kindness, respect and compassion for those experiencing mental health issues. We observed staff talking with and supporting patients until further help arrived. Staff listened to callers and demonstrated empathy with them during calls.

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.
- RMNs told us there was a lack of mental health pathways for patients experiencing mental health issues and this had an impact on the quality of care patients received.
- During 'hear and treat' calls we observed the clinicians discuss treatment options with patients, contact patients general practitioner's(GPs) and make arrangements for the GP to visit.
- Clinicians on the CHUB would also advise patients about managing their own health needs. This also included advising people to contact their GP.
- 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, the mental health crisis intervention team.

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- The CHUB had access to a directory of services (DOS). The DOS provided staff with information for signposting callers to services other than hospital.
- The CHUB used the Manchester Triage System this provided staff with clinical decision support, including evidence based self-care advice. This meant staff could advise some callers on managing their own symptoms without the need for referral to other health care services. For children under two years of age the CHUB would make use of pathways to Health Visiting teams and GP's.
- The trust had a number of alternative pathways across London. The CHUB would advise crews when required on pathways for patients.

Is emergency operations centre responsive to people's needs? (for example, to feedback?)

Good



We rated responsive as good because:

- The service had a number of different clinical specialist services designed to meet the needs of the local population. This included the metropolitan police desk (METDG) and community first responders (CFR).
- The service had a surge management plan to cope with different levels of demand on the service.
- Patients could phone or text the service and staff identified where patients had additional needs including interpreting services for patients whose first language was not English.
- The service had systems and processes in place for frequent callers and patients with complex needs.

However, we also found:

- Patients were informed of how to complain, but staff thought complaints handling processes could be improved.

Service planning and delivery to meet the needs of local people

- LAS served a population of eight million people in Greater London, covering an area of around 620 square miles. The service includes 70 ambulance stations with 900 vehicles. LAS received in the region of 1.6 million calls a year.
- The London Ambulance Service (LAS) operated its control services function from the EOC at trust headquarters (HQ) in Waterloo and the EOC in Bow. Both sites acted as one virtual control room using computer-aided call taking and dispatch.
- Each Control Room had call-taking and dispatching functions which allowed the transfer of any sections of the operation to either site depending on the needs of the Service.
- The Emergency Operations Centre (EOC) received and triaged 999 calls from members of the public and other emergency services. Staff provided advice and dispatched ambulances to the scene as required.
- The EOC provided assessment and treatment advice to callers who did not need an ambulance response, a service known as 'hear and treat'. Staff gave callers advice on self-care, making an appointment for a general practitioner (GP) or directed them to other services. The EOC also managed requests by health care professionals to convey people either between hospitals or from the community into hospital.
- The trust had two emergency operations centres (EOC). One in Bow and a larger EOC at trust headquarters in Waterloo. The two EOC's worked as one virtual EOC and all calls were routed to the next available operator across the two centres. Clinicians worked at both EOCs triaging lower priority calls and providing clinical advice to patients.
- The EOC had three core sections: call takers, dispatchers and a clinical hub. There was also a central support unit, dispatch and distribution support desk, and an intelligence conveyance desk. At Waterloo there was an emergency bed service, helicopter emergency medical service (HEMS) and advanced paramedic practitioner (APP desk). The desk co-ordination worked between the ambulance service and the Metropolitan Police Service. This desk was referred to as METDG and was based at Bow.

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- Staff told us the trust had introduced a new initial phrase for call handling. This included a set first question, “Is the patient breathing.” Staff said this was to aid staff in capturing and prioritising patients earlier in the conversation.
- The trust had a control services surge management plan in place to ensure that at times of sustained high pressure the EOC provided a consistent service to those critically ill patients. The plan allowed for seven colour-coded surge levels to manage fluctuations in demand, as defined by the trust’s surge plan. Green was the lowest level and black the most severe level of demand; the levels in order of priority were: green, amber, red, purple, purple enhanced, blue, and black. At the time of our visit the EOC were operating on surge level red. Surge purple and purple enhanced could be authorised by the on-duty incident and delivery manager. The higher levels could only be authorised by the trust’s “gold commander”. Surge black, the highest level, had never been used by the EOC.
- The triggers for escalation of surge levels were to enable a review of the real time situation and agree the appropriateness of implementation. The surge plan specified that there would be times when escalation may not be appropriate as the case-mix of 999 calls being received meant the majority of calls were not suitable for self-care advice and an escalation of surge level would lead to greater clinical risk. For example, the New Year’s Eve Outage a decision was made not to escalate surge levels.
- The LAS surge management plan ensured that at times of sustained high pressure the EOC provided a consistent service to 999 callers. The purpose of the plan was to ensure that at times of sustained high pressure LAS could take an overview of the whole of London and provide a consistent service to 999 callers. Implementation of the plan released additional vehicles from normal operational duties and allowed demand to be managed in a manner which continued to enable the patients with the highest level of need to be responded to in the quickly and provided the safest possible management of all patients.
- The surge management plan allowed for calls related to patients between two and 74 years old to be routinely redirected to the 111 service.
- A few staff told us there were insufficient numbers of ambulances to deal with the increasing demands on the service. Staff said ambulance crews were often delayed at A&E departments for two to three hours.
- The METDG desk was not permanently staffed. However, staff told us the service had been staffed 24 hours of the day seven days a week in January 2017. Staff told us the service had seen the benefits of having the desk due to the savings in ambulance time. Staff could re-triage people by speaking with police directly at the scene, and this enabled staff to assess whether an ambulance was required or referral to another service was the appropriate course of action.
- The trust had introduced a Non-Emergency Transport Service (NETS). This was one of the initiatives supported by commissioners to reduce pressure on the control room and front-line staff. The target was 10 calls per hour to be transferred to NETS with a minimum of one to two hour timeframe. The targeted use of NETS was to enable front-line ambulances to be freed up for the sickest and most seriously injured patients and reduce the delays in responding to the patients whose needs did not specifically require an ambulance and who often waited too long for conveyance to care. The decision to transfer calls to NETS was based on the patients presentation at the time of the assessment and not their past medical history, for example, a patient presenting with a limb injury and a cardiac history did not require a frontline response in order to conduct a routine electrocardiogram (ECG), this is a test of the hearts rhythm and electrical activity.
- Dispatch and deployment of HART resources was through the incident management desk (IMD) when it was operational. EOC sector staff liaised with the IMD when they identified a HART suitable call. When the IMD was closed, sector staff liaised directly with the HART team supervisor who advised on the appropriate resource to dispatch.
- As well as the HART dispatch criteria, the team could also be dispatched to Red 1 calls if they were the nearest resource or were required as an additional resource. Where they were the nearest, they would be backed up with sufficient numbers of LAS clinical resources as soon as possible to enable HART to be released for a HART suitable call should one come in. The national service specification states that this must occur within 15 minutes.

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- HART were dispatched to clinical calls within standard fast response unit (FRU) or accident emergency unit (AEU) operating procedures. These vehicles did not carry their HART specific personal protective equipment so there was no need for them to be unavailable for the first and last hour of their shift for equipment checks.
- A separate procedure existed when HART resources were moved to work on ambulances, or were required to respond to Red2 calls as a first response.
- EOC allocators and dispatchers were assigned a dedicated geographical area. Staff knew their areas including the locations of; roads, bridges, hospitals, traffic levels and temporary traffic limitation (i.e. road works). Staff worked closely with a limited number of ambulance crews which were allocated to a similar geographical area to ensure effective communication.
- There were standard operating procedures (SOP) for METDG team and the CHUB. These outlined the roles and responsibilities of each team.

Meeting people's individual needs

- Emergency calls from patients for whom a frequent caller procedure was in place. Frequent caller procedures had been locally determined; these procedures related to individual patients and were agreed with the patient and the main care provider, for example, GPs and community mental health teams.
- Between July 2015 and October 2016, the proportion of calls from patients for whom a locally agreed frequent caller procedure was in place was similar to the England average. The trusts frequent caller rate drops below the England average from June 2016 to October 2016. There were registered mental health nurses (RMN) available to provide advice relating to patients with a mental health problem, but this service was not routinely provided 24 hours a day.
- Dispatchers had access to two specialist bariatric vehicles. However, these were provided by a contract with an external provider.
- Staff had access to a language support line for 999 calls where the caller did not speak English as a first language. The aim was to achieve language support within 90 seconds from the time a call was received. A senior manager told us this was achieved and callers needing interpreting services needs were met.
- Staff had access to a text service to help people with hearing loss and/or a speech impairment to access the telephone system.

- The call handling system allowed alerts to be recorded for frequent callers, patients with complex needs, learning disabilities as well as for patients from other vulnerable groups. However, in cases where several people lived at the same address, for example, in blocks of flats, staff were unable to establish promptly which flat the alert corresponded to. An area controller told us vehicle crews were required to update the information stored but that sometimes this didn't happen.

Access and flow

- Between January 2016 and January 2017 the EOCs in Waterloo and Bow received 1,688,623 calls. Demand on the LAS was continually monitored by the duty incident delivery manager (IDM) and supported by the EOC general manager. When an increase in demand triggered an escalation in Surge level a Surge conference call chaired by the IDM was held and attended by Trust Gold, Senior Clinical on-call, Clinical Hub Manager, EOC General Manager and Duty Emergency Planning and Resilience Officer.
- The call handlers were responsible for answering and triaging calls in accordance with clinical need. The CHUB was staffed by clinicians, including specialists such as paramedics, nurses and registered mental health (RMN) nurses. The dispatch team was responsible for allocating calls to vehicle crews in accordance with clinical priority and location of vehicles. The central support unit was responsible for supporting the call handlers with advice for more complex calls, ensuring welfare checks were made (particularly if there was a delay in a vehicle arriving on scene) and providing advice to emergency responders.
- The business portal allowed staff access to the trust's electronic system, which allowed staff to monitor the number of calls being held at any time in a 24 hour period. The system was monitored by the area controllers, and had colour coding to give staff a visual display of the time an individual call had been held. This facilitated staff in prioritising non-emergency response calls.
- The emergency bed service also handled safeguarding referrals. The HEMS desk was responsible for dispatching the air ambulance and the METDG desk triaged Metropolitan Police Service calls to determine an accurate priority and facilitate more effective use of LAS resources.

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- We viewed an indicator that reflected how the whole urgent care system was working, rather than simply the ambulance service or hospital accident and emergency departments. It reflected the availability of alternative urgent care destinations, for example, walk-in centres, and providing treatment to patients in their home. We found the percentage of emergency calls resolved by telephone advice at LAS, (10% to 14%) was better than the England average, (9% to 11%), between July 2015 and October 2016. From April to September 2016 the rate of calls being resolved with telephone advice dropped, however this was never lower than the England average.
- When comparing the trust to the average of all ambulance trusts for time to answer calls using the 'Call Connect' 95th and 99th percentiles, the time below which 95% and 99% of calls were answered. The trust were performing in between the England maximum answer time and the England minimum. The trusts figure for this indicator had remained consistent throughout the time period from August 2015 to October 2016 unlike the England maximum and minimum. The trust has reported a consistent median figure of zero from August 2015 to October 2016.
- The total number of abandoned calls for the week commencing 23 January 2017 was 75 abandoned calls, but this in context related to an average of over 32,000 calls per week received in January 2017.
- There was a protocol for referrals to the HART team. The CAD system also offered staff prompts on which particular vehicles should be sent to particular calls.
- There was a protocol, OP023, to monitor call-backs when ambulance crews could not be dispatched, 'Procedure for the Dispatch of Resources by the Emergency Operations Centre.' The procedure was provided for EOC staff in the form Surge Action Cards. Adherence to the policy was monitored on a live basis by the allocators, area controllers and watch managers. The Business Intelligence system GeoTracker provided live information to allow monitoring of ring backs.
- 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. 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 operations to either site depending on the needs of the service.
- The trust had 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 reduce the arrival of ambulances across London hospitals and reduce the number of ambulances attending the busiest hospital EDs. The ICD team monitored the number of ambulances waiting at hospitals as well as the time spent waiting.
- The staff working at the intelligence conveyance desk (ICD) could contact ambulance crews and redirect them if a hospital A&E was particularly busy. However, staff said sometimes ambulance crews took patients to busy A&E departments even though they had been advised by staff at the ICU that the A&E department was busy and there was a wait.
- There were personal support plans developed for people who required frequent support. These were available from the CHUB. Call handlers and vehicle crews did not routinely have access to these documents and were required to obtain it from the CHUB desk.
- Dispatchers and allocators were responsible for allocating jobs to the hazardous area response team (HART). HART teams were also dispatched to regular category Red1 and Red2 calls, if they were free to respond. HART paramedics said the EOC were not able to man the incident management desk (IMU), which had been set up to oversee the management of large incidents, for much of the day and night. The HART staff felt this had resulted in the HART team being sent to calls that did not meet the HART criteria. However, managers at the EOC told us HART teams were allocated by the electronic system, and there was a protocol which prompted staff to send the HART team to a reported event. Staff at the EOC said they were not aware of multiple episodes of inappropriate dispatch of the HART team.

Learning from complaints and concerns

- Staff told us learning from complaints was disseminated through monthly 'Team Talk' newsletters and quarterly 'governance in action' newsletters, as well as bulletins from control services. However, a senior manager told us complaints could be improved. There was a system

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for recording complaints and the action taken in response. The system identified which complaints related to which team and the overall nature of complaints.

- Compliments were managed by a dedicated team with referrals most often being made via a specific email facility. This team would alert the staff concerned via the local management teams.
- Complaints were received via telephone (32%), mostly via the duty officer facility operated by the patient experiences team, email (57%), letter (10%), in person or by twitter (via communications team), monitoring of patient-focused websites (1%). Depending on the nature of the complaint, input was sought from the relevant department. In cases involving the clinical care provided or staff attitude and behaviour, a copy of the complaint was made available to the staff involved via the local management team; the staff were asked to offer their account about what happened and address the specific issues raised in the complaint via a proforma. Where the complaint involved clinical care it would be peer reviewed by the Clinical and Quality Directorate, who would assess the record of the care provided as completed by the staff concerned and their account of what happened. Once prepared, the draft response to the complaint was made available to contributors to verify their input had been understood and then sent to the Executive Office. Once signed off, the response was shared with the staff involved via the local management team and they have opportunity to speak with their line manager and the Head of Department if they had concerns. Any actions indicated were implemented, for example, a member of staff had completed a reflective practice exercise in response to a complaint about staff attitude. Staff told us complaints information and lessons learnt were disseminated through monthly 'Team Talk' newsletters.

Is emergency operations centre well-led?

Requires improvement



We rated well-led as requires improvement because:

- Some staff felt there was a 'top down' approach to management and staff did not feel fully consulted and engaged in the trust change agenda.

- Some staff who worked on New Year's Eve 2016/17 during the CAD system outage, told us staff including senior managers did not appear to know how to respond initially to the outage of the system, even though staff had received training on the system.
- Senior managers we spoke with told us the benefits of an electronic back-up system had been discussed informally following the New Year's Eve outage, but there was no formal plan in place in regards to a back-up system.
- The EOC clinical strategy was complete and work was in progress on a new organisational strategy. However, this was not embedded.
- Managers we spoke with highlighted that LAS could be bureaucratic and implementing change could be a slow process.
- The number of BME staff employed did not reflect the demographics of the population the service served.

However, we also found:

- There was a clear governance structure with accountable roles for staff and managers.
- There were frameworks in place to manage risk and quality assurance. Managers and knew the key risks to the service.
- The new director of operations for EOC was popular amongst frontline staff and managers.
- Both EOCs reported improvements in the culture of the EOCs, with the trust having taken action to intervene where there were reports of staff bullying and harassment.

Leadership of service

- There was a new governance structure in place. The EOC director of operations reported to the trust board. There were five general managers that operated across both Waterloo and Bow EOCs.
- We spoke with some staff who had worked on New Year's Eve 2016/17 during the CAD system outage. Some staff told us staff including senior managers did not appear to know how to respond initially to the outage of the system, even though staff had received training on the system. Staff said a real life situation was very different to a desk top exercise. Some staff also expressed concerns about the trust not having an electronic CAD back up system. However, senior

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managers we spoke with told us the benefits of an electronic back-up system had been discussed informally following the New Year's Eve outage, and these discussions were on-going.

- Staff told us there was support from the executive management team and most staff were aware of the individuals on the executive team. Staff were particularly complimentary about the new director of operations. Staff said the deputy director of operations for control services was visible in both Waterloo and Bow EOC and staff said they found them approachable. However, a number of staff said they were not aware if the CEO's position was permanent or interim, and a few staff said there had been a number of changes in the executive team and they had found this confusing.
- EOC managers had regular managers meetings at 7.30am every day and briefed the EOC team following the meetings.
- Managers we spoke with highlighted that LAS could be bureaucratic and implementing change could be a slow process.

Vision and strategy for this service

- Staff told us the EOC clinical strategy was complete and work was in progress on a new organisational strategy. Staff also told us they were aware an EOC strategy was in development. The EOC strategy document was in consultation and a draft had been sent to EOC managers for feedback.
- All staff received a trust induction which was linked to the LAS values. Staff we spoke with were of the LAS values, as the "3 Cs", these were care, clinical excellence and commitment. The trust values were also communicated to staff via the trust's intranet 'Pulse'.

Governance, risk management and quality measurement

- There were clear quality assurance processes in place. For example, we viewed minutes from the control services governance and quality group dated 20 January 2017. The minutes clearly detailed the discussion that had taken place during the meeting and reviewed the groups' action log and the status of actions from previous meetings. The action log had a colour coded key to enable monitoring of outstanding actions or whether actions had been completed. For example, the log from the 20 January 2017 recorded the actions identified in the EOC winter plan on the 24 November 2016 had been completed.
- EOC had weekly management team meetings which had a standard agenda. Staff told us these meetings were not routinely minuted. We viewed the agenda for the 1 February 2017. We also viewed the action log resulting from the meeting; this included the dates actions were due to be completed by. For example, the scoring metrics for the Surge Plan were agreed and actioned on the 2 February 2017, with a review due six weeks later.
- A quality assurance manager monitored 1% of calls on a daily basis. These were chosen from the staffing sheet. Staff were also monitored individually by the quality assurance manager for key performance indicators (KPI) on a monthly basis; these were based on call handling time, compliance with trust procedures, and the number of calls taken by specific staff members. We were shown action plans addressing where staff had fallen short of their KPI indicators.
- All clinical audits in the LAS were undertaken in line with the EOC's clinical audit strategy. The clinical audit work programme included the clinical performance indicators (CPIs), which were monitored by the Clinical Audit and Research Group Steering Committee (CARSG). CARSG was a multidisciplinary group of clinical and non-clinical staff supported by external specialists. The group was chaired by the LAS medical director. An independent annual review of the LAS's clinical audit practices was carried out by a member of the patient's forum to provide additional assurances, and the review was reported to CARSG.
- In addition to the advice and oversight provided by CARSG, each clinical audit project had an allocated LAS clinical lead who provided assurance that the project design was clinically relevant and met the service's needs. The clinical leads also clinically reviewed patient records where expert opinion was required.
- CARU provided quarterly update reports to CARSG, which included progress against each project and the implementation of actions to improve clinical quality. These reports were also presented to the Clinical Development and Professional Standards Committee who then reported upwards to the Quality Governance Committee and Trust Board.
- An Annual Clinical Audit Report, summarising audit findings, achievements and impacts, was also presented directly to the Quality Governance Committee and, through them, to the trust board.

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- LAS produced monthly Clinical Performance Indicators (CPI) and continuous quality monitoring reports that were distributed across services. Key compliance figures were also entered in to the trust's quality dashboard each month, with findings highlighted to the LAS's Executive Leadership Team (ELT) through the monthly Quality Report. In addition, a set of indicators related to Cardiac Arrest, Stroke and St-Elevation Myocardial Infarction were further reported to NHS England through the Ambulance Clinical Quality Indicator dashboard.
- The EOC maintained a risk register. We viewed the risk register dated November 2016. There was a total of 12 risks identified on the risk register. The last risk identified on the register was on 11 June 2016. This related to the expansion of functions in Control Services and front line operations resulting in insufficient space to adequately function in the event of a CAD failure planned or otherwise. The risk was rated as a moderate and "possible" risk. The risk register had been reviewed and updated on 3 November 2016 and recorded that the service were identifying potential suitable sites for expansion, both internally and externally, and reviewing the relevancy of the service's dispatch model, as well as reviewing the numbers of staff required for each function. The register also recorded assurance actions in regard to the plan for paper operations (OP66) being up to date and available on the Pulse intranet. Dates were also planned to test the Control Services plan for paper operations. The date for the next risk register review was recorded as 31 March 2017.
- However, we did not see that all risks were listed, for example the failure of the CAD system in the EOC. The system had failed on New Year's Eve, resulting in the EOC having to resort to paper based systems. Staff told us the system had crashed on more than one occasion. However, the CEO highlighted that the trust were not an outlier in regards to CAD system failures. In mitigation the trust informed us that the CAD risks had been added to later copies of the risk register.
- The quality assurance team, audited all 999 calls and monitored operational performance against national requirements. All calls were recorded and a proportion was audited on a random basis. The quality assurance manager told us 1% of all calls were monitored for quality assurance purposes.
- Staff working in the CHUB advised us that they undertook daily peer reviews, listening in to each other's calls. Check sheets were used and they would provide feedback to colleagues on their performance.
- Some managers and staff we spoke with said the trust needed an electronic CAD back up system. Staff said the EOC practiced the paper-based back up system regularly, but, staff highlighted that demands on the service had increased and hence the demands on staff operating from a paper-based system had increased. A senior staff member said, "We've outgrown a paper-based system."
- The trust's IT department were in the process of undertaking a Root Cause Analysis (RCA) of the CAD New Year's Eve Outage, supported by the Chief Information Officer from NHS England. The trust had also commissioned a private consultancy to undertake a separate review of the entire CAD system and IT infrastructure. Updates were regularly discussed at Executive Leadership Team meetings and trust board meetings.

Culture within the service

- Most of the staff we spoke with said there had been positive changes in the EOC culture in the previous 12 months. Although staff and managers acknowledged that further progress on the culture and initiatives needed to be further embedded. Staff said there were a few isolated incidents of bullying and harassment of staff, but said these had reduced in the previous 12 months, as the trust were taking action to address workplace bullying and harassment. Staff said the trust were more focused on looking at how to support staff rather than criticize, which staff said was a culture change.
- Most staff we spoke with told us staff morale had improved. Staff said they were aware that the trust were making improvements and trying to make the EOC a better place to work. For example, staff highlighted the recent refurbishment of the EOCs and a new coffee machine for staff at Waterloo. However, a few staff said they felt EOC staff were not valued as much by the trust as the operational staff. Some staff told us there had been a recruitment drive by the trust. This had involved some staff that were acting up, for example one staff member was a band 4 acting up to a band 6. Staff told us some staff had applied for permanent positions in the roles they were acting up to, but had not been

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shortlisted for interview. Some staff said they had not received satisfactory explanations as to why staff, “already doing the job,” had not been shortlisted, and this had affected staff morale.

Public and staff engagement

- Some staff we spoke with told us they felt there was a ‘top down’ approach to management and the trust and staff did not feel fully consulted and engaged in the trust change agenda. Staff told us they were “told” what was going to happen rather than consulted about changes. A staff member said, “Generally, I don’t think the staff are actively involved in service developments.”
- Some staff we spoke with told us they had not been always involved in decisions affecting their work and felt there was a ‘top down’ approach from managers. Staff told us information was disseminated to staff from the trust board, but felt there was limited information that was fed back to the board from the EOC. Managers said there had been a meeting in January 2017 to enable the area controllers and watch managers to pass on staff feedback; but said these types of meetings tended to be ad hoc.
- A few staff on family friendly rotas told us they did not have equal opportunities for promotion, training or development opportunities. However, other staff said it was a perception with some staff and the trust were supportive of staff on family friendly rotas. For example, one member of staff on a family friendly rota told us they had recently been promoted and the trust had facilitated their promotion around their rota.
- A number of staff and managers we spoke with expressed concern in regards to a new absence policy the trust had introduced. A manager told us the policy did not allow local managers any flexibility in administering and implementing the policy. Staff told us the policy had been viewed negatively by staff, due to the policy being a, “one-size fits all approach.”
- Some dispatch staff said they had been consulted on the change to the first phrase staff would use when speaking with a caller about a patient’s condition. Staff also said there had also been a dispatch review which was staff driven, although changes from the review had not been implemented at the time of our inspection.
- Staff told us they had been offered counselling support following the New Year’s Eve CAD outage from workers

the trust had trained in supporting other workers.

Managers told us the trust were more aware of debriefing staff promptly following an incident than they had been previously.

- The trust had introduced staff link workers. These were staff who had volunteered to support and advocate for staff. Link workers had received training in staff support and advocacy. Staff we spoke with were positive about the link workers. However, we found a general manager was a link worker and this may have made some staff feel apprehensive about discussing their workplace grievances or concerns. Link workers received supervision to support them with their role.
- The trust had introduced respect and dignity ambassadors. These were staff trained to intervene and support staff in situations of bullying or harassment.
- Managers were very complimentary of EOC staff following the New Year’s CAD outage. A senior manager said, “Considering the volume of calls and the switch to a paper system, they just got stuck in and did everything they could. They were amazing.”
- We reviewed a proposal document provided by the interim equality and diversity lead, in which it set out its aims to widen the opportunities for black and minority ethnic (BME) staff in LAS. The data indicated the LAS employed 5155 staff, of whom only 13% were from BME groups. This was significantly low when the demographics of London were taken into account. BME individuals made up 40% of the London demographics. Within the workforce 101 (11%) BME staff worked in a band 4 role, such as TEACS, EACs and NETS. 171 (7.14%) of paramedics and EMTs were BME working at band 5. Non-operational band 5 had 41 (36.6%) BME. Of the 297 non-operational managers and specialists band 6 & 7, 58 (19.5%) were BME. There were 487 Operational teams leaders, senior paramedics and resource staff band 6 & 7, of which 49 (10%) were BME. 123 managers band 8a and above, 13 (7.1%) BME. And there were 42 senior managers above band 8c, of whom 1 (2.3%) were BME.
- No BME staff were employed in the executive team or NEDS.
- The majority of BME staff 183 (3%) were employed in operational band 3 roles, followed by 57 (30.5%) in non-operational band 4 roles. Two BME staff (15%) were in operational band 2 roles, and 10 (50%) in non-operational band 2 posts.
- The proposal set out areas of focus, which included increasing the visibility of leadership, getting ready for

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future workforce. This would be done by focusing on schools, colleges and universities, as well as working with voluntary services. Other areas to be addressed include accessibility to recruitment and training opportunities, developing learning opportunities and the re-launch of the leadership programme.

- We reviewed the report presented to the trust board on 4 October 2016, which provided an update on the progress of the workforce race equality scheme, (WRES). This outlined the significant actions taken since the board had signed off the WRES action plan on the 26 July 2016. For example, a board seminar had been held on 8 September for executives, NEDs. This had been led by NHSE joint programme directors. Various meetings had been held with internal and external stakeholders, and external conferences and workshops had been attended. The staff survey undertaken for 2016/17 had also included a number of additional equality and diversity questions. (NB: I have requested these and the findings).

Innovation, improvement and sustainability

- The clinical hub was staffed with paramedics who covered the hub on rotation; registered general nurses (RGN) with backgrounds in accident and emergency, intensive care, and mental health nurses. The clinical hub provided 'hear and treat' services, which meant some patients could be treated without being transferred to hospital.
- Improvements and innovations made to the HART team did not contravene the national specification, and therefore did not require formal National Ambulance Resilience Unit (NARU) approval. However, where changes required NARU approval, a procedure was in place. The only instance where this had occurred in the previous 12 months was in relation to three identified estates issues, including the lack of a perimeter fence for HART vehicles. NARU had agreed an action plan in response and confirmed by letter on the 16 November 2016 that they were satisfied with the actions the trust had taken.
- 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 CAD was linked electronically with the equivalent system for London's Metropolitan Police.

- The trust had introduced a Non-Emergency Transport service (NETS) to reduce pressure on the control room and front-line staff. The targeted use of NETs was to enable front-line ambulances to be freed up for the sickest and most seriously injured patients and reduce the delays in responding to the patients whose needs did not specifically require an ambulance and who often waited too long for conveyance to care.
- In 2015 following trustwide staff and management engagement aspirational roadmaps were created to align future EOC initiatives and investment in IT with the trust's business planning. One of these, "Ensuring we respond well to people in need of our care 24/365," illustrated the aspirational roadmap to ensure EOC forward planning was aligned with the trust's roadmap, and included consideration of major system refreshes. The roadmap was in the process of being remodelled due to developments in the trust's IT strategy and changes in national initiatives since the roadmap was initially created.
- LAS had been involved in 'Exercise Unified Response (EUR).' This was a major incident exercise that took place between 29 February and 3 March 2016. The exercise was a joint venture with other London emergency services on behalf of the London Resilience Partnership and was co-funded by the European Union. The main aims of the exercise were to test the UK's ability to activate the European Union Civil Protection Mechanism (EU CPM), improve London's preparedness to respond to large scale emergencies, and improve multidisciplinary working in emergency preparedness. An evaluation report highlighting learning from EUR was released in January 2017. The trust were preparing an action plan in response.

Resilience planning

Safe	Good	
Effective	Good	
Caring	Not sufficient evidence to rate	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Since June 2011, responsibility for the delivery of emergency preparedness policy in NHS ambulance services in England has been delegated to NARU (National Ambulance Resilience Unit) NARU.

From April 2013, all NHS organisations have been required to contribute to co-ordinated and planning for both emergency preparedness and service resilience through their local health resilience partnerships (LHRPs).

The London Ambulance (LAS) service has a crucial role in the national arrangements for emergency preparedness, resilience and response (EPRR). The service is part of the civil contingency planning for both the NHS and the wider emergency preparedness network, and as such must be in a position demonstrate it can effectively manage the impact and aftermath of a major incident.

The EPRR function was provided trust wide from its Emergency Operations Centre at Waterloo.

The Trust has two HART bases in London, one in East and one in West. The team based in East London is the major HART team and administration for the department is undertaken here.

HARTs are comprised of specially recruited and trained personnel who provide the ambulance response to particularly hazardous or challenging incidents, and in some cases where there is a mass casualty incident. Incidents may involve chemical, biological, radiological or nuclear (CBRN) or other hazardous materials, or could

involve incidents such as train crashes, large-scale motorway accidents, building collapses or significant fires, and could be the result of an accident or caused deliberately.

The HARTs work alongside the police and fire and rescue services within what is known as the 'inner cordon' (or 'hot zone') of a major incident. The job of the HART team is to triage and treat casualties and to help save lives in very difficult circumstances. They are also there to look after other emergency personnel who may become injured whilst attending these difficult and challenging incidents. Specialist equipment and a range of vehicles are available to support the resilience function and included vehicles containing equipment for mass casualty events.

The national vision, support and training for all HART teams is provided by the National Ambulance Resilience Unit (NARU).

The EPRR department works collaboratively with multi-agency services and has responsibility for:

- Major incident planning
- Two Hazardous area response teams (HART) located in the London Boroughs to Tower Hamlets (HART East) and Hounslow (HART West).
- Event planning.
- Chemical Biological Radiological and Nuclear (CBRN) Capabilities.
- Initial Operational Response.
- Tactical Response Unit (TRU).

Resilience planning

- Joint Response Unit (JRU).

The LAS EPRR planned for and responded to a wide range of incidents and emergencies. These included the following Ambulance Service capabilities:

- Safe working at height
- Confined space
- Inland and swift water rescue
- Marauding Terrorist Fire Arm Attack
- Chemical Biological Radiological and Nuclear (CBRN) Capabilities/HAZMAT
- Initial Operational Response
- Specialist Operational Response
- NHS Decontamination of Casualties
- Mass Casualty Capabilities
- Joint Response Unit

The HART bases contained specialist equipment and a range of vehicles to support the resilience function; in addition, vehicles containing equipment for mass casualty events were based at Hubs around the region.

At our June 2015 inspection we identified serious concerns about how the trust were fulfilling their responsibilities to deliver HARTs, capable of meeting the National Ambulance Resilience Unit (NARU) specification, because of insufficient paramedics.

We re-inspected the HARTs in August 2016 and found improvements had been made in the recruitment of staff and medicines management.

We conducted an announced inspection on 7-9 February 2017 and visited both HART locations and inspected equipment and vehicles at both bases.

We inspected the security and administration systems for medicines within the locations and on vehicles. We spoke with a variety of staff including paramedics working across the wider EPRR department, front-line HART paramedics and both junior, middle and senior managers.

We were unable to observe direct patient care because the opportunity to accompany a crew to a call-out did not arise. We spent some time observing an exercise involving the police and fire brigade

The trust was introducing the Medical Emergency Response Intervention Team (MERIT) at the time of the inspection which was due to go live on 1 May 2017. It will be located within the EPRR.

Resilience planning

Summary of findings

We rated this service as good because:

- Much progress has been made since the 2015 inspection to ensure the service met national standards and LAS was able to provide an effective and timely response to planned events and catastrophic incidents.
- The number of paramedics in the HARTs had increased and was in line with NARU guidance.
- There had been a significant improvement in attendance at specific training for HARTs.
- Response times were in line with national standards.
- Security at the HART sites had been improved and action taken to mitigate risks.
- The uptake of appraisals was much improved and staff were positive about the training they had attended.
- There was effective partnership working with organisations across London for major events along with multiagency training.
- Staff were using evidence based practice and working to national guidance for HART/CBRN/Marauding Terrorist Fire Arms Attacks (MTFA).
- Although unable to observe EPRR providing care, LAS provided us with examples of positive feedback from patients/public about care provided by EPRR staff.
- Improvements since the 2015 inspection meant the EPRR were able to respond more effectively to severe or catastrophic disruptions to normal activities in the community.
- HARTs were meeting national response times.
- There was a clear leadership structure and staff were aware of the structure.
- Staff were positive about their immediate line and local managers but, some still felt more could be done to improve communication and taking action in response to feedback from staff.

- Systems to monitor the quality and safety of services were in place and there was some feedback at local level.

However:

- Learning from significant events attended by EPRR staff was shared but learning from incidents in other crews was not so well developed.
- The HARTs were still using leased vehicles at the time of the inspection but, permanent HART specific vehicles were on order and due to be delivered in May 2017.
- The trust business continuity plan needed to be aligned with other trust policies/plans.

Resilience planning

Is resilience planning services safe?

Good



We rated safe as good because:

- Many improvements had been made since our last inspection.
- Staffing levels in the HARTs had been increased and recruitment was ongoing.
- There was a good uptake of mandatory training.
- Staff were aware of the action to take if they suspected or witnessed abuse and there was a good uptake of safeguarding training.
- Security at the HART sites had been improved.
- The trust had introduced a new system for reporting incidents and staff were aware of how to report incidents.
- Learning from EPRR incidents took place along with multi-agency debriefings.

However:

- Sharing learning from incidents across the trust needed further development.
- The trust's business continuity plan needed to be aligned with other trust policies.

Incidents

- HART, Chemical, biological, radiological and nuclear defence (CBRN) and Marauding Terrorist Firearms Attack (MTFA) planning within the trust guidance from the National Ambulance Resilience Unit (NARU).
- Since the 2015 inspection the trust had introduced an electronic incident reporting system (2016) and staff we spoke with were aware of how to report incidents. They were supported to report incidents through the 'single point of access team', a team dedicated to inputting incidents reported by frontline staff into the IT system. Staff were able to call a dedicated line from the ambulance and report an incident which would be recorded on the IT system by the single point of access team. Staff told us this had made the system of reporting incidents quicker and smoother. They were able to provide us with examples of incidents they had reported and changes made.

- The trust had not reported any Never Events between January and December 2016. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between May – December 2016, the 81 incidents with the majority of them near miss/no harm, 16 were low/minimal harm and two were moderate/no permanent harm.
- Feedback from incidents was at an individual level and at team meetings. Feedback was also via the EPRR newsletter, which included information from national and local incidents and 'Insight', a new learning from experience magazine which highlighted learning which as a result of serious incidents, risks and complaints. An example of this was learning from a significant incident at a London airport involving the East HART team in October 2016.
- Although learning from incidents related to the EPRR was taking place, learning from incidents in other services was not so well developed. Responses from staff about examples were variable.
- The trust had an effective debrief system following external incidents and events. All staff involved in EPRR incidents including control room and support staff were involved in debriefs. An example was an incident where a tram became derailed in south London in November 2016. Multiple agencies were involved and at the time of the inspection a full inter-service review was in progress. In February 2016 LAS participated in Exercise Unified Response which was one of the largest multi-agency live play exercises ever undertaken in the UK and LAS was involved in the multi-agency debrief.

Mandatory training

- Since the inspection in May 2015 compliance with NARU training requirements for HARTs had improved. All HART staff had a dedicated week out for training every seventh week. The training was in line with National Training Standards with annual recertification for some procedures e.g. breathing apparatus. Additional training for HART staff in specialist functions included, chemical, biological radioactive or nuclear incidents (CBRN), rescue from height, rescue from water, mass casualty

Resilience planning

incidents and firearms and terrorist incidents. The majority of staff had completed their training; for example 86 staff against a target of 89 had completed Safe Working at Height.

- All staff in the Tactical Response Unit had completed training in Tactical Medicines Operations.
- We requested information about mandatory training provided for non-specialist staff but did not receive it.
- Core skills refresher (CSR) training was provided for all clinical staff and was a combination of both statutory and mandatory training. CSR included topics such as infection prevention and control, safeguarding and adult and paediatric resuscitation basic life support and dates and locations for training were incorporated into the calendar year. For 2015/16, 93% Safeguarding of clinical staff had attended safeguarding training and Prevent and 92% had attending infection prevention and control. This was against a trust target of 75%.

Safeguarding

- The trust had an Adult Safeguarding Policy due for review in May 2018 and a Safeguarding Children and Young People Policy due to be reviewed in February 2017 along with a safeguarding lead who was trained to level 4. The chief quality officer was the accountable executive director lead for safeguarding.
- The trust had recently changed from making safeguarding referrals via fax to using the same IT systems as used to report incidents. Concerns of actual or potential abuse could be telephoned in to the emergency bed service between 8am and 8pm for adults and 24.7 for children.
- Staff we spoke with at both sites carried a pocket guide on safeguarding and all knew how to report a safeguarding concern and seek advice.
- There was a good uptake of safeguarding training.

Cleanliness, infection control and hygiene

- The two locations we visited were visible clean. Each location was cleaned daily and we saw signed cleaning schedules. The cleaning score for HART West was 100% in January 2017. For HART East the score was 97%.
- Hand gel was available at key points throughout the buildings and paramedics carried their own hand gel, which we observed.

- Waste was segregated correctly into domestic and clinical waste, and followed professional guidance.
- Vehicles we inspected were clean and staff took responsibility to ensure their vehicle was clean. We observed staff cleaning their vehicles.
- Chemical, biological, radioactive and nuclear (CBRN) waste procedures were in place, adhered to and followed national guidance.
- Compliance with infection prevention and control training was low at 22% for level 1 with 74 staff still to complete.

Environment and equipment

- Both HART locations were accessible by road and on industrial estates. The previous inspection had highlighted some non-compliance with the NARU specifications related to security.
- Following the 2015 inspection NARU carried out a review of the estate at both HART sites.
- There were three areas of non-compliance; a lack of a secure perimeter fence and gated vehicular access (HART East), a specified two-bar pressure water supply with the appropriate coupling and protection for HART areas and equipment which could be accessed by the majority of LAS employees. In response to the review the trust undertook a series of improvements including enhanced CCTVs at both sites, adding a number of door swipe card locks to secure the HART areas (only operation and only designated staff had access), and securing permission from the Local Authority to utilise the fire hydrants at the sites as an alternative solution to the water supply requirement. The actions were reviewed in November 2016 by NARU to confirm that security has been increased at both sites to mitigate the main areas of non-compliance with the specification. They were happy to provide derogation to LAS for the three principle areas of non-compliance providing the additional security was maintained.
- Office premises were secure with front doors locked. Office doors had key pad locks. At HART West there was an open corridor to the mess room, and the training room and lecture room were on the first floor. At HART East the mess was downstairs along with the training rooms.

Resilience planning

- Office premises were visibly clean and tidy with computers switched to screensaver when not in use.
- LAS had three sets of vehicles; two sets required by the HART teams and a third national resilience set. Each set of vehicles consisted of the following; three (of each) primary and secondary response vehicles, two personnel carriers, one staff welfare vehicle and one for incident technology. Incident command vehicles contained briefing screens, laptop positions and video and phone conferencing.
- New HART vehicles were on order and the trust was using hired vehicles that could accommodate the specific HART equipment. The permanent vehicles were due to be received by the trust in May 2017. In May 2017 the vehicles had arrived in the country but due to the required importation and inspection requirements had not yet been delivered to the trust. A second set of HART vehicles have been procured and are due to be delivered at the end of 2017.
- Specialist equipment was in line with NARU specifications and purchased through the NARU central procurement facility.
- Breathing apparatus was stored in a specific room along with log books where checks were documented. We saw that regular checks had been completed.
- Vehicles contained on the vehicles included Equipment included, defibrillators, suction machines, oxygen cylinders, personal protective equipment (PPE), and we saw these had been checked.
- Marauding Terrorist and Firearms Attack staff had ballistic armour that met national specifications.
- Both locations had disabled facilities, separate showers, changing rooms and a Physical Competency Assessment (PCA) room which was well equipped. Staff said it was “well used” before and after shifts and there was a Lone user policy for the PCA room.
- Medicines and controlled drugs were stored in a secure cage in the vehicle garage.
- We checked the medicines and controlled drugs stock in the HART cabinets against registers and checked the date and quantity of a random selection of items. We found that drugs were properly accounted for and had not exceeded their expiry date. We saw drugs were stored securely while in transit.
- Fridges were used solely for storage of the team’s personal annual flu vaccines. Temperatures recorded and within range on chart seen.
- Staff demonstrated an understanding of the procedures for receipt, administration and disposal of drugs.
- Medicines management audits for January 2017 showed good overall compliance. HART West achieved 100% compliance for all standards except for daily audits of controlled drugs books which was 86% and availability of spare sealed paramedic drug use bags. For HART East it was just one standard below 100% availability of spare sealed paramedic drug bags.

Records

- At the time of our inspection, the trust used paper records to record patient care. Patient records were sent to team leaders for logging and auditing which we observed taking place.

Assessing and responding to patient risk

- At the time of the inspection, HART staff were either paramedics or working towards their paramedic qualification. They followed trust policies and procedures regarding patient care, observation and escalation. In addition, the team attended specialist training in dealing with hazardous environments including chemical, biological radioactive and nuclear (CBRN) incidents, water rescues, enclosed space rescues (including using breathing apparatus) and mass casualty incident training.
- Staff on scene were able to escalate incidents, which required additional resources by alerting control room staff. Serious incidents were passed to the Emergency Operations Centre where they could be reviewed by senior staff. Advance notification to receiving hospitals, additional resources and further escalation to senior managers was completed from the Emergency Operations Centre.

Medicines

- Following the inspection in 2015 improvements had been made to the safety and management of medicines.
- The trust had a medicines policy which staff could access via the intranet.

Resilience planning

- Paramedics on the tactical response unit worked as part of multi-agency teams to respond to firearms incidents and received specific training to undertake their role.
- All paramedics in EPRR were able to seek advice including medical advice, from the Clinical Support Desk within the control rooms including requesting additional resources. Information could be exchanged via radio, telephone or electronically.
- We were given examples of the how trust worked with other agencies, police and fire brigade, to manage major events such as the Notting Hill Carnival and how this had been enhanced with developments in IT.

Staffing

- Following the last inspection the trust increased its HART staffing establishment to meet NARU specifications. The trust currently has 6 staff in the HART over and above the 84 operatives previously required as part of the national specification. Two further staff were due to commence in June with one being already trained and ready for deployment.
- The trust formally reported HART staffing on a shift by shift basis to NARU. Where staffing fell below required levels mutual aid arrangements with the South East Coast Ambulance Service NHS Trust (SECAMB) HART would be activated, where SECAMB would deploy the HART based at Gatwick Airport to provide a response for London Heathrow Airport. At the time of the inspection this mutual aid plan had not been triggered.
- HART staff were supported by an operations officer in each location and clinical team leaders.
- The HART dashboard for December 2016 showed there were three day shifts in December when there were less than six staff in both teams (98% of shifts were covered). For night shifts there were four occasions in HART East when there was less than six staff and two occasions in HART West. At the time of the inspection 99% of HART shifts were covered which was a significant improvement since the inspection in 2015 when only 24% were covered.
- There were 12 emergency medical technicians (EMT) in HART across both locations. A number of EMT were undergoing additional training via differing routes, leading to a paramedic qualification. They were not being used as paramedics.

- There were nine emergency planning and resilience officers.
- There were 15 vacancies in the Tactical Response Team and in December 2016 there were five occasions when there was less than 10 staff (MTFA core standard) on duty.

The trust was in the process of implementing its new meal break policy and staff had mixed views about the outcome.

Anticipated resource and capacity risks

- The Director of Operations oversaw the trust's emergency preparedness efforts including the business continuity management programme.
- The trust incident response plan was rated amber and more work was needed to align it with other trust policies. The scheduled date for completion is August 2017.
- We saw evidence that the trust maintained local risk assessments in line with Standard 31, Appendix 3 of the NHS Service Specification 2015/16: Hazardous Area Response Teams (HART) to maintain local risk assessments.

Is resilience planning services effective?

Good



We rated effective as good because:

- There had been a significant improvement in compliance with national standards for HART, CBRN and MTFA.
- Response to incidents was informed by best practice and staff followed national clinical guidance.
- Response times from HART locations to incidents at locations of interest met national standards.
- Staff competencies were maintained and tested in accordance with NARU recommendations.
- There was effective co-ordination with other emergency organisations and staff engaged in joint planning and exercises.

However:

Resilience planning

- There was a lack of awareness among other ambulance staff of the role of some of the teams in the EPRR.

Evidence-based care and treatment

- The trust had an up to date EPRR framework.
- The trust's self-assessment of compliance with the NHS England Core Standards 2015/16 found they were fully compliant in most areas and had improved on the previous year's return. Information provided by NHS England showed the Review Team agreed with the assessment. The trust was fully compliant with the MTFA, CBRN core standards and HAZMAT CBRN equipment check.
- For the HART core standards, they were compliant in all areas except vehicles, which were on order and due to be delivered in May 2017, and security which was actioned following the assessment. Areas where further work was required included incident response plans being aligned with other plans and completion of the business impact assessment and business continuity plan. These were rated amber, which indicated progress since the last assessment.
- LAS had developed a set of Incident Response Action Cards. The cards were based on national best practice from NHS England, National Ambulance Resilience Unit (NARU) and the Joint Emergency Services Interoperability Programme (JESIP). For example, the acronym METHANE is used throughout LAS. METHANE was introduced by JESIP and established a common basis for the exchange of information between and within organisations.

M-ajor incident declared

E-xact location

T-ype of incident: for example, explosion, fire in tall building, CBRN etcetera.

H-azards present and potential

A-ccess routes known to be safe

N-umber, type, severity of casualties

E-mergency services now present and those required.

- All paramedics had access to the Joint Royal College of Ambulance Liaison clinical practice guidelines and kept a pocket sized version with them.

Assessment and planning of care

- Working in line with NARU training, specifications and equipment meant LAS had effective procedures in place to respond to events and incidents.
- LAS had a range of vehicles and equipment which enabled it to respond and support events and incidents. Mass casualty equipment vehicles carried enough equipment to treat 100 seriously injured patients. Equipment support vehicles enabled speedy delivery of equipment and supplies. Command support vehicles provided the ability to deploy a team from Control Services to act as liaison between the Emergency Operating Centre and the manager on scene.
- The Emergency Bed Service (EBS), which was operational 24/7, kept hospitals and health organisations informed during major incidents. Information about the number of casualties and type of injury was relayed to hospitals and specialist units. This assisted in getting patients to the most appropriate hospital for treatment. Decisions about where patients should be admitted were made by the specialist operations centre co-ordinating the incident.
- The EBS also provided information about the availability of beds in mental health units and intensive care unit.
- The Tactical Response Unit worked in teams alongside armed police and London Fire Brigade. This enabled casualties to be located and receive immediate lifesaving treatment.
- Paramedics in the Joint Response Unit (JRU) provided assessment and support to patients involved in police generated events in 12 London boroughs.
- Paramedics in the HART teams, Tactical Response Units and Joint Response Unit responded to core service calls. This enabled them to maintain their core clinical skills.
- The Emergency Planning Resilience Planning Officers carried out emergency planning work to respond to specific locations, stadium, airports and railway hubs, as well as generic incidents.

Response times

- NHS HART Interoperability standard eight specifies that four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call

Resilience planning

be being accepted by the provider. We were shown computer records which showed that response times had been met in respect of all incidents classified as a HART response. To ensure LAS was able to meet this standard, while it was recruiting paramedics, it had a mutual aid agreement with SECAMB.

- The HART and Tactical Response Unit supported core service calls; it did not transfer patients to hospital but provided an initial response. If an incident requiring HART response was called, the crews assisting the core service would then be released to respond to the HART incident.
- Interoperability standard 11 required HART staff to be on scene within 45 minutes at strategic sites of interest. For security reasons LAS were not able to provide us with details of specific locations. The original modelling for HART considered the running times to these locations and informed where HART would be located. Response times from HART locations to real incidents at locations of interests were within 45 minutes.
- The locations for the HART teams meant they were able to achieve this.
- The JRU was introduced four years ago in response to the Metropolitan Police Service experiencing long waiting times for the crews to attend. Information provided by the trust showed there had been a decrease in the waiting times since it was introduced.

Patient outcomes

- Patient outcomes were not directly monitored by HART managers or the Tactical Response Unit. These teams responded to incidents where their additional training and equipment enabled them to reach patients and provide an initial service. Once patients had been made safe or removed from the hazardous area, core service staff transported them to hospital. Patient outcomes were reviewed as part of a major incident debrief and identified areas, which went well, and what could be done differently or better.
- Outcomes for the JRU were assessed in terms of the number of patients conveyed to hospital. Information was collected by borough and compared with non JRU conveyance.

Competent staff

- Each location had a dedicated HART trainer and there was a trust wide CBRN trainer and a training officer for emerging threats.
- All operational staff on the HARTs were qualified paramedics and maintained their accreditation which was in line with NARU best practice. In addition, training programmes were designed to meet the NARU national training standards and fitness levels, this included team leaders and managers.
- Strategic command courses are aimed at staff that are required to undertake the role of the Trust Strategic (GOLD) Commander. Within the EPRR the Assistant Director of Operations for Resilience was the only member of staff required to complete the course which he had done. The Head of Resilience and Special Operations has also attended the Multi Agency Gold Incident Command (MAGIC) training programme.
- The emergency planning and response officers (EPROs) and HART & CBRN team provided an advisory role at all command levels (on LAS policies/procedures/incident management). They had undertaken an internal training course and a period of mentoring and consolidation to operate in an advisory role and completed the nationally recognised National Inter-Agency Liaison Officer (NILO) course. The EPRR advisor roles were provided by: 11 EPRO/Advisors who have all completed the NILO and internal training programme and five HART and one CBRN Support Officer.
- The Joint Emergency Services Interoperability Programme (JESIP) was established in 2012 to address the recommendations and findings from a number of major incident reports and was supported in 2013 with the release of the 'Joint Doctrine Interoperability Framework'. JESIP training has been implemented by LAS and approximately 278 Operational and Tactical Commanders have received the JESIP training programme appropriate to their role which was in line with the guidance. Refresher programmes were available through e-learning. Following a review of the JESIP programme in 2015, the trust embedded the JESIP principles into the EPRR section of the vocational induction programme for operational staff, which includes a JESIP familiarisation presentation.

Resilience planning

- Staff had on-going Physical Competence Assessments (PCA) in line with Standard 25, (Appendix three of the NHS Service Specification 2015/16HART). Completion of assessments had improved significantly since the inspection in 2015, when we found staff hadn't undertaken it for two years. At the time of this inspection all staff were up to date with this training. Staff returning to work after a break had a competency assessment and HART staff were assessed every six months
- TRU staff had training days every five weeks, which included some training in multi-agency exercises, also specific training at the.
- Appraisal uptake in the EPRR department had improved and was 88.5% at the time of the inspection. All of the paramedics in the TRU had an appraisal and nine HART paramedics remained outstanding. In the January 2017 staff survey 97% of HART paramedics reported .They had training, learning or development in the last 12 months compared with 75% across the organisation.
- In the report of the 2015 inspection we reported that whilst in the past, HART staff were required to intubate patients, the trust had now removed this expectation from their roles. This was raised again, following the inspection, as an issue by some HART staff. They feel this should be part of their roles.
- Staff told us they had regular team meetings monthly and felt supported by their immediate line managers.

Co-ordination with other providers

- LAS was able to provide evidence of where they had provided mutual aid (in line with the UK Ambulance Services National Memorandum of Understanding Concerning the Provision of Mutual Aid). Examples included an incident at City Airport in October 2016 and the Croydon tram major incident in November 2016.
- They also supported major public events including the London Marathon and local large events at licensed stadiums.
- The incident command suite had a live view of Transport for London, to identify any transport issues.
- Each of the emergency planning resilience officers were members of one of the six London local resilience forums (LRFs). risk assessment, plan-making, business continuity arrangements and warning and informing procedures. There were also daily one to one phone

calls and emails. During our meeting three alert calls came through and we were also provided with notes of meetings to verify the communications. We found good working relationship with all London local authorities.

- Joint training exercises, for HARTs and TRU, took place with specialists from the fire brigade and police service. During the inspection we attended an exercise involving the TRU, police and fire brigade in east London, armed police making safe a building following a marauding terrorist fire arms (MTFA) incident.
- Information provided by the trust showed that in February 2016 LAS participated in an Exercise Unified Response which was one of the largest multi-agency live play exercises ever undertaken in the UK and ran over four days from 29 February – 3 March 2016. It was designed to test London's response to a large scale emergency and involved 4,000 responders and 2,500 casualty volunteers.
- LAS provided up to 12 JRUs on Thursday, Friday, and Saturday nights between 6pm and 4am. They were the priority response to requests from the police for the LAS and the types of calls they attend include assaults, stab/shot wounds and road traffic accidents.
- HART staff had attended NARU run multi agency strategic CBRN command courses.
- The EPRR provided Special Operations Resilience Training (SORT) to local NHS trusts. The training included CBRN, HazMat, roles, clinical signs and interventions and roles.

Multidisciplinary working

- This was an area that the trust was working to improve internally. There was a lack of awareness among other crews about the work of some teams in EPRR, in particular the HART team. Actions to improve this included information about their work on induction programmes and HART teams being released to support core service crews. The additional paramedics being recruited to HART would support some of this happening.
- During major incidents EPRR staff worked closely with EOC, core service crews and paramedics on the scene.
- Within EPRR there was good multidisciplinary working across the different teams. EPRR staff had access to clinical advice from the Medical Response Incident

Resilience planning

Team (MERIT) which provided per-hospital expertise at a range of emergency incidents. At the time of the inspection there was one trauma doctor and paramedic and the trust was in the process of recruiting more medical staff. Staff told us they received advice as needed. Staff told us there was more cross service training, for example new entrants were made CBRN aware; (CBRN being deliberate contamination whereas HAZMAT is accidental), and Incident Response officers were being offered training on some NARU courses, as well as attending multi agency courses. Staff told us there was more cross service training, for example new entrants were made CBRN aware; (CBRN being deliberate contamination whereas HAZMAT is accidental), and Incident Response officers were being offered training on some NARU courses, as well as attending multi agency courses.

Access to information

- Staff described a number of bulletins, EPRR News, that they received and were displayed on the staff notice board and/or discussed at team meetings.
- Policy guidance documents and other clinical guidance were accessible via the intranet and they had their pocket size JRCALC clinical guidelines.
- Staff also had their own email accounts which could be used to circulate information to teams or individual correspondence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of their responsibilities in relation to consent and the Mental Capacity Act 2005.
- Given the nature of the work of the HART/TRU teams this meant they had to make decisions in patient's best interests in line with their training. These decisions were recorded on the patient report form.
- In January 2017 many staff, 87%, in EPRR had completed capacity and consent training which was classed as essential training.
- In January 2016 LAS had introduced a Mental Capacity Aide-Memoire for staff.

Is resilience planning services caring?

Not sufficient evidence to rate

We were unable to rate caring as the opportunity to observe interactions between staff and members of the public did not arise during the inspection. However, the trust was able to provide us with feedback from incidents that EPRR staff had attended.

- Thank you letters described the paramedics as 'kind' and 'absolute stars' and praised them for their professionalism and calm approach.
- A relative wrote about the care her father had received and said the paramedics had '...shown the utmost respect for a London resident'. Another relative appreciated the consideration shown her while paramedics were treating her husband, keeping him comfortable and 'attending to his every need'.
- A person who had a cardiac arrest wrote to thank paramedics for 'saving their life'
- A member of the public contacted LAS to thank the paramedic who responded to a call from a passer-by who thought he had collapsed when he was trying to change a tyre on his car.
- One person commented on the information provided by paramedics about their condition and recommendations about managing their condition.

We were also giving copies of feedback from external agencies regarding interaction with the HART teams and senior officers which were all complimentary and described the 'professionalism' of the staff.

Is resilience planning services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as good because:

- Improvements since the last inspection meant that the EPRR was able to respond more effectively to severe or catastrophic disruptions to normal activities in the community.

Resilience planning

- HARTs were meeting national response times.
- Services were developed to meet the needs of the local population.
- Complaints were investigated and learning identified and shared with relevant staff.

However:

- Attendance at Equality, Diversity and Human Rights training was low.

Service planning and delivery to meet the needs of local people

- The EPRR had protocols, guidance and resources in place ensure it was able to respond to severe or catastrophic events in London. This included Joint Emergency Services Interoperability Programme (JESIP) protocols and an agreed Operational Order for Planned Mutual Aid with South East Coast Ambulance service (SECamb). The order was dated December 2015 and included clear criteria for when SECamb HART would provide support to LAS. The order including a risk assessment and controls. This meant LAS met Standard 31, Appendix three of the NHS Service Specification 2015/16.
- LAS had a range of vehicles and equipment, which met NARU specifications. Other equipment and vehicles at the HART locations and headquarters had the capability to respond to large scale or major incidents, suspected terrorist attacks, trains stuck in tunnels, explosions and fire.
- General information cards colour coded for each type of incident were carried by all emergency response staff. If they were unsure of their personal role, reference to the cards would highlight what was required of them to assist the public in the current situation.
- The JRU provided safe, effective on - scene treatment to people and in some instances reduce the need for an ambulance or for a person to be transferred to hospital.
- TRU crew were released to support core service crew daily along with JRU crew. Once recruitment to HART was completed the intention was that the additional paramedics would be released to support core service crews each day except in the event of sickness or annual leave.

- Emergency planning resilience officers and senior managers within LAS attended Local Resilience Forums, regional exercises and event planning meetings. We were provided with evidence of attendance at the

Meeting people's individual needs

- Translation services were available via phone.
- National Ambulance Service Medical Directors group has been working to produce a national dementia strategy for ambulance services and LAS have been part of the group working on production of this strategy. Once the national document has been approved and gone through the appropriate governance systems the trust intended to produce local action plans.
- Statutory training included Equality, Diversity and Human Rights completion of which was low at 6.45%.

Access and flow

- HART staff and vehicles and mass casualty equipment vehicles were not used for patient transport, which meant that hospital turnaround times, or issues in the wider healthcare economy did not affect them.
- Records showed that when dispatched to an incident within Home Office Model Response Strategy guidelines, the team had always met the required response times of 15 and 45 minutes. The Home Office Model Response Strategy identifies locations where HART response times must be met.
- Information showed that following the introduction of the JRU Metropolitan Police Waiting had decreased.

Learning from complaints and concerns

- LAS had a Complaints and Feedback Policy and Procedure updated in April 2015.
- During the inspection we reviewed three out of four complaints for the EPRR department. These were mainly about staff attitude. In all cases, we saw a detailed process had been followed from start to finish. This included investigation and feedback to the relevant member of staff, such as required learning and development. The complainant was provided with a detailed letter of apology.
- Staff were given a leaflet about the complaints process at their induction.

Is resilience planning services well-led?

Resilience planning

Good



We rated well-led as good because:

- Significant improvements had been made in EPRR and the service was now compliant with national standards.
- The EPRR had a framework which reflected national guidance.
- Management and recording of risks had improved.
- Staff told us managers were visible and approachable.

However:

- Despite improvements in communication some staff felt they were not listened to and their concerns were not acted on.
- Further work was needed on the business continuity plan.

Vision and strategy for this service

- In June 2016 the trust launched its new vision of 'Making the LAS Great' and its values; Care, Clinical Excellence and Commitment.
- The trust had a framework for the EPRR department dated November 2016. The framework took account of the Civil Contingencies Act, National Ambulance Resilience Unit and Joint Emergency Services Interoperability Programme guidelines. It made reference to the resilience arrangements being mutually compatible with other resilience arrangements within the wider health economy.
- Since the last inspection there has been significant investment in EPRR, particularly in the HART in terms of the numbers of staff and equipment.

Governance, risk management and quality measurement

- Within EPRR the governance stem had improved since the last inspection. The governance structure covered the different functions of the department. Governance, risk and quality were reported to the trust board through various sub committees, EPRR Development Group, Operations Delivery Board and Risk Compliance and Assurance Group.

- The trust had a major incident plan to ensure it 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. However, the plan needed to be aligned with other trust policies.
- The EPRR risk register had improved; it was more robust and reflected the risks the department may have to deal with such as responding to major incidents and MTFAs. Specific risks included inadequate equipment or staff to respond to an MTFA and insufficient capacity in the HART. The register included the degree of risk, mitigating actions and named person responsible and review dates.
- Systems for reporting to NARU and NHS England about the HART capacity had improved; formal arrangements were in place to report staffing on a shift by shift basis to NARU.
- Guidance had been developed for the exceptional circumstances when the HART may be deployed to support normal operations for the executive and senior managers involved in those decisions.
- At a local level information was shared with staff at team meetings held with their team leader or manager.
- The trust had more work to do in relation to developing a comprehensive business continuity plan which encompassed all aspects of service delivery including control services demand management systems and rolling out the business impact assessment procedure to all part of the service. It was estimated this would be completed within 12-24 months.
- The trust used PROCLUS, a software tool, which enabled HART staff to input live information about incidents and actions. The system enabled managers to review information and assess response. Reports were generated and used for training purposes. It was used for reporting incidents and training by HART. Some staff told us the system was slow to access at HART West.

Resilience planning

Leadership of service

- The teams within the EPRR reported to the Assistant Director of Operations who was supported by the Head of CBRN and HART and the Head of Resilience and Special Operations. Two HART Operations Officers covered the east and west teams.
- Many of the senior staff and paramedics in EPRR had worked for LAS for a significant number of years.
- Staff were clear about their role within EPRR and the management structure. They told us about some of the changes since the inspection in 2015 and that their managers were open and approachable. They confirmed they had regular team meetings.
- In the 2016 NHS Staff Survey the top five ranking scores for the trust were in good communication between senior managers and staff, opportunities for flexible working, equal opportunities for career progression and fairness and effectiveness of systems for reporting incidents. The trust scored better than the national 2016 average for ambulance trusts.
- The response rate for HART and CBRN staff was 40% compared with 42.2% for the trust. They scored better than the rest of the trust in some questions including having a set of shared objectives, support from manager in a personal crisis, regular to discuss the team's effectiveness and training development. They scored worse than the rest of the trust in questions about the effectiveness of communication between senior managers and staff, senior managers acting on feedback and recommending the organisation as a place to work.

Culture

- Since the last inspection much progress had been made to improve the culture and morale across LAS.
- Staff within the EPRR department acknowledged the changes including improved communications with staff through forums and newsletters. Staff in all teams told us their managers at all levels were approachable and supportive.

- In the January 2017 staff survey 85% of HART staff said their team had a set of shared objectives compared with 62% of staff across the organisation. In the same survey 92% of HART paramedics reported they communicated closely with each other to achieve the team's objectives
- We found morale was good among many staff across all teams in the EPRR and they 'loved their job' and had worked for LAS for a long time. They were all motivated and keen to deliver a quality service. However, while recognising the improvements some HART staff still felt that they were not always listened to. They raised concerns about travelling time to training venues and the lack of visibility of senior managers until prior to the inspection along with a lack of understanding among other staff about their role. The trust was in the process of taking some action to improve understanding of the HART among other staff by including information at induction and updates. In the January 2017 staff survey, 11% of HART paramedics reported that senior managers acted on staff feedback compared with 23% across LAS.

Public and staff engagement

- Staff were aware of the forums that had been held across the service by senior managers/executive team and some had attended.

Innovation, improvement and sustainability

- During 2016 the EPRR participated in the largest live play exercise undertaken in the European Union. The scenario was based on a building collapse in a central London mainline station and involved 2,500 casualties. The exercise enabled the testing of both the command and response of the LAS major incident plan over a protracted period of time with casualty numbers never previously experienced. In collaboration with NHS England it allowed the wider NHS systems to assess specialist networks and patient flow arrangements.
- The Joint Response Units were aimed at managing demand for both the ambulance and police services within London through the availability of dedicated ambulance response staff for the Metropolitan and City of London Police. This initiative is now being rolled out across other parts of England.

Outstanding practice and areas for improvement

Outstanding practice

- Frontline staff were caring, compassionate, and kind. Patient care was at the centre of their role.
- Staff were understanding of patient needs and treated them with dignity and respect.
- Patients told us staff went out of their way to ensure they were well looked after and always involved them in their treatment of care.
- We saw staff spending time with patients to allay their fears and anxieties. They found a common ground with all their patients to make them feel comfortable and reassured.
- Staff treated patients equally regardless of their circumstances and were non-judgmental. They treated patients in difficult environments in a calm professional manner.
- The London Ambulance Service was the first ambulance service to “spotlight on maternity” and had taken the following actions. They currently have joint maternity education in progress with midwives across the capital. They have established a maternity risk summit, which meets every six weeks and has a focus on maternity safety, which identified the following themes: recognising deterioration in pregnancy, management of preterm delivery and managing temperature in newborns.

Areas for improvement

Action the hospital **MUST** take to improve

- We have issued the provider with a requirement to improve staff uptake of mandatory safety training subjects. The recording of such training must be more efficient and subject to scrutiny.

Action the hospital **SHOULD** take to improve

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

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The uptake of mandatory safety training subjects, including safeguarding vulnerable people and infection prevention and control was not meeting the trusts own targets. The recording of such training was not efficient, and was not subject to scrutiny. Regulation 12.—(1) Care and treatment must be provided in a safe way for service users. Part (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely